Migration motherhood and maternity care in Thailand: An ethnographic study of the experiences and practices of Burmese women and maternity staff

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Dedication

I would like to dedicate this thesis to all the Burmese women and health staff who participated in this research: in particular, the 10 Burmese women who shared their personal stories and experiences of motherhood and of accessing Thai maternity services during and after their pregnancies. It is very humbling to know that the women and Thai maternity services were willing to trust me and allowed me to observe them. I would also like to dedicate this thesis and its findings to all women migrants and refugees who have experienced difficult circumstances in their lives during or after pregnancy. I hope that this research can improve services for these women and encourage them to actively engage in health-promoting activities.
Acknowledgements of Scholarships Received During This Research

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I also received student research funds from the School of Nursing and Midwifery Scholarship, Western Sydney University (AUD 6,000) during this research.
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Statement of Authentication

I certify that the work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text, I hereby declare that I have not submitted this material, either in whole or in part, for a degree at this or any other institution.

I acknowledge that I have read and understood the University’s rules, requirements, procedures and policy with the rules, requirements, procedures and policy of the University.

Titaree Phanwichatkul
Outcomes of this Thesis

Refereed journals:


Published conference presentations:


Oral presentations:


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**Title:** Negotiating competing demands: Living and working conditions for Burmese women in southern Thailand


**Title:** Working together to provide antenatal care for migrant Burmese women: The perspectives of health professionals and bicultural health workers in southern Thailand


**Title:** Burmese women’s experience of maternity care in the south of Thailand: An ethnographic study

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**Title:** ‘Having more children creates a happy family’: Motherhood experiences of migrant Burmese women living in southern Thailand
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Ethics

This research was approved by the University of Western Sydney Human Research Ethics Committee on 4 May 2015 in a letter from Professor Elizabeth Deane, Presiding Member, Human Researcher Ethics Committee. The protocol number assigned to this research was H11099.
## List of Abbreviations

<table>
<thead>
<tr>
<th>Abbr</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>acquired immune deficiency syndrome</td>
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<tr>
<td>ANC</td>
<td>antenatal care</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of South East Asian Nations</td>
</tr>
<tr>
<td>CHW</td>
<td>community health worker</td>
</tr>
<tr>
<td>ECHO</td>
<td>protection department of the European Commission</td>
</tr>
<tr>
<td>GDM</td>
<td>gestational diabetes mellitus</td>
</tr>
<tr>
<td>HIC</td>
<td>high-income countries</td>
</tr>
<tr>
<td>HIV</td>
<td>human immunodeficiency virus</td>
</tr>
<tr>
<td>ID</td>
<td>identification</td>
</tr>
<tr>
<td>IOM</td>
<td>International Organisation for Migration</td>
</tr>
<tr>
<td>KRCEE</td>
<td>Karen Refugee Committed—Education Entity</td>
</tr>
<tr>
<td>LIC</td>
<td>low-income country</td>
</tr>
<tr>
<td>LMIC</td>
<td>low- and middle-income countries</td>
</tr>
<tr>
<td>MCH</td>
<td>maternal and child health</td>
</tr>
<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
</tr>
<tr>
<td>MHV</td>
<td>migrant health volunteer</td>
</tr>
<tr>
<td>MIC</td>
<td>middle-income countries</td>
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<tr>
<td>MHW</td>
<td>migrant health workers</td>
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<tr>
<td>MMR</td>
<td>maternal mortality ratio</td>
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<tr>
<td>MOUs</td>
<td>memorandums of understanding</td>
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<tr>
<td>NGO</td>
<td>non-government organisations</td>
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<tr>
<td>NV</td>
<td>nationality verification</td>
</tr>
<tr>
<td>PHC</td>
<td>primary health care</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Description</td>
</tr>
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<td>-------------</td>
<td>--------------------------------------------------</td>
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<tr>
<td>SEM</td>
<td>social–ecological model</td>
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<tr>
<td>SGA</td>
<td>small for gestational age</td>
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<tr>
<td>TB</td>
<td>tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>traditional birth attendant</td>
</tr>
<tr>
<td>TBBC</td>
<td>Thailand Burma Border Consortium</td>
</tr>
<tr>
<td>TBC</td>
<td>Thai Border Consortium</td>
</tr>
<tr>
<td>TMR</td>
<td>Thailand migration report</td>
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<tr>
<td>VHW</td>
<td>village health worker</td>
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<tr>
<td>VHV</td>
<td>village health volunteer</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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<td>ZOA</td>
<td>South East Asia (international NGO)</td>
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</table>
Abstract

**Background:** The transition to motherhood can be difficult. For some women, it can be a distressing time, especially those who do not have social support. Studies indicate migrant women demonstrate higher levels of distress and perinatal depression. Migrant women primarily attribute their feelings and experiences to separation from family and usual support systems, financial hardship, poor working conditions and difficulties in adapting to life in a new country where traditions and culture are different. Experiences can also be affected by less-than-optimal care and poor engagement with health services. Most research on migrant mothers has been conducted among those living in high-income countries, with few studies of women who begin their lives as mothers having migrated from a low-income country to another low-income country or middle-income country.

Recently, there has been a dramatic increase in the number of migrant workers coming from Burma to Thailand; over time, many become parents. However, little is known about their experience of motherhood and perceptions of maternity services. Understanding the experiences and challenges that Burmese women encounter when seeking maternity care in Thailand is important because receiving inadequate care is linked to increased rates of morbidity and mortality.

**Study aims:** This study aimed to explore Burmese migrant women’s perceptions of becoming a mother and their health care and support needs. It also aimed to examine their perceptions of maternity services, including access to and use of Burmese interpreters. The research also examined the
experiences of Burmese interpreters and Thai health professionals caring for Burmese migrant women. The social-ecological model is used as a framework to conceptualise the multiple factors influencing the experiences of Burmese women and to identify implications for service delivery.

**Methods:** Ethnography informed the study design. Between May and December 2015, data were gathered through individual interviews with three participant groups. These included 10 Burmese migrant women, four Burmese interpreters and nine Thai health professionals. Observations of the interactions among participants of the study occurred in two antenatal and postnatal settings in Ranong, southern Thailand. General observations of the activities and interactions in the clinics were also conducted in the villages of some participants. The data were analysed using thematic analysis.

**Results:** All women in this study who migrated to Thailand came for employment and all held legal status with a work permit. They lived in a tight Burmese community but their living and working conditions were difficult. Becoming a mother was important to them; however, they had to juggle work and care for young children. Most realised that once their child was school age, the children would be sent to Burma to live with relatives. The women valued Thai antenatal care, but they combined this with traditional practices, particularly cultural practices, that they believed would protect their baby in pregnancy and after birth. Due to poverty, many women could not afford a nutritious diet and were at risk of gestational diabetes and anaemia. The women were well supported by their families and social networks during pregnancy and following the birth of their babies.
Although Thai health professionals spoke positively about the Burmese women they cared for, they were also critical of certain cultural practices and became irritated when Burmese women did not follow their advice (e.g., taking iron and folate, and agreeing to sterilisation once they had two children). The theme ‘being processed’ captured the numerous barriers to accessing antenatal care while ‘being cared for’ provided insights into the care and support from professionals that women found helpful. The final results chapter examines the role and experiences of Burmese interpreters (lam in Thai) identifying their dual role as interpreter and healthcare worker. Key challenges included lack of clarity around role boundaries and low remuneration.

**Implications:** The findings contribute to a conceptual understanding of Burmese migrant mothers in their journey towards motherhood. Participants, including the interpreters, indicated that they required service providers to be culturally competent and compassionate. The findings could be used to guide Thai nurse-midwives and other health providers in providing care for migrant women. Health care provision in Thailand needs to be supplemented by an understanding and awareness of the needs of migrant women. This is particularly important to facilitate health services for migrant women, who are in unstable circumstances and have to balance their responsibilities as mothers and migrant workers.
Chapter 1: Introduction

1.1 Introduction

Motherhood is a significant part of many women’s lives. However, the transition to motherhood can be difficult and, for some women, a distressing time, especially if the woman is separated from her usual support network (Amoros, Callister & Sarkisyan, 2010; Etowa, 2012; Goodwin & Huppatz, 2010; Liamputtong, 2006; Liamputtong, Yimyam, Parisunyakul, Baosoung & Sansiriphun, 2004; Murray, Windsor, Parker & Tewfik, 2010; Tsai, Chen & Huang, 2011). Studies of migrant women, from various ethnic groups, now living in high-income countries (HIC) report a higher risk of health complications in pregnancy and childbirth, and a higher risk of maternal and infant death (Almeida, Caldas, Ayres-de-Campos, Salcedo-Barrientsos & Dias, 2013; Urquia, Berger & Ray, 2015). Following birth, a higher proportion of migrant women experience depressive symptoms (Falah-Hassani, Shiri, Vigod & Dennis, 2015; Fellmeth, Fazel & Plugge, 2017; Schmied, Black, Naidoo, Dahlen & Liamputtong, 2017). Experiences can also be affected by less-than-optimal care and poor engagement with maternity care facilities (Almeida et al., 2013; de Jong, Pavlova, Winters & Rechel, 2017; Downe, Finlayson, Tunçalp & Metin Gülmezoglu, 2016).

Most research on migrant mothers has been conducted among those living in HIC, with few studies of women who begin their lives as mothers having migrated from a low-income country (LIC) to another LIC or middle-income country. Recently, there has been a sharp increase in the number of workers migrating from Burma to Thailand; over time, many become parents. However, little is known about the motherhood experiences of these migrant women. Understanding the difficulties that Burmese women encounter when seeking maternity care in Thailand is important.
because receiving inadequate care is linked to increased rates of morbidity and mortality. This has necessitated an appropriate response from Thai health services, particularly those who provide services to women living in difficult circumstances. The purpose of this doctoral thesis is to explore Burmese migrant women’s perceptions of becoming a mother in Thailand and their health care and support needs during pregnancy, birth and postpartum, and to examine Burmese migrant women’s perceptions of Thai maternity services.

This chapter introduces the study briefly, outlines its context, aims and objectives, research questions and significance. A brief explanation of key terms and the Burma–Myanmar name change will be provided. This chapter will also include a brief discussion of the researcher’s background and interest in the study. The last section provides an overview of thesis chapters.

1.2 Context of the Study

Global international migration has steadily increased over the past two decades (Natali, McDougall, Tunon & Barber, 2014), primarily influenced by the need for a better quality of life, an escape from poverty, or refuge from violence, war and political persecution (Abel & Sander, 2014; Cheema, McNally & Popovski, 2011; Lori & Boyle, 2015). In Burma, over the past three decades, thousands of people have been displaced due to the conflict between ethnic political groups and the central government’s armed forces over control of the region’s resources (Oo & Kusakabe, 2010). Many Burmese have lived under terrifying conditions in these conflict zones, and in the case of Rohinya refugees, continue to do so (Beyrer & Kamarulzaman, 2017). The Internal Displacement Monitoring Centre (2009) reported that the number of people displaced in the rural areas of eastern Burma exceeds 451,000 people,
including 100,000 in Karen state alone, driven out by the intense military offensive against Karen ethnic insurgents (Oo & Kusakabe, 2010).

In Thailand, over approximately three decades, the *Thailand Migration Report* (TMR) from 2014, reported increasing numbers of migrants, especially from Burma. Currently, there are around three million Burmese migrant workers working in Thailand (Natali et al., 2014). According to the TMR (2014), there are 1,174,900 Burmese workers with work permits in Thailand, in both professional and low-skilled careers. The breakdown of Burmese workers by region is: southern (30 per cent), central (25 per cent), Bangkok region (20 per cent), Bangkok (13 per cent), northern (10 per cent) and north-eastern (two per cent) (Huguet, 2014). In the south of Thailand, there is a high proportion of Burmese migrant workers employed in lower-skilled and difficult jobs (Aung, Pongpanich & Robson, 2009; Fujita, Endo, Okamoto, Nakanishi & Yamada, 2010; Srivirojana, Punpuing, Robinson, Sciortino & Vapattanawong, 2014).

Burmese nationals who arrived as refugees (humanitarian migrants) or socio-economic migrants to Thailand often continue to experience difficulties related to living and working conditions, even in situations in which they are legal immigrants. In particular, many experience financial hardship, poor housing and have limited access to support services such as health care (Pearson & Kusakabe, 2012; Perry, Zulliger & Rogers, 2014). Further, there are reports of harassment by Thai police if Burmese nationals are unable to fund health or other services (Lwin et al., 2014; Pollock & Lin Aung, 2010). This situation presents Thai health services with a range of challenges related to ensuring service access (Chotiga, Crozier & Pfeil, 2010; Srivirojana et al., 2014).
Despite the poor working conditions experienced by many Burmese migrant workers, they are generally happy to be able to earn an income in Thailand. Many were forced to leave Burma due to lack of work and low wages (Pollock & Lin Aung, 2010; Srivirojana et al., 2014). Moving to Thailand to work and seek economic opportunities improves the lives of not only the workers, but also their family back in Burma (Oo & Kusakabe, 2010; Pearson & Kusakabe, 2012). Many workers send a considerable portion of their pay to their families in Burma, and endure hardships to earn a living and provide for their family (Pearson & Kusakabe, 2012; Satawedin, 2017).

Studies on migrants have identified gender differences in the migrant experience (Benza & Liamputtong, 2014; Higginbottom, Hadziabdic, Yohani & Paton, 2014; Noom & Vergara, 2014; Pearson & Kusakabe, 2012). Importantly, approximately 50 per cent of displaced people migrating from Burma to Thailand are women (Carden, 2014). Many migrant and refugee women are of child-bearing age and will have their first or subsequent children in a new country (Adanu & Johnson, 2009; Chotiga et al., 2010; Kusakabe & Pearson, 2010). This poses challenges in terms of pregnancy and infant care, fulfilling domestic responsibilities and responsibility for maternal, newborn and child health (Benza & Liamputtong, 2017; Madziva & Zontini, 2012; Tsao, Creedy & Gamble, 2015). Apart from fulfilling their mothering role, female migrants also experience a higher incidence of sexual and reproductive violence (Carden, 2014; Oo & Kusakabe, 2010), difficulties in social adaptation and culture shock, and homesickness (Noom & Vergara, 2014). Many migrant women must adapt to leaving their families and children behind after migration, while simultaneously caring for the children of wealthy families (Kusakabe & Pearson, 2014; Madziva & Zontini, 2012). This experience of transnational mothering is personally challenging and many women reported the necessity of developing resilience to
manage these difficulties (Naidu, 2013). Despite this, these women try to create better lives for themselves and their families, especially for their children (Denison, Varcoe & Browne, 2014; Kirmayer et al., 2011; Naidu, 2013).

A common vulnerability of female workers in host countries is the lack of a work permit or legal status as an immigrant worker. Many have temporary state permits with no job security (Benza & Liamputtong, 2017; Kusakabe & Pearson, 2014). When migrant women are pregnant and on maternity leave, they are not paid if they cannot work, which places further strain on the family. Employers often do not employ female pregnant workers because these workers are in a particularly weak position (Noom & Vergara, 2014; Pollock & Lin Aung, 2010). In this context, migrant women of reproductive age face continued discrimination and deprivation of income (Kusakabe & Pearson, 2010; Noom & Vergara, 2014). Employers favour those who can work for as long as the employer requires (Pearson & Kusakabe, 2012). This affects women’s autonomy and their capacity to contribute to the family income and quality of life. Some factors that lead to ill health in female migrant workers away from their homeland include discrimination, racism and reproductive health stressors (Noom & Vergara, 2014; Schmied et al., 2017). Studies on migrant mothers after birth have discovered an increase in the number of migrant women experiencing anxiety and depression that directly correlates to isolation from families and the debilitating effects of social adaptation in a new culture (Fellmeth et al., 2017; Schmied et al., 2017).

Further, migrant women are forced to make unhealthy food choices and lack access to quality health care (Satawedin, 2017). For instance, there is a higher number of migrant workers in Thailand facing ill health, such as those with human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS)
(Crozier, Chotiga & Pfeil, 2013), tuberculosis (TB), and those experiencing the effects of human trafficking, who are more likely to live in poor conditions and lack of autonomy over their own lives (Satawedin, 2017; Vittaporn & Boonmongkon, 2016). An ethnographic study of Thai health programs for Burmese migrants with TB (Vittaporn & Boonmongkon, 2016) reported that the health of Burmese migrant workers was affected by widespread discrimination. Following this, the Thai government’s concern about the spread of TB in this migrant community led to an increased focus on education and awareness of infectious disease (Vittaporn & Boonmongkon, 2016). In Tak province, in northern Thailand (along the Thailand–Burma border), many Burmese migrants have been identified as suffering from TB; these migrants needed to be treated to enhance TB control (Tschirhart, Thi, Swe, Nosten & Foster, 2017).

International research also indicates that women who are migrants, particularly displaced people such as asylum seekers and refugees, have less access to antenatal care than non-migrant women do (Heaman et al., 2013; Lin, Shieh & Wang, 2008). Even women who acknowledge their need for antenatal care often receive delayed access (Adhikari, 2010; Almeida et al., 2013; Crozier et al., 2013). Barriers to accessing antenatal care include socio-economic barriers such as low income and limited financial resources (Gurnah, Khoshnood, Bradley & Yuan, 2011; Panagiota, 2008), difficulty travelling to primary health care (PHC) clinics, a lack of knowledge about accessing health services (Correa-Velez & Ryan, 2012; Gagnon et al., 2010) and language barriers (Almeida et al., 2013; Heaman et al., 2013; Higginbottom et al., 2014; Panagiota, 2008; Reitmanova & Gustafson, 2008). Notably, migrant women experience difficulties obtaining high-quality health care due to conflicts with their
cultural beliefs, religion and traditional practices (Higginbottom et al., 2014; Stapleton, Murphy, Correa-Velez, Steel & Kildea, 2013).

Most studies cited have been conducted in HICs, where the health of migrant and refugee women, and the health services offered, differ from those in their homelands. However, very few studies have examined migrant women’s access to maternity services when they have moved from low- to middle-income countries (LMIC).

In LMIC, women undertake many socially and culturally accepted practices to ensure their health and babies’ wellbeing. Thus, some women decline antenatal care as they perceive it as unnecessary (Liampuntong, 2009; Phathammavong, Ali, Souksavat, Chounramany & Kuroiwa, 2010; Rijken et al., 2012). It is also likely that Burmese migrant workers whose jobs are casual and who will not be paid for time missed may avoid antenatal care (Lehane & Ditton, 2012; Srivirojana et al., 2014). These women have to deal with multiple demands of working and living in their host country and relying on their income to survive (Mon, 2010; Pollock & Lin Aung, 2010). This causes them to return to work soon after delivery, reducing the time they can spend with their infant and missing out on postnatal care (Canavati, Plugge, Suwanjatuporn, Sombatrungjaroen & Nosten, 2011; Kusakabe & Pearson, 2014).

Some health services in HICs have implemented strategies to improve access to health care for migrants and refugees (Correa-Velez & Ryan, 2012; Downe, Finlayson, Walsh & Lavender, 2009). However, many migrant and refugee women continue to experience social and emotional difficulties that prevent them from accessing available services, which negatively affects their health (Adanu & Johnson, 2009; Higginbottom et al., 2014; Lin et al., 2008). Understanding the access barriers to adequate and appropriate antenatal and postnatal care for migrant and refugee
women is important; inadequate care is linked to increased maternal and infant morbidity and mortality in both high- and middle-income countries (Downe et al., 2009).

1.3 Study Aim and Objectives

The study undertaken for this doctoral thesis aimed to explore Burmese migrant women’s perceptions of becoming a mother and their health care and support needs during pregnancy, birth and postpartum. It aimed to examine Burmese migrant women’s perceptions of maternity services, including access to and use of Burmese interpreters. Further, it examined the experiences of Burmese interpreters and Thai health workers caring for Burmese migrant women.

The study objectives are:

1. to examine Burmese migrant women’s perceptions of health and wellbeing during pregnancy, their health-promoting practices and their experiences with Thai antenatal services
2. to explore Burmese migrant women’s experiences of becoming a mother while living in Thailand and their perceptions of motherhood, family support and traditional postpartum practices
3. to identify the role and experiences of healthcare interpreters (lam) working in Thailand
4. to explore the perspectives of Thai health professionals and migrant Burmese women regarding the role of the Burmese interpreters
5. to describe the perceptions and practices of Thai health professionals providing maternity care for migrant Burmese women and women’s experiences of healthcare encounters in Thailand.
1.4 Research Questions

The study addressed six questions:

1. What are Burmese women’s perceptions and experiences of becoming a mother in the context of migration to Thailand or maintaining employment in Thailand?

2. What are Burmese women’s perceptions regarding their health care and support needs in pregnancy, birth and postpartum?

3. What hinders or facilitates Burmese women’s access to maternity care in Thailand?

4. What are Burmese women’s views about the quality of the care received and their experience of their interactions with the Thai maternity team?

5. What are the views of health professionals and Burmese interpreters regarding the needs of Burmese women and their experience of providing maternity care to this group of women?

6. What are the perceptions and practices of the Thai maternity team providing maternity care for Burmese women?

1.5 Significance of the Study

This study is significant for several reasons. Ranong province is located on the Thai–Burma border in southern Thailand and has the second-largest Burmese community in Thailand. It reports one of the highest numbers of both legal and undocumented Burmese workers living in the country. According to a survey of migrants in Ranong province, many lack the means to access medical care particularly because of language barriers and lack of knowledge about where to obtain information about health and other services. Although migrants have registered work permits with health insurance cards, they continue to face difficulties in accessing health care
services (Srivirojana et al., 2014; Voelkner, 2011). More recently, there has been an increase in the number of Burmese people who remain living in Burma but travel daily by boat to Ranong province for work (Srivirojana et al., 2014). Many of these women are undocumented workers. With these recent migration and employment patterns, there has been an increase in the number of Burmese women working in Ranong province who are pregnant, seeking Thai medical care and want to birth in a Thai hospital (Ratchaputi, 2015). According to the records from Ranong Hospital, 50 per cent of women who receive antenatal care, birth and postnatal care are Burmese (see Table 3.1). To meet the increasing demand from Burmese women for maternity services, Ranong province health services established a Burmese-specific antenatal clinic (the Pak-Klong Clinic) in 2011 in the hope of increasing attendance at antenatal services (Ratchaputi, 2015). Further, anecdotally, staff at both the Pak-Klong antenatal clinic and the Ranong Hospital antenatal and postnatal wards have expressed concern about the health of Burmese women during pregnancy and the challenges they may experience caring for their infant, as they need to return to work soon after birth.

Research in other areas of Thailand indicates that some Burmese women are hesitant to use healthcare services and there are recent reports of Burmese women using low-skilled attendants such as TBAs and informal practitioners (Belton & Whittaker, 2007). Some pregnant women receive inadequate antenatal care, as they believe pregnancy is normal and health care is not essential (Rijken et al., 2012; Wichaidit, Kaewkungwal, Sirivichayakul, Taechaboonsermsak & Suvithayasiri, 2011). In addition, some women resist attending as it requires time away from the workplace. This is because of the need to earn an income. Attending a health service on a workday can affect their livelihood (Kusakabe & Pearson, 2014). Female workers
are much more likely to have their employment terminated during an economic downturn than the male workers are (Pollock & Lin Aung, 2010).

Understanding Burmese women’s experiences of maternity care and becoming a mother will help to identify the service improvements needed in Thailand to enhance access to these services for this vulnerable group of women. This study will generate new knowledge about the experience of Burmese women seeking maternity care in Thailand at the Thai–Burma border and provide information for health professionals and services. This will benefit not only Burmese women living on the Thai–Burma border, but also other Burmese migrants living in non-borderland areas.

Finally, this study is important because almost all the English-language literature, reporting the experience of migrant women becoming mothers appears to be about those living in HICs. While there are numerous studies of how pregnancy, birth and motherhood are experienced by women living in low- and middle-income countries, few appear to focus on women who are economic or humanitarian migrants.

1.6 Terminology and Definitions

The following terms have been used widely throughout this document.

*Migrant:* The definition of this term varies. Migrant generally refers to ‘any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence’ (International Organisation for Migration [IOM], 2011). In this study, ‘migrant’ refers to people who have moved to seek work and earn money to improve their living conditions. Many migrants in this study send money to their families in Burma.

*Burmese migrants:* Most participants in this study came from the southern part of Myanmar, previously Burma. They described themselves as Burmese, and their
language was Burmese. They entered Thailand to work and send money to their families in Burma.

*Karen people*: These people are primarily from the north of Myanmar. They are culturally and linguistically diverse, but most are the original ethnic group living in Burma.

*Legal migrants*: This term refers to migrants who came to live in Thailand with registered documents to work and stay for the registered period.

*Illegal migrants*: These are migrants who came to live in Thailand without work permits or registration documents. Due to their status as unregistered migrants, they must conceal the fact that they work.

### 1.7 Name Change from Burma to Myanmar

In 1989, a name change was proposed for Burma. The military junta decided to rename Burma as Myanmar (the Union of Myanmar). In 2011, the country became the Republic of the Union of Myanmar. This name (the Republic of the Union of Myanmar) remains contested because many local governments in the country feel this name is insulting (Steinberg, 2013). This is because they believe that name changes must be democratically approved, and, partly because many people believe that Burma has taken on the form of an ethnocratic state, dominated by Burman culture and people (Seekins, 2017). Prior to 1989, the name Burma was used to indicate continuity of action for Burman, who were members of the majority ethnic Burmese group. The term ‘Burmese’ refers to people who are citizens of Burma, displaying the ethnicity and linguistic background of the country. In this study, the name Burma is used rather than the Union of Myanmar since the key informants referred to their ethnic group as Burmese. All Burmese participants who came from the ethnic majority group had lived in Burma and wanted to be known as Burmese. ‘Burmese’ refers to people who have
adopted the designation of all citizens of the country regarding ethnicity and linguistics (Steinberg, 2013). Thus, in this study, the name Burma is used rather than the Union of Myanmar to maintain consistency with participants’ descriptions.

1.8 Researcher’s Background

I am a Thai nurse and have worked in health care since 2002. In 2010, I worked in the postnatal ward of the hospital and became a nursing educator in maternity care. Since 2010, I have worked as a lecturer at Suratthani Rajabhat University in southern Thailand. My passion for quality maternity care inspired me to enrol in the PhD program and investigate the current status of maternity care in Thailand. I am also a woman and a mother of two daughters. The diverse role that I play as a researcher, a woman and a mother encouraged me to improve maternity care services for women and babies, health professionals, and develop services system supports for women, including migrant women. It is anticipated that the results of the study will help to optimise the health and wellbeing of women and their families.

The Burmese migrant women in this study participated in interviews with me. The experiences they shared influenced the way I conducted this research and enabled me to cope with challenges along the way. Being a nurse and a mother, I was able to empathise with the experiences of the Burmese women in this study. My reflections provide an insight into my experiences as a researcher as well as the women’s experiences, which will be explored more thoroughly in Chapter 3.

1.9 Outline of the Thesis

Chapter 1 has briefly introduced the study, providing background context, study aims and objectives, research questions, the significance of the study and a brief description of the methodology. Key terms have been defined and the Burma–
Myanmar name change has been explained. This chapter concluded with a brief discussion of the researcher’s background and interest in the study.

Chapter 2 provides a background to the study. The first part of this chapter describes Thai policies relating to migration and the provision of health care. The second part of this chapter provides an overview of relevant literature reporting migrant women’s experiences of motherhood, pregnancy and birth in general. Further, the child-bearing experiences of women living in South-East Asian countries is discussed.

Chapter 3 details the methodology underpinning the study design and methods used in the study. It briefly discusses the qualitative approach, social constructionism and ethnography, the methodology selected to inform the study design and the data collection methods. The chosen methods, which aligned well with the methodology, included interviews, observations in the community, and observations of women and health providers. The study setting is described, as are study participants, data collection and analysis, and translation and transcription of data. The chapter concludes with ethical considerations and reflexive thoughts on me as researcher and a mother, and the potential impact of this on data collection and analysis.

Chapter 4 is the first of four findings chapters. This chapter describes aspects of the daily lives of Burmese migrant women living and working in Thailand. I present the sociodemographic characteristics of the 10 women who were informants in this study, with the reasons they chose to migrate to work in Thailand. Then, I describe life for the women, primarily using field notes from observations in the community and interviews with women, Burmese interpreters (lam) and health professionals. I describe the living spaces, lifestyle and the working environments to illustrate their
potential impact on women’s health and wellbeing in pregnancy and during motherhood.

Chapter 5 draws primarily on the data from interviews with the 10 key informants, relating to their experiences and perceptions of becoming a mother in Thailand and their access to services.

Chapter 6 reports on the perspectives and experiences of Thai health professionals providing maternity care for Burmese migrant women. Next, the data from the Thai health professionals’ interviews is presented, as well the observations of the interactions between the health professionals and the women.

Chapter 7 reports on the findings on the role of Burmese lam and their accounts of supporting maternity care providers as interpreters.

Chapter 8 is further discusses the findings, while Chapter 9 presents an overview of the findings and discusses these in relation to the extant literature. The last section of this chapter focuses on implications for practice, which points to future directions in maternity care delivery. The strengths and limitations of the study, and recommendations for further research are provided.
Chapter 2: Study Background, Literature Review and Conceptual Framework

2.1 Introduction

This chapter provides the background to the study. First, I describe the study context and the reasons why many Burmese people are leaving their country and migrating to Thailand. Further, I provide an overview of Thailand, its population, migration polices, Thai worker registration system, Thai healthcare system and maternity services in Thailand. I then draw on peer-reviewed literature to describe what is known about the experiences of Burmese people who migrate from Burma to Thailand, both those who come as refugees and are living in the border camps and those who come as economic migrants seeking employment. In the second section of the chapter, I provide an overview of migrant women’s experience of motherhood in a new country, including a report on maternal health outcomes. I then draw on current literature to describe the experiences of migrant women seeking maternity care in their host country. Finally, the social–ecological model is introduced as a conceptual framework for this study and is used to summarise the diverse factors identified in the literature that may affect women’s lives as mothers, their health and that of their children and family. The social–ecological model will be discussed further in Chapter 9 to assist in the interpretation of findings.

2.2 Burma (Myanmar) and the Health of the Burmese People

Burma (Myanmar) is part of South-East Asia and has a population comprising over 100 ethnic groups; the population is about 54 million people (Worldometers, 2018). It is bordered by India and Bangladesh to its west, Thailand and Laos to its east,
China to its north and north-east, and the Bay of Bengal and the Andaman Sea to its south (see Figure 2.1). Burma (Myanmar) has a tropical climate but has been exposed to climate changes and many natural disasters: cyclones, storm surges, floods, landslides, earthquakes, droughts and forest fires (UN Office for the Coordination of Humanitarian Affairs, 2016). As explained in Chapter 1, Burma is now known as Myanmar, but in this thesis, the preference of the participants has been to identify as Burmese.

Figure 2.1. Map of Thailand–Myanmar (Burma) borders.

The Burmese people have experienced significant hardships for over three decades. The political unrest, armed conflict and the oppressive role of the Burmese military in the 1980s and 1990s and continuing ethnic conflict has meant that much of the population has inadequate food and housing, limited educational and employment opportunities and little or no access to health care (Holtz, 2016; Mon, 2010; Pollock & Lin Aung, 2010). Natural disasters such as drought and cyclone have also contributed to these challenges (Seekins, 2009). Presently there is low monetary and
social investment in Burma (Myanmar); this continues to affect employment, especially in remote regions of the country (Grundy, Annear, Ahmed & Biggs, 2014). Due to persecution and poor employment prospects, many Burmese people have been forced to leave their country to seek refuge and the hope of a better life in neighbouring countries such as Thailand (Holtz, 2016; Lehane & Ditton, 2012; Natali et al., 2014). Many fleeing the country, particularly those from persecuted minority groups, continue to be subject to human rights abuses and human trafficking (Latt et al., 2016).

The health of the Burmese people is among the worst in South-East Asia (Grundy et al., 2014; Zaw, Htoo, Pham & Eggleston, 2015). According to the World Health Organization (WHO), in 2013, Burma (Myanmar) was one of the world’s 22 high-disease burden countries, with 525 cases of TB per 100,000 people (WHO, 2013). Hospital data from Burma (Myanmar) attribute 22 per cent of deaths to infectious and parasitic diseases, 17.1 per cent to circulatory diseases, 11 per cent to injury, poisoning and other external causes, 8.6 per cent to respiratory diseases and 7.7 per cent to digestive diseases (Latt et al., 2016). The highest mortality rates in Burma (Myanmar), particularly from TB and malaria, are reported among displaced people, such as ethnic Karen, Karenni and Mon (Richards et al., 2009). These communities have little access to treatment and there is widespread drug resistance (Holtz, 2016; Latt et al., 2016; Richards et al., 2009). In addition to the communicable diseases, the Burmese population experiences health problems related to inadequate nutrition, prevalent tobacco use and poor mental health (Parmar et al., 2015; Sayburn, 2015). Some of these non-communicable health problems are also linked to environmental issues, including climate change, which affects food availability (Latt et al., 2016). Burmese refugees living in border camps have particularly elevated levels of mental illness (Cohen & Asgary, 2016). Cardozo et al. (2004) found that among Karenni refugees in
the Mae Hong Son camps, there were high rates of post-traumatic stress disorder (41 per cent), depression (42 per cent), but low levels of anxiety (4.6 per cent).

Despite a move towards democratic processes in Burma (Myanmar), there is still limited access to effective health care (Grundy et al., 2014; Zaw et al., 2015). Burma (Myanmar) has a serious lack of health facilities, health providers and medical supplies (Holtz, 2016; Latt et al., 2016; Loyer, Ali & Loyer, 2014). Government expenditure on health care in Burma (Myanmar) was 3.4 per cent of general government expenditure in 2014. According to Latt et al. (2016) in 2014 there were 61 medical doctors, 100 nurses and midwives, and seven dental surgeons per 100,000 people in Burma (Myanmar), while in South-East Asia in the same period, there were 59 doctors, 153 nurses and midwives, and 10 dental surgeons per 100,000 people. Only government employees, which is a considerable proportion of the population, have access to publicly funded health care; others must purchase health insurance and the cost is very high (Khaing, Malik, Oo & Hamajima, 2015). Because the cost of health insurance is high and wages are low, many people will tolerate illness and use health care services only when they are seriously ill. Many people also seek health care to neighbouring countries. For example, large numbers of refugees living in border camps cross into Thailand to receive medical treatment in Thai border towns such as Mae Tao (Holtz, 2016). Thai health clinics have been treating people from Myanmar for over 20 years (Frellick & Saltsman, 2012).

Myanmar was a signatory to the Millennium Development Goals (MDGs) for poverty eradication and now is a signatory to the Sustainable Development Goals. The MDGs indicate that there have been improvements in the health of women and newborn babies in Myanmar. For example, MDG 5 (reduced maternal mortality) indicated a decline in maternal mortality ratios (MMR) from 520 in 1990 to 178 in
2015 (Latt et al., 2016). This was achieved by increases in attendance for antenatal care, the proportion of births attended by skilled health personnel (from 64 per cent in 2007 to 72 per cent in 2013) and the contraceptive prevalence rate, and reductions in the adolescent birth rate, and unmet family planning needs. Further, in Bumra (Myanmar), there was moderate progress in the reduction of child mortality (MDG 4) from 1990 to 2015. This was based on three indicators: a reduction in under-five mortality rate from 106 per 1,000 live births in 1990 to 79 in 2000 and 52 in 2012 (Latt et al., 2016); and a reduction in infant mortality from 79 per 1,000 in 1990 to 41 in 2012; and an increase in the proportion of one-year-old children immunised against measles. MDG 6, the control of infectious diseases (HIV/AIDS, TB and malaria), also demonstrated improvements (Latt et al., 2016). However, Burma (Myanmar) has a low rate of maternal and child health (MCH) services use, particularly in rural areas. Only two-thirds of pregnant women in rural areas had the recommended minimum of four antenatal visits, and only one-quarter gave birth at health services (Pilasant et al., 2016).

2.3 Thailand: Population, Economic Status and Migration Policy

The kingdom of Thailand is one of the 10 members of the Association of South East Asian Nations (ASEAN). It is located in the centre of South-East Asia, bordered to the north by western Burma and Laos, and to the east by Laos and Cambodia (see Figure 2.1). Based on the 2013 census, Thailand’s population is currently about 69.2 million people (Thailand Population, 2018). According to world population statistics, conducted in 2014, 95 per cent of the population is Buddhist and the official language is Thai (Jahan et al., 2015). Thailand has demonstrated outstanding economic growth in the past three decades. Eichengreen et al. (2013) reported that in 2012, of the 28 countries in South-East Asia, only Indonesia, Malaysia and Thailand were classed as
stable middle-income countries (MICs). Thailand became an upper middle-income economy in 2010 (Rigg, Promphaking & Le Mare, 2014). Further, Thailand has become an increasingly industrialised economy. Manufacturing, agriculture and tourism contribute most to the economy (Eichengreen et al., 2013). In 2015, the per capita gross national income equalled USD 5,720 (World Bank, 2017). Thailand has been ranked second in quality of life in ASEAN countries (Felman et al., 2014). It has also become a leader in economic growth including tourism and investment, within the ASEAN, and Asia-Pacific Economic Cooperation.

The improving economic status has attracted increasing flows of international migration to Thailand. An IOM Development Fund report, with official support from the Ministry of Foreign Affairs of Thailand (IOM, 2013) has shown that the region is experiencing increased flows of permanent and temporary migrant workers. Migrants to Thailand include humanitarian migrants (refugees) and economic migrants, who come for employment to improve their circumstances and that of their families in their home countries (Ford, Jampaklay & Chamratrithirong, 2009; Kusakabe & Pearson, 2014; Noom & Vergara, 2014). In 2013, the IOM reported that the primary reasons for migrating to Thailand were:

- to improve quality of life, including economic reasons, such as earning an income or more prosperous employment opportunities (74.9 per cent)
- personal reasons, such as the requirement to follow family or friends, or for personal experience (13.4 per cent)
- security (seven per cent).

Moreover, the length of stay in Thailand is increasing, with 41.3 per cent of new arrivals having been in Thailand for 0–4 years and 31.9 per cent for 5–9 years (IOM, 2013). The Thai economy has developed dramatically and many workers are
required to overcome labour shortages (Chalamwong, 2012; Srivirojana et al., 2014). Migration to Thailand is expected to continue to grow because of the commitment to establishing the ASEAN community and the connectivity of member states (Martin & Abella, 2014).

2.3.1 Burmese humanitarian migration (refugees).

Border camps are administrated by the communities themselves and overseen by the royal Thai government (Frelick & Saltsman, 2012; Thompson, 2008). The Thai government established the Thailand Burma Border Consortium (TBBC) to oversee individual camp committees in 2004. The camp justice systems are aligned with the Thai Ministry of Justice (Frelick & Saltsman, 2012; Thompson, 2008).

According to the Thai Border Consortium’s (TBC) statistics from December 2016, the 10 refugee camps on the Thai–Burma border are home to almost 200,000 refugees. Most migrants are from Burma and have lived in the border camps since 1984; that is, for over 30 years (Lee, 2014; Thompson, 2008). Refugees from Burma by ethnicity include Karen (79.4 per cent), Karenni (10.4 per cent), Burman (three per cent), Mon (0.8 per cent) and other (6.4 per cent) (TBC, 2016).

The February 2014 TBBC report on population statistics for refugee camps in Thailand identified a 7.1 per cent decline in new refugee arrivals and resettlement. The TBBC also reported that most Burmese refugees sought work in Bangkok or elsewhere in Thailand; a small proportion returned to Burma rather than live on the border (Bruce, 2014).

The Rohingya refugees are one of the groups who fled Burma in the early 1990s. The Rohingya are a Muslim ethnic group who originate from the northern Rakhine state of western Burma. They fled from ethnic persecution in Burma (Beyrer & Kamarulzaman, 2017; Pocock, Mahmood, Zimmerman & Orcutt, 2017). Recently,
an estimated one million Rohingya people in Burma (Myanmar) were identified as illegal and irregular migrants (or asylum seekers) (Fuller & Cochrane, 2015). They have fled Burma and over recent years. Most went to Malaysia or Bangladesh (Fuller & Cochrane, 2015). On their way to Malaysia, most were turned over to human traffickers and some were reported to be missing at sea (Mydans, 2009). In 2015, many migrants died during the voyage and their bodies were thrown out to sea (Fuller & Cochrane, 2015).

Thailand is accused of rejecting Rohingya migrants because Thai officials decline to receive migrants who arrive by boat. These migrants are not allowed into Thailand, as they are deemed illegal (Mydans, 2009). In 2015, although the Thai government did not help them fully, the Thai military provided some water and food when they passed through the country (Fuller & Cochrane, 2015).

Refugees in Thailand have limited opportunities for education and employment (Benner et al., 2010; Lee, 2014). Some of those living in the camps have been able to cross the Thai border to attend a camp school. Education is also provided by Community Burma Organizations such as the Karen Refugee Committee—Education Entity (KRCEE) and supported by international non-government organisations (NGOs) like South East Asia (ZOA) Refugee Group (KHRG) (Frellick & Saltsman, 2012). In 2010, the NGOs, ZOA and the protection department of the European Commission Humanitarian Aid (ECHO) decreased funding for education and health care assistance for refugees on the Thai–Burma border. Cuts to essential services led to loss of teachers in the camps and declines in school resources. To keep the camp schools running, the KRCEE increased school fees, requiring parents to pay THB 100-300 Baht (AUD 3–10) a year for each student, depending on the grade level (Frellick & Saltsman, 2012). The benefits of children being able to attend school were
emphasised by a participant in a study by Cohen and Asgary (2016), who stated, ‘at least my children can go to school every day and if they are sick they can go to the clinic’ (p. 79).

However, living conditions in the border camps are poor and many continue to endure hostility and conflict with elevated levels of violence, and consequently, experience poor health and wellbeing (Benner et al., 2010; Cohen & Asgary, 2016; Fellmeth et al., 2018; Frellick & Saltsman, 2012).

2.3.2 Burmese economic migrants in Thailand.

Of the estimated foreign population residing and working in Thailand in 2013, there were 3,681,245 migrants from Cambodia, Lao People’s Democratic Republic and Burma (IOM, 2013). According to the Thai Ministry of Labour’s Department of Employment in 2013, the number of migrants to Thailand who held work permits following the process of nationality verification (NV) totalled 899,658 (Huguet, 2014). Of these, 10 per cent (89,618) were from Cambodia, four per cent (31,782) were from Lao and 86 per cent (778,258) were from Burma. Almost half the Burmese migrants were women (43 per cent) (Huguet, 2014). Estimates of the number of children accompanying migrant families ranged from 25,000 to 37,000, with 18 per cent of the migrant population aged under 15 years (Chinvarasopak et al., 2013). Over 80 per cent of women were of reproductive age (15–49 years) (Chamchan, 2014). In a report from IOM Thailand and the Asian Research Center for Migration (Huguet, 2014), it was noted that over 50 per cent of Burmese migrants surveyed were married, 68.6 per cent of married migrants had children, more than 90 per cent of those were living in Thailand with their spouse. Among Burmese migrants with children, over half (56.8 per cent) had all their children living with them in Thailand, and 30.9 per cent reported that all their children remained in Burma. Only 10.6 per cent had children living in
both countries. Employment or better employment in countries such as Thailand also enables Burmese migrants to send money to their families in Burma. For example, many economic Burmese migrants who sought employment in southern Thailand are able to support their families (Fujita et al., 2010; Srivirojana et al., 2014). A great deal of economic migrants usually send remittances home quarterly or yearly (Pollock & Lin Aung, 2010).

Due to increasing numbers, the migrant population has moved not only into the border provinces, but also into non-border regions. Migrants living in non-border provinces in Thailand are more likely to come to Thailand through brokers, than are migrants living in border provinces. It is estimated that over two million undocumented and unregistered migrant workers are working illegally in Thailand (Chalamwong, 2012). According to Thai law, these people will be deported to their home countries if they do not have a non-Thai identification card and household registration (Huguet, 2014).

2.3.3 Thai Worker registration system.

Thailand has implemented a range of migration polices to enable migrant workers to work legally. In 2001–2003, the Thai government established a registration system for migrant workers from Burma, Laos and Cambodia. Under this scheme, migrant workers had to register to work in specified occupations, such as factory and domestic workers for one more year (Mon, 2010). From 2004–2005, the government tried to legalise irregular migrant workers who were undocumented and hidden. The NV policy (Chalamwong, 2012) and the implementation of the Memorandums of Understanding (MOUs) in 2006 aimed to protect the rights of migrant workers and improve the safety of migration (Mon, 2010). However, lack of information among employers and migrants and the operation of unregulated brokers means that many
migrants still encounter problems. For example, many migrants are charged high fees by agencies as they do not have networks and language barriers prevent most of them from accessing registration information (Chalamwong, 2012). Recently, the Thai government attempted to amend migration polices to permit migrant workers to work legally, including the provision of legal support and medical services for migrants and their families.

Migrant workers must submit numerous documents to Thailand’s Department of Employment to obtain a work visa. Burmese people must apply for a working visa from the Home Affairs Ministry in Burma before they come to Thailand. If they arrive without a Burmese identification (ID) card and household registration documentation, they must return to Burma, as they are unable to apply for a Thai work permit (Fujita et al., 2010). Additionally, they require documentation from their prospective Thai employer about the demand for their labour, a copy of their employment contract, a referral letter, a worker application, copies of previous work permits and temporary passports, and Burmese ID cards and household registration documentations. If Burmese or other nationalities arrive without documentation or are unable to comply with the Thai worker registration system, they will be working illegally. It is estimated that over a million Burmese people are working illegally in Thailand (Natali, McDougall & Stubbington, 2014).

The cost of a new work permit depends on the sector and province of employment. Domestic workers and labourers pay between THB 900–1,800 (AUD 30–60) a year for their work permit, depending on the province. The Ministry of Public Health conducts medical examinations and collects registration fees. Employers must pay THB 3,780 (AUD 126) for each worker; this comprises THB 600 (AUD 20) for health examinations and TBH 1,300 (AUD 43) for health insurance for
one year, THB 100 (AUD 3.50) for a work permit application and THB 1,800 (AUD 60) for a one-year work permit. A further THB 80 (AUD 2.70) is required for photographs and registration documents (Tor Ror 38/1). Typically, employers deduct this in monthly instalments from employees’ salaries (Chalamwong, 2012; Mon, 2010).

2.3.4 Thai nationals’ perceptions of migrants.

With increasing numbers of migrant workers from Burma travelling to Thailand, a survey was undertaken in 2012 to ascertain Thai nationals’ perceptions of Burmese migrant workers (Sunpuwan & Niyomsilpa, 2012). The survey revealed that in general, Thai nationals were worried that the increasing number of migrants (including legal migrants, refugees and illegal migrants) from Burma posed a threat to public safety, as they were perceived to be disease carriers (Sunpuwan & Niyomsilpa, 2012). Respondents also believed that migrant workers were a threat to their own job prospects and their ability to own their own house. Thais also believed that migrants and refugees created excess waste from refugee camps (Brees, 2010). In particular, Thai people in urban areas had a more negative perception of Burmese migrant workers on these issues than Thais living in rural areas did, even though migrants were prohibited to work in some occupations (e.g., trading goods and services) (Sunpuwan & Niyomsilpa, 2012).

2.3.5 Working conditions of migrants.

In Thailand, it appears that migrants’ working conditions are better, particularly their level of remuneration and minimum daily wage, in areas such as in Bangkok and Phuket than they are in Chiang Mai and Ranong province (Mon, 2010). In these two provinces, migrant workers receive lower salaries. Reportedly, in Ranong province where this research was conducted, there is a substantial number of migrant
laborers on the borderland who have the lowest salaries and poorest living conditions in Thailand (Fujita et al., 2010). The highest fatality ratio of Burmese migration is also reported here (Srivirojana et al., 2014).

Migrant workers who enter Thailand are low skilled and tend to take what is known as the ‘3 D’ jobs: ‘dangerous, dirty or difficult’ (i.e., deep-sea fishing, fish processing, rubber-tapping, housekeeping and construction work) (Benach, Muntaner, Delclos, Menéndez & Ronquillo, 2011; Fujita et al., 2010; Noom & Vergara, 2014; Srivirojana et al., 2014). In these jobs, some migrants are forced to work long hours and are not paid for overtime (Fujita et al., 2010; Mon, 2010; Veerman & Reid, 2011). Further, employees face hazards such as risk of accidents and physical abuse (Benach et al., 2011; Mon, 2010; Srivirojana et al., 2014). Based on the current cost of living, migrant workers (especially undocumented workers) have low wages and cannot afford health care (Lehane & Ditton, 2012; Mon, 2010). This is the main barrier to health care for Burmese migrants in the border provinces (Veerman & Reid, 2011).

Migrant women were more likely than men were to report difficulties in earning money, as their household composition is increasingly challenging and they need to support their children (Pollock & Lin Aung, 2010). Burmese female migrant workers face many health issues when migrating to and working in Thailand. Around half of Burmese migrant workers are documented; however, both documented and undocumented women and men workers experience difficult working conditions. Most migrant women undertake heavy work in factories and receive low wages, which are often paid late. Some women work excessive hours. For example, construction labourers are required to undertake heavy manual labour for more than 12 hours per day. They work seven days per week and there are restrictions on mobility in the workplace (Srivirojana et al., 2014; Veerman & Reid, 2011). If they want or require a
break from working, this will be deducted from their daily wage (Fujita et al., 2010; Kusakabe & Pearson, 2014). Poor working conditions combined with poor housing and limited access to services means many women experience hardships when they are pregnant and/or have young children. Of the Burmese migrant women responsible for supporting children, 75 per cent had one child, 22 per cent had two children and three per cent had up to three children. Simultaneously, the women are negotiating work and conflicting responsibilities for their families and household duties (Kusakabe & Pearson, 2014). In a United Nations international survey on the role of women and international migration (IOM, 2013), it was reported that historically, most migrant women accompanied their partners or husbands upon migration and continued to perform the main role as homemaker and child caregivers while the men worked outside the home. However, in recent times, an increasing proportion of migrant women work not only in the home as cooks, cleaners and caregivers, they also go out to work. For example, they work in garment factories and perform household duties as cleaners, domestic staff or child carers in their host country (Kusakabe & Pearson, 2014; Rangsitpol, 2014).

2.3.6 The Thai health care system.

A universal healthcare coverage program commenced in Thailand in 2002. It is known as ‘30-Bath scheme’ and requires a nominal financial contribution, paid either through taxes or independently with an amount of THB 30 (AUD 1) to access one occasion of health service or one hospital admission (Tangcharoensathien, Limwattananon, Patcharanarumol & Thammatacharee, 2014). Registered Thai residents, or those with a visa, can apply for a health card and can access services provided by a contractor network in a district health facility or health centres. In Thailand, people who are not covered by private health care can access a
comprehensive range of healthcare services provided by public organisations. The Civil Servant Medical Benefit Scheme and Social Security Scheme (Limwattananon, Tangcharoensathien & Prakongsai, 2007) is a health insurance system for the entire population. It provides services for people in need of health care at a lower cost than private insurance (Limwattananon, Tangcharoensathien & Prakongsai, 2011). This scheme provides access to public health services for civil servants and their families free of charge. Under this scheme, employers contribute five per cent of the employee’s wage to social security, allowing the employee access to any health centres or networks in a district (Kongsri, Limwattananon, Sirilak, Prakongsai & Tangcharoensathien, 2011). Registered migrant workers can join the social security scheme on the same basis as Thai workers. To be eligible, they must pay five per cent of their wage to gain access to health care, including accident insurance, disability and life insurance, support for childbirth and monthly child benefit payments (Pearson & Kusakabe, 2012).

Thai health care is provided by both the public and private sectors. Public health care in Thailand is the responsibility of the Ministry of Public Health and hospital managers (Gruber, Hendren & Townsend, 2014). Specialist medical doctors are limited, and primarily only available in public or private hospitals. Most PHC centres do not have a doctor present. Surgical procedures are provided in secondary or tertiary public hospitals and some private hospitals. The public maternity system provides free care, including at least four prenatal appointments, and birth and postnatal care services (Kongsri et al., 2011).

In Thailand, as in many middle and low income countries, Village Health Workers (VHW) play a key role in the Primary Health Care Service. Typically, they provide basic health care and health education to the community including aspects of
antenatal care. They are employed because they come from the communities they serve and therefore are able to reach out into the community. Their roles are dependent on the healthcare settings but they are primarily working in the community and or Primary Health Centres. In Thailand, the VHW is also referred to as a community health worker (CHW) and some who are not employed are known as Village Health Volunteer (VHV) (Lewin et al., 2010; Obilade, 2015).

In Thai cities and provinces with large numbers of migrants and refugees, the VHW will typically be migrant women who are generally known as Migrant Health Workers (MHW) or Migrant Health Volunteers (MHV). These workers have the role of preventative health education as well as the role of translating or interpreting for the community (Suphanchaimat, 2017). The MHW or MHV like the CHW or VHW can assist individuals in a community to access health care services, and provide both socio-cultural support and cost-effective care (Andrews et al., 2004). MHW and MHV are migrants who have been living in Thailand for some time and who are familiar with the Thai healthcare system. In contrast to the Thai VHW or CHW, the MHW also are located in health facilities with the aim of assisting local health staff to reach the hard-to-reach patients and interpret for local health providers (Suphanchaimat, 2017). In the Ranong hospital and the Pak Klong PHC clinic, the study sites in this thesis, the primary role of these workers was as an interpreter.

2.3.7 Maternity services in Thailand.

In Thailand, maternity services are provided by a registered nurse or nurse-midwife. In Thailand, all registered nurses complete a bachelor-level, four-year nursing education program. This four-year program includes 18 months of maternity nursing training. Therefore, Thai nurses who undertake the professional nursing educational program qualify as a nurse-midwife.
Within the Thai hospital system, nurse-midwives usually provide pregnancy and birth care for low-risk women. For complicated cases, high-risk pregnancies and labour, care is provided by obstetricians, but usually women receive care from a team including medical students and midwifery staff (Chunuan, Kala & Kochapakdee, 2004; Wisanskoonwong, 2012). In general, women (both Thai and migrant women such as those from Burma) use the maternity services in Thai public hospitals, as they are funded by the universal healthcare coverage known as ‘30-Bath scheme’. The universal health coverage is available for all Thai women and migrant women who have legal worker status in Thailand. It provides maternity services, including antenatal and postnatal care, postnatal appointments and immunisations for babies (Tanglakmankhong, 2010). In addition to the universal coverage, some women use the Medical Welfare Scheme, provided by their employees through the Social Security Scheme, as Thai workers are covered by at least one of the health insurances (Chotiga, 2010).

Private hospitals offer maternity care and many Thai women prefer to give birth in private hospitals with their own obstetricians. They believe that obstetricians in private hospitals provide better care during pregnancy and delivery (Liamputtong, 2005). Patients can reserve the place of birth (private or luxury room), choose delivery options and feel confident that their needs are addressed (Tanglakmankhong, 2010). However, giving birth in a private hospital with a private obstetrician involves extra charges, which the universal system does not cover (Chunuan, Vanaleesin, Morkruengsai & Thitimapong, 2007). Private hospitals are managed by private organisations and some of the hospitals are managed by government organisations or other agencies. Recently, there have been reports of increasing caesarean section rates in private hospitals (Charoenboon, Srisupundit & Tongsong, 2013; Souza et al., 2010),...
reaching 40 per cent of births in 2016 (Lumbiganon, 2017). Many obstetricians recommend birth by caesarean section to ensure what they argue is quality care for women and the avoidance of uncertainty (Chunuan et al., 2007; Culhane-Pera, Sripetchcharawut, Thawsirichuchai, Yangyuenkun & Kunstadter, 2015).

Typically, routine maternity care services both in PHC clinics and the hospitals provide at least four antenatal check-ups. In Thailand, a pregnant woman should receive basic antenatal care with the initial visit within the first 12 weeks of gestation. In 2012, it was reported that 65 per cent of pregnant women received antenatal care before 12 weeks of gestation (Wisanskoonwong, 2012). Antenatal visits are recommended every month until 28 weeks gestation, then every fortnight until 36 weeks. In the last month, women have to attend antenatal care every week until birth. However, the number of antenatal check-ups differs depending on the decisions or choices of the pregnant woman, the service and nurse-midwives’ judgement.

Taking medical history and physical examination such as blood testing, urinalysis, diagnosis, treatment and importantly, providing referrals for women with high-risk pregnancies, are some nurse-midwife responsibilities. Additionally, tetanus toxoid vaccination is provided for pregnant women. Education and health care is offered to women and all women have a baby book to record the maternity care provided (Chotiga, 2010). Women who have a normal vaginal birth will stay in hospital around two to three days; if they have a caesarean birth, they usually stay around four days (Areemit et al., 2012). In hospital, rooming-in is promoted as well as breastfeeding and keeping the baby skin-to-skin with the mother (Baiya, Ketsuwan, Pachaiyapoom & Puapornpong, 2014; Petcharapun & Gongsumrit, 2014).
2.4 Migration, Motherhood and Maternity Care

2.4.1 Becoming a mother in a new country.

Motherhood is a major life transition that has a significant impact on a woman and her family (Etowa, 2012; Goodwin & Huppatz, 2010; Korukcu, Aydin, Conway & Kukulu, 2017; Murray et al., 2010). The transition to motherhood can be a time of happiness, excitement, hopes and dreams, but also a transition that brings about struggles or challenges for women (Etowa, 2012; Goodwin & Huppatz, 2010; Liamputtong, 2006; Miller, 2005). The experience of motherhood (including pregnancy and birth) and the construction of maternal identity have been studied across Western countries and, to a lesser extent, LMICs for the past four decades (Hays, 1998; Katz-Rothman, 1988; Kitzinger, 1988; Maher & Saugeres, 2007; McMahon, 1995; Miller, 2007; Oakley, 1981; Ruddick, 1985). The meanings associated with motherhood are shaped by historic, social and cultural values (Miller, 2005) and have different meanings for women, both within and across cultures (Hoang & Yeoh, 2015; Liamputtong, 2006; Murray et al., 2010).

Research has continually demonstrated that the discourse of the ‘good mother’ dominates and informs experiences and practices of motherhood. In many regards, it has changed little in this time, despite the activism of some feminists (Pedersen, 2012). Shaped by historical understandings of gender roles and contemporary cultural representations in Western society, the ‘good mother’ is supposed to enjoy motherhood, know intuitively what to do for her child; care for her child without ambivalence, and be a pivotal figure in family life (Pedersen, 2012). Moreover, in Western, middle-class notions of intensive mothering, mothers remain the ultimate in relational devotion, affection and importance (Arendell, 2000).
However, motherhood often falls short of these idealistic images and instead, is frequently experienced by women as overwhelming (Etowa, 2012; Goodwin & Huppatz, 2010; Hays, 1998; Liamputtong, 2006; Naidu, 2013; Nyström & Öhrling, 2004) and characterised by feelings of powerlessness, insufficiency, guilt, loss, exhaustion, ambivalence and resentment (Amoros et al., 2010; Benza & Liamputtong, 2017; Husmillo, 2013; Liamputtong et al., 2004). The negative impact of motherhood may be felt most by women with few economic resources (Armstrong, 2006), lack of support or a baby that is unwell or has special needs (Fenwick, Barclay & Schmied, 2008). Mothers are also acutely aware of and experience the judgement of others and are the subject of surveillance from other mothers, medical professionals and family members, who assess their efforts to protect the wellbeing of their infants (Etowa, 2012; Nilsson, Bondas & Lundgren, 2010; Shafiei, Small & McLachlan, 2012; Tsai et al., 2011). It is also argued that these powerful images and discourses contribute to elevated levels of distress and postnatal depression and anxiety reported in Western countries (Allen, 2005; Beck, 2002; Wittkowski, Patel & Fox, 2017).

2.4.2 The experience of migrant mothers.

Authors have questioned whether women from non-Western cultures experience motherhood in the same way. Research on women from diverse non-Western cultures (both non-immigrant and immigrant women) demonstrates the central place of motherhood. Becoming a mother can provide women with meaning, life purpose and a sense of fulfilment, and is empowering when it offers status within the family and social context (Choudhry, 1997; Etowa, 2012; Liamputtong, 2006; Liamputtong et al., 2004). This is reinforced by the high regard with which mothers are held. For example, they are popularly referred to as ‘the light of the home’ (Madianou, 2012). In a recent book about mothering in Muslim cultures, the editors
stated that ‘mothers are revered in Muslim societies, they are respected and offered generosity, and kindness, by their children’ (Pappano & Olwan, 2016, p. 1). ‘The phrase, a “paradise lies at the feet of the mother” … shows the great esteem, honour and respect that Islam has for mothers’ (p. 1).

Migrant mothers talk about their feelings of pride, happiness and self-worth and their strong feelings of love for their children (Benza & Liamputtong, 2014; Etowa, 2012; Liamputtong & Naksook, 2003; Liamputtong et al., 2004; Schmied et al., 2017; Shafiei et al., 2012; Tsai et al., 2011). Liamputtong described the ‘transformation of self’ experienced by migrant Cambodian, Vietnamese, Lao and Thai women (Liamputtong, 2006). Several discourses of the good mother were evident in her research, particularly mothers’ roles as the ‘keepers of morality’, holding an ethic of care and responsibility for others, especially their children.

This research describes the multiple challenges women experience. When combined with difficulties of migration, motherhood becomes a double burden. Women also experience the double burden of multiple roles. As women and mothers, they are expected to juggle the roles of female worker, mother, wife or daughter, and face multiple gendered pressures (Graham & Jordan, 2011; Naidu, 2013; Noom & Vergara, 2014; Pearson & Kusakabe, 2012; Pollock & Lin Aung, 2010). Other authors agree; for example, South-East Asian and Indian-born women living in HICs have described the self-sacrifice and endless concern they experience, and the relentless, demanding work of child-rearing (Liamputtong et al., 2004; Raman, Nicholls, Ritchie, Razee & Shafiee, 2016b; Schmied et al., 2017). Being a mother is exhausting and affects their health.

Motherhood brings great responsibility. Indeed, this responsibility may be more overwhelming for mothers who do not have close family members living nearby
who would traditionally have shared this responsibility (Etowa, 2012; Tsai et al., 2011). African-Canadian women discussed their responsibility to care for their children in the right way. They wanted to raise their children to be responsible citizens (Etowa, 2012). African women living in Canada expressed dissonance; they had come to Canada because they wanted a safer place to raise their children, but they had to work long hours and were unable to provide their children with the supervision they deemed necessary (Etowa, 2012). African migrant mothers from a range of countries (e.g., Nigeria, Sierra Leon, Kenya and Malawi) living in South Africa expressed similar concerns, that it was not easy to keep their children close, as they to work long hours to provide for their children (Naidu, 2013).

This significant burden of responsibility cannot be shared with families in the traditional way (Cheung & Pan, 2012; Naidu, 2013; O’Mahony, Donnelly, Bouchal & Este, 2013; Schmied et al., 2017). In many situations, the only support available to mothers is from their partner/husband. A few studies have examined the experience of fathers who are migrants or refugees living in a new country. In one review, fatherhood was perceived as a core aspect of men’s identities (Williams, Hewison, Stewart, Liles & Wildman, 2012). Fathers focused on their availability to their children, providing physical care, communication with children, economic provision, protection and helping their children learn. Williams et al. (2012) also identified factors associated with parenting difficulties for immigrant fathers, including mental and physical health, poverty, social isolation, children’s behavioural problems, stresses associated with changing gender roles, family structure, trauma, acculturation difficulties and differing cultural expectations (Williams et al., 2012).
2.4.3 The importance of traditional practices.

Concerned about being good mothers, many migrant women engage in, or wish to engage in, traditional practices to ensure their children’s and their own wellbeing (Benza & Liamputtong, 2014; Finlayson & Downe, 2013; Higginbottom et al., 2014; McGinnis, 2012; Shafiei et al., 2012). Traditional practices such as wearing a brooch on a maternity dress is believed to protect them from the evil that might harm their pregnancy (Diamond-Smith, Thet, Khaing & Sudhinaraset, 2016; Liamputtong, Yimyam, Parisunyakul, Baosoung & Sansiriphun, 2005; Raman et al., 2016b; Sein, 2013). Thai women believe strongly in adhering to dietary precautions during pregnancy. These dietary practices are called ‘Khong Salaeng’. They include avoiding papaya salad or pickled foods because they have negative effects on babies. For example, the baby may be born hairless, weak and unhealthy. Likewise, it is believed that consuming Thai eggplants during pregnancy will lead to anal pain after the baby is born (Liamputtong et al., 2005). In contrast to many Western women, migrant and non-migrant women from LMICs often avoid rigorous exercise during pregnancy. Thai women for example believe that rigorous activities during pregnancy might result in a miscarriage (Liamputtong, 2005).

Infant feeding practices have also been a focus of study. Internationally, reports on the prevalence of breastfeeding consistently report higher rates of initiation and duration of breastfeeding among migrant groups (Grewal, Andersen, Sellen, Mosdøl & Torheim, 2016; Hohl, Thompson, Escareño & Duggan, 2016; Schmied et al., 2012), although there is some indication that acculturation may play a role in influencing infant feeding and other child-bearing practices (Groleau, Soulière & Kirmayer, 2006; Schmied et al., 2012; Zhou, Younger & Kearney, 2010). For example, migrant women who had lived in the United Kingdom (UK) for many years were more likely to
formula feed than were south Asian women who were newer arrivals. Schmied et al. (2012) conducted a meta-ethnographic review of 11 studies, demonstrating that breastmilk and breastfeeding were afforded high status among migrant women from diverse cultures, with only two studies finding that some women perceived formula milk as equivalent to breastmilk. Despite the positive view of breastfeeding and the importance of breastmilk for infants, migrant women can struggle to continue breastfeeding while managing life with a new baby in a new country. Many migrant women have to return to paid work soon after birth; they are also expected to maintain the house without their mothers, mothers-in-law and other family members to support them (Schmied et al., 2012). This prompts some women to abandon breastfeeding (Groleau et al., 2006; Vaughn et al., 2010), particularly if important postpartum rituals of their native countries that maintain health and energy cannot be adhered to (Groleau et al., 2006; Schmied et al., 2012). Groleau et al. (2006) argued that the ritualised exposure of mothers to heating (use of heat lamps or fire-warmed rock on the abdomen) and other practices are ‘the cornerstone of a rite of passage to motherhood, a key moment for primiparas to acquire their new identity as mothers’ (Groleau et al., 2006, p. 520). If a woman is unable to maintain these practices, she may become anxious about her ability to produce sufficient milk and cessation of breastfeeding is the most likely outcome (Groleau et al., 2006; Langdon, Johnson & Diong, 2000; Rossiter & Yam, 2000).

Migrant mothers reported their husbands are emotional and financial supports during pregnancy, birth and the postpartum period (Benza & Liamputong, 2014; Hoban & Liamputong, 2013; Williams et al., 2012). Further, there are other demands in migrant mothers’ daily lives, such as the need to provide an income for the family. However, they were likely to suffer unemployment and lack of livelihood when
pregnant or recovering from birth. They experienced structural barriers such as financial hardship and expressed worries about job shortages (Fellmeth et al., 2018; O’Mahony et al., 2013; Pearson & Kusakabe, 2012).

Migrant mothers experience additional stresses that affect their transition to motherhood. Lack of employment, underemployment and limited income or access to financial resources is a common burden for new migrants (Falah-Hassani et al., 2015; Higginbottom et al., 2014; Pearson & Kusakabe, 2012). Similar burdens related to discrimination in the workplace, limited job security and poverty are reported by working migrant mothers living in LMICs (Noom & Vergara, 2014; Pollock & Lin Aung, 2010). Reports of women losing their jobs when pregnant are common (Belton, 2007; Noom & Vergara, 2014; Pearson & Kusakabe, 2012). A study of Burmese women living on the Thai–Burma border demonstrated that when women have few options, they are likely to seek unsafe abortions (Belton, 2007).

However, few studies have been conducted of Burmese women becoming mothers who have migrated for economic reasons or sought refuge in neighbouring countries such as Thailand or HICs such as Australia, the United States (US) and Canada. Two studies have reported the hardships experienced by a community of displaced women from Burma (mainly Karen) as they became mothers in Australia (Koh, Liamputtong & Walker, 2013; Niner, Kokanovic & Cuthbert, 2013). Although Australia was considered a safe haven, and women were grateful for the resettlement services and the maternity care they received, many felt confused and did not understand the procedures, many of which were unfamiliar to them (Niner et al., 2013).

**2.4.4 Health of migrant women and their babies.**

Many women who migrate for economic or humanitarian reasons are of child-bearing age and either have young children or will have their first child within five
years of arrival (Higginbottom et al., 2014; Liamputtong, 2006; Watts, Liamputtong & Mcmichael, 2015). Migrant women in general are at a disproportionately higher risk of a poor pregnancy outcome, including low birth weight, preterm birth, and perinatal and maternal morbidity and mortality (Almeida et al., 2013; de Jong et al., 2017; Wichaidit et al., 2011). A recent European study by de Jong et al. (2017) found MMRs, perinatal mortality ratios and antenatal-intrapartum complications among migrant mothers were higher than they were in non-migrants. However, many previous studies of stillbirth and infant death among migrant populations indicate there is marked variation between groups of migrants and host countries, with greater heightened risks in some groups and no elevated risks in others (van den Akker & van Roosmalen, 2016). Those without a legal resident permit are most vulnerable (van den Akker & van Roosmalen, 2016). Gissler et al. (2009) found that in over half the studies they reviewed, stillbirths and infant deaths were higher in migrant groups. Again, refugees were the most vulnerable group. For non-refugees, non-European migrants in Europe and foreign-born blacks in the US had the highest excess mortality. In general, adjustment of background factors did not explain the increased mortality rate among migrants (Gissler et al., 2009). Higher preterm birth rates explained the increased mortality figures among some migrant groups. The increased mortality from congenital anomalies may be related to restricted access to screening and differing attitudes towards screening and termination of pregnancy (Gissler et al., 2009). Dahlen, Schmied, Dennis and Thornton (2013) reported a higher stillbirth rate in infants of Lebanon-born mothers living in Australia.

Less is known about maternal and infant mortality among migrant women living in Thailand. Hegde, Hoban and Nevill (2012) reported that maternal mortality due to childbirth complications among Cambodian migrant women on the Thailand–
Cambodia Border was related to limited knowledge of safe sex practices and modern contraceptives. The authors concluded that these migrant women were unable to prevent unwanted pregnancies and had unsafe abortions (Hegde et al., 2012).

2.4.5 Maternal and infant morbidity.

Migrant women in general experience poorer pregnancy health and birth outcomes than non-migrant women do (Almeida et al., 2013; Urquia et al., 2015). Those who are undocumented, asylum seekers or refugees faced worse health outcomes (de Jong et al., 2017). Migrant women have higher rates of gestational diabetes mellitus (GDM) (Carolan, Davey, Biro & Kealy, 2012; Dahlen et al., 2013), and anaemia and preeclampsia (de Jong et al., 2017). Cheung and Pan (2012) conducted a systematic review of childbirth outcomes of migrant women in China. They discovered that migrant women experienced more adverse birth outcomes (e.g., haemorrhage, amniotic fluid embolism and pregnancy hypertension) than local residents did (Cheung & Pan, 2012). As a consequence of these health problems, which are partly explained by poverty (Hayward et al., 2012), there is an increased incidence of low-birth weight babies, small for gestational age babies (SGA) and intrauterine growth restriction (IUGR) in migrant and refugee populations.

Some studies indicate that migrant women have higher rates of caesarean section and instrumental births, but this varies across country of origin and receiving country (Merry, Pelaez & Edwards, 2017; Vangen, Stoltenberg, Skrondal, Magnus & Stray-Perdersen, 2000). Dahlen et al. (2013) analysed an Australian administrative dataset and discovered that women born in India had the highest rate of caesarean section (31 per cent) compared to Australian-born women (27 per cent) and instrumental birth rates (16 per cent v. 10 per cent). Indian women also have the highest rates of SGA (22 per cent), compared with 9.4 per cent in Australian-born women.
This can result in increased newborn investigations and, at times, unnecessary admission to neonatal nurseries, thereby separating mother and baby. A review of 76 studies comparing the rates of caesarean births between migrant and non-migrant women living in the Organisation for Economic Co-operation and Development countries showed that women from Sub-Saharan Africa, Somalia and South Asia consistently have more caesareans than receiving-country-born women, while Eastern European and Vietnamese women have lower overall caesarean rates. North African/West Asian and Latin American women have higher emergency caesarean rates (Merry et al., 2017).

Migrant mothers have poorer self-rated health than Canadian-born mothers do (Vang, Sigouin, Flenon & Gagnon, 2017). Gagnon et al. (2013) discovered that migrant mothers have more postpartum health problems such as pain, bleeding and high blood pressure. They also have poorer mental health. Rates of postnatal depression among migrant women are consistently higher than they are among non-migrant women (Anderson, Hatch, Comacchio & Howard, 2017; Falah-Hassani et al., 2015; Fellmeth et al., 2017). Norhayati, Hazlina, Asrenee and Emilin (2015) reported prevalence rates of postnatal depression, varying from 2 per cent to 82 per cent in HIC and from 5 per cent to 74 per cent in LMIC. Symptoms of perinatal depression with high co-morbidity experienced by migrant women in South-East Asia are one of the most common symptoms in migrant women, due to stressors experienced during migration (Fellmeth et al., 2017). This low mood is most commonly associated with social isolation and poor economic situations resulting in elevated levels of stress and anxiety, low self-esteem and depression (Anderson et al., 2017; Falah-Hassani et al., 2015; Schmied et al., 2017).
2.4.6 The reproductive health of migrant Burmese women.

A few studies have examined the health issues experienced by Burmese women living on the Thailand–Burma border. Belton studied the reproductive health experiences of women living on the border, but not in camps, in Tak province. She reported an increasing incidence of abortion among Burmese women on the border, with over a third of pregnancy loss being self-induced (Belton, 2007). This was explained by the necessity for migrant Burmese women to work to support their families. It was also attributed to high rates of domestic violence and abuse (Belton, 2007). Likewise, mistimed or unwanted babies are barriers to opportunities for work. In Tak province, Burmese women find it difficult to access modern methods for abortion (Belton & Whittaker, 2007) and they often use traditional techniques such as herbal pills, massages, pummelling and stick abortions to induce abortion. Access to abortions was described by one participant in Belton’s study in a very distressing manner:

I have a friend in Burma who is a traditional birth attendant (TBA) who does massages, deliveries and abortion. She is very skilled. She uses a special root to poison the baby. She can do very strong massage with her foot into the woman’s perineum and pelvic area which produces an abortion. I heard a story once about a female massage abortionist who had such strong hands she could break the baby’s neck through the wall of the womb (p. 1519).

Falb et al. (2014) undertook a cross-sectional study of women living in one of three refugee camps along the Thailand–Burma border. They examined the association between the lifetime prevalence of any violence/victimisation, including conflict victimisation, intimate partner violence and violence perpetrated by non-partners in camps and self-reported symptoms of pregnancy complications. They discovered that
approximately one in six women described feeling very weak and tired, having frequent abdominal pain, fever in pregnancy and had experienced complications associated with their most recent birth within the last two years, such as stillbirth (Falb et al., 2014). Conflict victimisation was strongly associated with heightened risk of self-reported symptoms linked with pregnancy complications among women in refugee camps along the Thailand–Burma border. Notably, 90 per cent of women sought help for their symptoms (Falb et al., 2014).

No studies have investigated women’s birth experiences, although Rijken et al. (2012) noted that a main concern expressed by women was the danger of childbirth, which they mainly attributed to poor fetal position or malposition. When Burmese women become mothers, they have a strong culture of breastfeeding. White and colleagues (2012) reported that Karen women breastfeed; however, skin-to-skin practices are limited due to the strong belief in early swaddling at birth. The Karen women believe that swaddling makes the baby feel secure and protects it from potentially harmful spirits.

One large study examined MCH outcomes for Karen women and their children living along the Thailand–Burma border at Ratchaburi province (Wichaidit et al., 2011). Of the population studied, most had low levels of education and were illiterate and 60 per cent of pregnant women did not have legal status in Thailand. In this study, the authors discovered that adolescent pregnancy was more common among Karen women on the border than it was in the general Thai population; the percentage of grand multiparas and the average number of children born per mother were also significantly higher. The proportion of homebirths and en route deliveries was higher it was than among the general Thai population. Further, the proportion of births attended by skilled medical personnel, such as doctors or nurses, was lower than it was
among the general Thai population. The average birth weight was also lower than that of the general Thai population. The proportions of women having low-birth weight babies and premature deliveries were not significantly different from the general Thai population. The physical growth of children in the area was significantly different from the growth of children in the general Thai population. The average height-for-age and weight-for-age of children were significantly lower than they were among the general Thai population. The proportions of children who were stunted and underweight were significantly higher than in the general Thai population (63.74 per cent v. 12 per cent and 30.7 per cent v. 7 per cent respectively). Only 26.37 per cent of the children in the study had no abnormalities in weight and height measurements.

A study by Carrara, Hogan, De Pree, Nosten and McGready (2011) found that in the preceding 10 years, there had been a reduction in the proportion of premature births, low birth weight babies and a 40 per cent reduction in neonatal mortality among women living in border camps. This change was attributed primarily to a reduction in malaria and smoking during pregnancy, and an increase in delivery with skilled birth attendants.

Almeida et al. (2013) undertook a systematic review of studies reporting the access, use and quality of health care in migrant women during pregnancy and the postpartum period, with particular emphasis on how this affects health outcomes. In conclusion, Almeida et al. (2013) stated that delays in accessing information on medical treatment lead to inappropriate treatment because of inadequate diagnosis. Inadequate antenatal care can contribute to adverse pregnancy outcomes such as low birth weight and perinatal morbidity (Cheung & Pan, 2012; de Jong et al., 2017; Heaman et al., 2013). In a large study of Burmese migrant women and their infants (Wichaidit et al., 2011), attending fewer than four antenatal care visits was
significantly associated with preterm births, and a considerable proportion of babies were low birth weight (birth weight < 2,500 grams), stunted and underweight.

2.4.7 Barriers to accessing maternity services.

Giving birth in a new country can be a very frightening experience for women who are not aware of the practices in their new country (Benza & Liamputtong, 2014, 2017). This places responsibility on health services, particular maternity services, to adequately and appropriately provide care for diverse groups. Access to and engagement in services is a significant concern among migrant populations in HICs and LMICs (Almeida et al., 2013; Downe et al., 2009; Wichaidit et al., 2011).

The WHO stipulates that all pregnant women attend at least four antenatal visits, reporting no difference in MMR between women attending fewer antenatal appointments (4–9 visits) and those adhering to the traditional practice of antenatal care (12–14 visits) (Villar, Carroli, Khan-Neelofur, Piaggio & Gülmezoglu, 2001). However, 20 per cent of MMR were attributed to women who had fewer than four antenatal visits or failed to receive adequate antenatal care (Downe et al., 2009). Reasons for inadequate antenatal attendance have not yet been fully evaluated.

Again, little is known about how Burmese women access antenatal care. However, two studies in the past decade demonstrate the importance of access to PHC and maternity services for Burmese migrant women. Carrara et al. (2011) studied whether improvements in literacy among women living in Thai border camps were associated with positive change in birth outcomes. This change was attributable to a reduction in malaria in pregnancy and smoking, and an increase in delivery with skilled birth attendants (Carrara et al., 2011). The authors stated that while these improvements were not directly associated with improvements in literacy, changes in
health behaviour (such as reduced smoking) did not preclude an indirect impact of improved literacy (Carrara et al., 2011).

Rijken et al. (2012) conducted a mixed methods study to explore Burmese women’s perceptions and acceptance of ultrasound in pregnancy. They discovered that relatively few Burmese women living on the Thailand–Burma border believed in the use of ultrasound in antenatal care. The women and midwives in this study questioned the safety of ultrasound technology and did not believe that it improved the safety of pregnancy and birth. A minority of women described being shy or anxious before the ultrasound but reported that these feelings could be ameliorated with improved information and staff communication. Unintended consequences, such as overuse and gender-selective abortions, were not common in this population. They also reported that migrant women expressed immense trust in health staff (Rijken et al., 2012).

Yet many Burmese women living in border camps, and possibly elsewhere in Thailand, continue to underutilise maternity services (Belton, 2007; Kusakabe & Pearson, 2010; Wichaidit et al., 2011). Thus, it is important to understand the barriers to care. Studies in HICs demonstrate that many migrant mothers encounter difficulties when seeking maternity care, and expressed a need for more support from health services (e.g., provision of interpreter, and facilities that respect cultural background and beliefs) and families and communities (Heaman et al., 2013; Higginbottom et al., 2014; Maria da Conceição & Figueiredo, 2015; Stapleton et al., 2013). Other studies have also emphasised that practical issues such as limited knowledge of, and access to, transportation can make it difficult for women to attend an appointment (Almeida et al., 2013; Atuyambe, Mirembe, Annika, Kirumira & Faxelid, 2009; Gagnon et al., 2010; Heaman et al., 2013).
Many migrant women believe in traditional cultural practices related to pregnancy and birth, such as the concept of pregnancy as a normal event in which nothing will go wrong if they follow traditional practices (Carolan & Cassar, 2010; Panagiota, 2008). Some women might not want to access maternity care due to their views that traditional practices are interrupted or dismissed by Western maternity services (Higginbottom et al., 2014; Stapleton et al., 2013).

A systematic review by Cheung and Pan (2012) reported that 63 per cent of the migrant women are undocumented; these women were hesitant to use maternity services or antenatal care due to fear of arrest and deportation. In particular, migrant women who do not have legal status cannot access universal health care. Therefore, they are required pay for services (Noom & Vergara, 2014). Most women from Burma cannot afford to pay, which means many will not access health care. In many cases, migrant women do not have time to wait for appointments, as they are working and time away from the workplace jeopardises their employment. Thus, women often resist antenatal care (Correa-Velez & Ryan, 2012; Fisher & Hinchliff, 2013; Gurnah et al., 2011; Lin et al., 2008). Services provided may also be inappropriate or differ from women’s previous experiences or cultural beliefs (Correa-Velez & Ryan, 2012; Gurnah et al., 2011; Higginbottom et al., 2014). Several studies (e.g., Reitmanova & Gustafson, 2008; Lin et al., 2008; Panagiota, 2008) found that most migrant women were unfamiliar with different local cultural practices, including those related to pregnancy, birth and postpartum care and services, particularly if they had only recently arrived in the host country (Salway et al., 2011).

Participants in the study by Carrara et al. (2011) on the Thailand–Burma border identified several of the access problems as lack of money, transportations cost, limited time and fear of arrest. Thus, some Burmese migrants do not access Thai health care.
This is likely to affect not only the migrant workers, but also their children. For example, their children will rarely receive immunisations (Canavati et al., 2011).

2.5 The Conceptual Framework—An Ecological Model of Motherhood

This chapter has drawn on policy documents and published research to describe what is known about the lives of migrant women having their first or subsequent children in Thailand. The review indicates that there is very limited nursing, midwifery or health-related literature exploring the lives of child-bearing Burmese women living in Thailand. The available research focuses mainly on the sexual and reproductive health needs of refugees from Burma, living in border camps in northern Thailand.

In situating this study of child-bearing migrant Burmese women living in southern Thailand, the literature has described the multiple factors that may affect the lives of these Burmese women and their families, their perceptions and experiences of becoming a mother in Thailand and the health-promoting decisions women make, including their decision to access Thai maternity services. Individual and family practices are influenced by the cultural context within which Burmese women grew up and by their lives in Thailand. Their movement across borders and their capacity to obtain work is influenced by Thai migration policy and their work permit status.

It is also evident from the literature that migrants, not only in LMICs but also in HICs, face many barriers when accessing maternity care. In some cases, this relates to the design of antenatal services, how accessible they are to all women in a community (e.g., transport, hours of service and interpreter availability) and their interactions with health professionals.

The social–ecological model (SEM) offers one approach or framework to conceptualise the factors that may influence or affect the motherhood experiences of
migrant Burmese women living in southern Thailand. This section of the chapter provides an overview of the SEM and relates some factors identified in the literature review to the levels of this model.

2.5.1 The social–ecological model.

Typically, in health research, the SEM has been used to inform the development of conceptual models for testing the relationships between multiple variables in cross-sectional or longitudinal studies (Krieger, 2001; Miller-Graff, Howell & Scheid, 2017). For example, the overarching design of the longitudinal study of Australia’s children is based on the SEM. Sophisticated statistical modelling techniques have been used to explore relationships between individual child factors, parental characteristics and the social and economic indices of the communities in which the children live (Gray & Sanson, 2005; Miller-Graff et al., 2017). Since the mid-1990s, the SEM has also been used to inform the design of multilevel interventions (e.g., in health-promotion initiatives) (Gray & Sanson, 2005; Miller-Graff et al., 2017).

It is less common, but nonetheless valuable, to apply the SEM to qualitative studies to show how the meaning of multiple factors can shape the lives of child-bearing migrant women (Shahabuddin et al., 2017). Indeed, the tenets of ethnography and the multiple sources of data used in ethnographic studies (adopted in this study) are well aligned to this approach.

As illustrated in Figure 2.2, a SEM is a multifaceted and multilevel or layered model that recognises the connected and intertwined relationship between an individual and their environment (Richard, Gauvin & Raine, 2011). Ecological models draw on systems theory and are developed by researchers in the fields of psychology and human development, who began to understand behaviour in a context of the
interplay of the individual and environment (Kok, Gottlieb, Commers & Smerecnik, 2008; Richard et al., 2011). This includes: Urie Bronfenbrenner’s ecological systems theory (1977), which focused on the relationship between the individual and the environment; McLeroy, Bibeau, Steckler & Gianz (1988) ecological model of health behaviours, which classified different levels of influence on health behaviour; and Daniel Stokols’s (1996) SEM of health promotion, which identified the core assumptions that underpin the SEM. This work has been applied in the fields of child development, health promotion, health, psychology, epidemiology and MCH.
In a SEM, health and development can be viewed as a function of individuals and the environments in which they live, including families, interpersonal networks, communities, organisations, societies and national and global systems. The SEM addresses the complexities and interdependences between socio-economic, cultural,
political, environmental, organisational, psychological and biological determinants of behaviour (Stokols, 1996).

Typically, the SEM is represented by a series of concentric circles (Kok et al., 2008; Richard et al., 2011) (see Figure 2.2). At the first or inner level is the individual child or adult, and the characteristics that influence their behaviour, such as temperament, knowledge, attitudes, skills and beliefs (Bronfenbrenner, 1977). In the literature, it is evident that whether a Burmese migrant woman uses antenatal services is dependent on her knowledge about those services and the attitudes she has towards pregnancy. If pregnancy is viewed as a normal life event, some women may not see the need for regular check-ups (Downe et al., 2009; Finlayson & Downe, 2013).

The second level, most proximal to the individual child or adult, are the interpersonal processes, which provide social identity and role definition such as partner, family and friends. Bronfenbrenner (1977) referred to this layer as the microsystem. In the research on refugee women living in camps on the Thailand–Burma border (Carrara et al., 2011; Rijken et al., 2012; White et al., 2012), there is a complex set of relations between the individual (adult woman) or the developing individual (child) and their environments, including the length of time they have lived in this context. At this interpersonal level, factors like traditions and cultural practices related to birth are reinforced at both the family and community level. Food choices by pregnant women may also be influenced by access to food for financial and climatic reasons, time pressures affecting the ability to cook and eat together, and the role of food in the context of family relationships (Dennis et al., 2007; Liamputtong & Kitisriworapan, 2014; Liamputtong et al., 2005; Sein, 2013).

At the third level are the neighbourhhoods and communities within which the individuals are embedded (Bronfenbrenner, 1977). This layer includes collectives of
people with common values and mutual concern for the development and wellbeing of their group or local context (i.e., villages, neighbourhoods). At this level, the influence of established norms and values, standards and social networks within a community become evident. Bronfenbrenner referred to this layer as the mesosystem (Kok et al., 2008; Richard et al., 2011).

The fourth level is the organisational level of the community or services provided to communities, such as health services, education and transport. It includes, or is bound by the rules, policies and formal and informal processes and structures for operation within the organisations. Bronfenbrenner (1977) referred to this as an exosystem. For example, the literature reports the difficulties that many migrant women encounter in accessing services due to poor or expensive transport. For others, this difficulty relates to lack of access to child care. Again, this is related to their isolation or separation from family in their host country.

The fifth level is the societal level and includes both national and global contexts, societal and cultural norms and values, government and national policies (such as health or migration policies) and the media. Bronfenbrenner (1977) called this the macrosystem. Bronfenbrenner later added a further system known as the chronosystem to reflect the non-static nature of influences as the child develops (Bronfenbrenner & Ceci, 1994). For instance, over time, parents can divorce, family membership can change, and the child can change school and neighbourhood. There are also changes in government policy that can have direct effects on children’s lives (e.g., introduction of paid maternity leave, accreditation of child care) or fewer direct impacts (e.g., increasing casualisation of the workforce).
2.5.2 Studies that have adopted the SEM.

Urie Bronfenbrenner (1977) was one of the first to articulate the SEM. He used it to explain influences on child development at all levels. Bronfenbrenner placed the child at the centre and argued that the child’s development was influenced not only by the more proximal, and relatively stronger influences of the family, peers, school and community, but also by the distal factors of the broader social context, such as the media, parents’ work arrangements and governmental policies, and as discussed in this chapter, civil unrest, conflict and migration policies. The child is not passive in this relationship but also affects the systems in which he or she is encompassed.

Sword (1999) was one of the first maternity care researchers to examine the SEM in relation to maternity care. She reviewed the literature on barriers to prenatal care among low-income women and proposed a model acknowledging various determinants of behaviour that operate within different domains and at multiple levels (Sword, 1999). These factors were rather similar to those reported later by Downe et al. (2009). However, Sword (1999) identified positive factors and processes that directly affect the individual. For example, when health care is appropriate and responsive to needs, it is more likely that individuals will use services. Conversely, when circumstances are less than ideal, there is correspondingly less likelihood that programs and services will be used.

The model also emphasised the interpersonal relationship between the client and health care professional as a determinant of use (Sword, 1999). Sword described how women are located within a sociopolitical environment that shapes their personal and situational characteristics and, ultimately, has a determining role in utilisation. It is recognised that socio-economically disadvantaged women experience multiple challenges and may have attitudes and beliefs that hinder participation in programs.
However, it is important to acknowledge these difficulties and viewpoints as consequences of processes operating at successively embedded levels of influence identified in the model. Similarly, the delivery of antenatal programs and services is affected by numerous factors. Characteristics of healthcare agencies, including priorities and philosophies of practice, determine program components and availability as well as how service providers deliver care. Despite increasing commitment to community involvement and development as a basis of health promotion and risk reduction intervention, many antenatal programs continue to reflect an ideology of practice that gives precedence to the knowledge and expertise of healthcare professionals to the exclusion of client experiences.

Researchers in Bangladesh (Shahabuddin et al., 2017) recently explored maternal healthcare-seeking behaviour of adolescent girls and their experiences related to pregnancy and delivery in Bangladesh. The SEM was used to analyse the qualitative data at four levels (individual, interpersonal and family, community and social, and organisational and health systems). The study found that while adolescent girls showed little decision-making-autonomy, interpersonal and family level factors played an important role in their use of skilled maternal health services. In addition, community and social factors, and organisational and health systems factors shaped adolescent girls’ maternal healthcare-seeking behaviour (Shahabuddin et al., 2017).

Dunn et al. (2015) used the SEM to quantify factors that influence a woman’s decision to initiate and sustain breastfeeding, specifically women enrolled in the Women, Infants, and Children programs in the US. They discovered that breastfeeding initiation and continuation were primarily influenced at the individual level of the SEM by attitudes, beliefs and behaviours, but also influences at the interpersonal, community and organisational levels (Dunn et al., 2015).
Miller-Graff et al. (2017) investigated the intergenerational transmission of multisystemic risk and resilience among families with high rates of exposure to violence and maltreatment. Their study demonstrated the effect of maternal victimisation at a young age or as an adult prior to or during pregnancy and the direct association with maternal depression in the perinatal period, which directly affects child outcomes. In addition, this study showed that maternal family satisfaction and maternal reports of neighbourhood quality also indirectly affected children’s later adjustment. Family satisfaction and level of support together with neighbourhood quality affected child outcomes via maternal depression. This study also suggests that neighbourhood quality may provide support and resources for the mother that indirectly benefit her child. They propose that this may occur because healthy neighbourhoods may have quality day care centres; mothers feel reassured that their children are safe and may be able to reduce parenting stress by better distributing caregiving burdens to other quality care providers (Gray & Sanson, 2005). Further, neighbourhoods of better quality are likely to be safer, so these environments may alleviate mothers’ stress about the safety of their families (Miller-Graff et al., 2017). This sense of security may reduce risk for depression and indirectly promote healthy child adjustment. Such hypotheses require closer examination in future studies.

2.6 Conclusion

This chapter has provided the background and context of this study, including a brief description of the current position of Burma (Myanmar), the health and wellbeing of Burmese people and the factors that motivate women and men to migrate to Thailand to escape civil unrest, and to seek improved work and living conditions. It has described Thailand’s migration policies, the Thai worker registration system, working conditions of migrants, and the health and maternity care systems. The second
part of this chapter explored the literature on contemporary motherhood and migrant women’s experiences of becoming a mother in a new country. It also outlined literature on the health of migrant mothers and their babies, noting the higher levels of maternal mortality and morbidity among migrant women and the barriers to accessing health care. Finally, the SEM was outlined as a conceptual framework to assist in interpreting the findings of this study.

The next chapter details the methodology and methods used in the study.
3.1 Introduction

This chapter outlines in detail the methodology underpinning the research design and methods used in this study. The aim of the study was to examine Burmese women’s experience of becoming a mother and their healthcare and support needs during pregnancy, birth and the postpartum period in Ranong province, Thailand. Health professionals and Burmese interpreters (*lam*) were also interviewed to gain in-depth insight into the perspectives of health providers and their perceptions of the needs of Burmese women. It was important to use a methodology and methods that would accommodate sensitive data collection from this group of Burmese women and allow effective engagement with health professionals. The methods employed in the study needed to be suitable for investigating perceptions and experiences of motherhood and the factors that facilitate or hinder Burmese women’s access to maternity care in Thailand. In addition, the study aimed to describe the perception of the quality of the care received, and the interaction between Burmese women and health professionals during the provision of maternity care. Thus, a qualitative approach was selected.

The first section of this chapter briefly discusses ethnography, the methodology selected to inform the study design and data collection methods. The chosen methods included participant observation and interviews. This chapter also includes a description of the study setting, participants, collection and analysis of data, and translation and transcription of data. Ethical considerations related to conducting research with Burmese migrant women, Burmese interpreters and Thai health professionals are also discussed. The chapter concludes with reflexive thoughts on my
role as a researcher, a Thai health professional and mother, and the impact that this
may have had on data collection and analysis.

3.2 Qualitative Research

A qualitative research design was selected for this study because the research
inquiry is focused on the experiences of participants and the actions of humans
(Liamputpong, 2013). Qualitative research designs are used to explore key aspects of
participant information to understand their perceptions (Liamputpong, 2013). This
provides the opportunity to examine all the behaviours and experiences of a person or
group (Kitto, Chesters & Grbich, 2008).

Qualitative methodologies enable researchers to interact with participants
through conversations in health care, communities and living environments. The
meaning an individual ascribes to their environment and circumstances can be
understood as socially constructed through language, signs and cultural norms
(Liamputpong, 2013). Accordingly, the meaning behind what is observed, heard and
understood from Burmese women’s experiences and how Burmese women progress
through maternity care was investigated using a social constructionist approach. For
example, women were observed in the context of their lives, in the fish market, their
community and hospital and clinic environments.

A qualitative approach offers the opportunity to explore the ‘behaviour,
processes of interaction, and the meanings, values and experiences’ of individuals and
groups (Kitto et al., 2008, p. 243). Saddler (2008) contended that the use of a
qualitative research design allows the inclusion of ‘the informants’ own words to more
fully understand his or her thoughts and feelings about the subject of interest’ (p.74);
strengthening the authenticity of the research. Therefore, the subjectivity of research
participants is central and valuable to answering the research question, rather than a threat to the validity of the research.

3.3 Social Constructionism—The Research Paradigm

A paradigm is a set of beliefs based on ontological, epistemological and methodological assumptions (Coghlan & Brydon-Miller, 2014; Denzin & Lincoln, 2011; Hathcoat, Meixner & Nicholas, 2018). Ontology refers to the nature of existence and of being, and is concerned with understanding the structure of reality or ‘what is’ (Crotty, 1998; Hathcoat et al., 2018). Epistemology links with ontology in deriving how what exists may be known and validated (Green & Thorogood, 2013; Hathcoat et al., 2018). Seeking to understand the social construction of reality requires a commitment to uncovering the meaning embedded in interactions between self and others, and the experience of being human (Burr, 2018; Coghlan & Brydon-Miller, 2014; Denzin & Lincoln, 2011). Constructionism, with an ontology that positions reality within the social creation of meaning, is an epistemology that was an appropriate paradigm for this research. It allows for the investigator and research participant to be interactively linked (Denzin & Lincoln, 2011; Hathcoat et al., 2018).

Objectivism is the epistemological stance that forms the basis of scientific research from the positivist perspective. The assumptions underpinning the positivist paradigm rely on the certainty of scientific knowledge and have absolute faith in scientific processes that seek to discover objective and empirically verifiable knowledge (Charmaz, 2014; Crotty, 1998; Hathcoat et al., 2018). However, the epistemological view of constructionism rejects the objectivist view that truth exists regardless of whether conscious beings are aware of it, and extends beyond the purely subjectivist belief that humans impose meaning on objects (Burr, 2018; Charmaz, 2014; Crotty, 1998). Truth or meaning for constructionists is derived from the interplay
between object and subject and is not discovered but constructed by humans engaging with the realities in their world (Charmaz, 2014; Coghlan & Brydon-Miller, 2014; Crotty, 1998; Hathcoat et al., 2018). Constructionism links well with interpretive perspectives such as symbolic interactionism and ethnography (Coghlan & Brydon-Miller, 2014; Creswell & Poth, 2018).

Social constructionism is a paradigm or world view that is commonly used to inform study design and interpretations in health-related contexts in which the focus is on deriving meaning from the social reality of people or participants (Berard, 2008; Burr, 2018; Creswell & Poth, 2018). Many qualitative research methodologies are informed by social constructionism (Coghlan & Brydon-Miller, 2014; Creswell & Poth, 2018; Liamputtong, 2017).

In social constructionism, the individual is viewed as an active constructor of their own actions; they assess, interpret, clarify and influence their own conduct (Burr, 2018; Wallace, 2006). Constructionism views truth and meaning as a product of social interaction with the reality of our world (Burr, 2018; Crotty, 1998). While it acknowledges that different people construct different meanings from the same phenomenon, it is focused more on ‘the collective generation and transmission of meaning’ (Crotty, 1998, p. 58). Constructivism focuses more on the ‘meaning-making’ of individuals but considers it within the constructionist view of the world (Burr, 2018; Crotty, 1998). In relation to this study, the Burmese migrant mothers may at times either conform to socially generated beliefs and expectations in their pregnancy and early parenting experience and/or they may challenge those beliefs.

Ethnography, the methodology selected in this study (see Section 3.4), involves the study of social interactions, behaviours and perceptions that occur within groups, teams, organisations and communities (Reeves, Kuper & Hodges, 2008; Willis &
Anderson, 2017). In undertaking an ethnographic study, the researchers immerse themselves in the group under study by watching and listening (Hammersley & Atkinson, 2007; Liamputtong, 2013). This has been the principal method used by anthropologists to study how people live and interact (Hammersley & Atkinson, 2007; Liamputtong, 2013).

3.4 Ethnography

Ethnography has informed the design and approach to data collection and analysis in this study. Ethnography helps to explain how people make sense of their world. The aim of ethnography is to provide rich, holistic insights into people’s views and actions, as well as the nature of the location they inhabit, through the collection of detailed observations and interviews (Liamputtong, 2013; Reeves, Peller, Goldman & Kitto, 2013; Willis & Anderson, 2017). As Hammersley (2013) described, the task of ethnographers is to document the culture, perspectives and practices of people in these environments to capture ‘what happens in “natural” settings’ (p. 11) based on data produced in these settings. The researcher listens to what people ‘say’ about what they believe and do, and supplements this with observational data to capture what they actually do. This acknowledges the ‘complex relationship between attitudes and behaviour’ (Hammersley, 2013, p. 11). Ethnography is the study of social interaction and culture in groups to move ‘inside’ the way each group of people perceives the world (Reeves et al., 2013, p. e1366). The researcher can perceive the intended meaning of their perceptions and gain an insight into participants’ experiences (Hammersley & Atkinson, 2007; Willis & Anderson, 2017).

In addition, ethnographic enquiry enables an in-depth exploration of values, norms, symbols, beliefs and practices of the cultural group being investigated (Silverman, 2016). An aim of ethnography is to demonstrate how actions in one
community can be interpreted and comprehended, and how these interpretations might apply in another community from an individual’s point of view (Reeves et al., 2008). Ethnography means ‘learning from people’ to understand the meanings others provide to their world and way of life. It also means to gain insight into how people act through an exploration of their circumstances and living or working environment (Hammersley, 2017; Liamputtong, 2013; Reeves et al., 2013; Silverman, 2016).

3.4.1 Using ethnography to study health care.

In ethnographic studies, data are commonly collected by means of participant observation and interviews (Liamputtong, 2013; Willis & Anderson, 2017). Hammersley and Atkinson (2007) stated that an ethnographic study is also concerned with exploring the traditional and cultural practices of humans, from evolutionary and social perspectives. In terms of data collection, ethnographic studies have their origins in anthropology, with the art and science of describing the life patterns of people who are being studied and their cultural interaction (Johnson & Welch, 2011), including how they view the situations they experience, how they regard one another, and how they see themselves (Hammersley & Atkinson, 2007).

Ethnography is an established qualitative methodology adopted in health settings that involves the examination of study participants’ perceptions and actions (Dykes & Flacking, 2016; Hammersley, 2017; Knobloch et al., 2017; Willis & Anderson, 2017). For example, Rollans et al. (2013a, b, c) conducted participant observations and interviews with midwives, nurses, pregnant women and mothers to examine the process and experiences of routine psychosocial assessment and depression screening undertaken during pregnancy and after birth. From these observations, they reported that midwives and nurses varied in their approach to psychosocial assessment. Some adopted a flexible approach and others were more
process driven, relying on structured tools. Midwives and nurses experienced tension during these assessments, at times feeling uncomfortable or intrusive. Pregnant women perceived the assessment questions as important; however, some experienced discomfort, surprise and felt unprepared to answer the questions. Crawford et al. (2017) conducted participant observation and informal interviews with nurses and parents to investigate nurses’ experiences of emotional communication with parents of a baby in hospital, and to investigate parents’ experiences of emotional communication with nurses in health care settings.

More recently, authors have synthesised ethnographic and other qualitative studies using techniques described by Noblit and Hare (1988). Meta-ethnographic reviews have the potential to influence healthcare policy. For example, Knobloch et al. (2017) conducted an ethnographic review of 12 qualitative studies of the healthcare practices related to infection control, and exposed the design features that complemented or hindered infection prevention. They highlighted the value of using video-reflexive ethnography to understand patient perceptions of isolation practices and highlight the influence of physical design on infection prevention practices. These findings can be used to support professionals to change practice (Knobloch et al., 2017).

The focus of this study was encounters between Thai health professionals, Burmese interpreters and Burmese women within antenatal and postnatal care. It also focused on their cultural perceptions and expectations of pregnancy and motherhood. Teasing out the expectations and experience of migrant Burmese women’s access to maternity care will provide more insight than exploring broader factors that facilitate or hinder access would. For example, Thai health providers may be domineering and tell women what to do, and Burmese or migrant women, while reticent, may still listen
to them. However, the women may not follow the directions of the health providers. Some Burmese women may be dissatisfied with the care they receive or may deny existing problems. This study involved an examination of the nature of the interactions and the context within which they occurred. Thus, an ethnographic approach was essential, as it included participants’ own words to more fully understand their views and feelings about the affair of interest (Liampittong, 2013; Willis & Anderson, 2017).

3.4.2 Macro and micro ethnographic perspectives.

This study, drawing on the ecological model presented in Chapter 2, adopted both macro and micro ethnographic perspectives in exploring the situation for Burmese migrants (Fetterman, 2010). Taking a micro perspective can include a focus on subcultures within a larger culture or research in small units, such as a single ward, and a small group of specialist nurses or mothers interacting with staff in a postnatal ward. It also provides a closer view of health professionals and their practices. Fetterman (2010) claimed that the micro perspective focuses on specific behaviours in small social settings, in contrast to a macro perspective, which examines the broader setting or organisation, such as hospitals or communities. It might also study the impact of government policies such as migration policies (Fetterman, 2010). This doctoral study adopted a micro perspective to explore and understand the individual experiences of the 10 key informants: that is, the daily lives of the women and how they adapted or made changes based on their pregnancies. This included decisions about participating in cultural practices, who they drew their support from and how they juggled their employment responsibilities. From a micro perspective, individual health staff and Burmese interpreters were observed as they worked, and their experiences caring for Burmese migrant women were described in interviews. A macro perspective allowed the researcher to examine how the maternity services were
organised, the care practices and procedures, and how this was negotiated with Burmese mothers, and the role of interpreters at micro and macro levels.

Hammersley and Atkinson (2007) contended that ethnographic studies that investigate how state and institutional policies influence interactions and practices are very useful in informing the broader social context. It involves the researcher ‘participating, overtly or covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal and formal interviews’ (p. 3). Both ethnographic perspectives (macro and micro) encourage the researcher to study in detail the community factors (including national or societal issues) and individual factors (such as family) (Dykes & Flacking, 2016). An example of studies that have adopted both micro and macro ethnographic perspectives include the work of Dykes (2006), who studied women’s experiences of initiating breastfeeding in a postpartum unit of a UK hospital. Observations and interviews with women and midwives were used to elicit beliefs, expectations and experiences concerning breastfeeding.

In this study, interactions between migrant Burmese women and healthcare staff occurred in a specific setting and context: a maternity unit and PHC clinic in Ranong province in Thailand. I observed the ‘natural’ context of an antenatal care clinic and postnatal ward, listened to what was said, observing who was present or absent, how women acted and reacted in this context, and how health staff acted and reacted. I interviewed women following interactions with health staff and also interviewed health providers, enabling me to gain an in-depth understanding of interactions between health professionals and Burmese women and to explore the meanings that Burmese women make of the interaction (Cluett & Bluff, 2006).
3.5 Study Design and Settings

In ethnographic research, the ethnographer is the primary instrument of fieldwork, situated within a natural community, using participant observation and interviews to gather data and collect field notes (Liamputtong, 2013; Willis & Anderson, 2017). These methods allow the researcher to capture all the significant people in the community and observe and analyse social and health-related situations (Silverman, 2016). This section describes the study setting, study participants and recruitment procedures.

The research was undertaken at the Ranong Hospital and Pak-Klong Clinic, located in the main city, Ranong province on the Thailand–Burma border. The Ranong Hospital is governed by the Thai Ministry of Public Health. Due to its proximity to the Burma border, many migrants travel across the border to Thailand to work or access maternity care services.

The research was undertaken at two antenatal care clinics in Ranong province: one was located in the hospital, and the other was a community-based clinic in the area where the Burmese community lived (Pak-Klong Clinic). This clinic forms part of the community-based PHC services and was first opened in 2011.

These healthcare settings serve many pregnant women and provide a broad range of antenatal care for pregnant Burmese women on the Thailand–Burma border. Ranong Hospital also offered the opportunity to observe postnatal care. Maternity unit managers provided data related to the number of Thai and Burmese women receiving antenatal and postnatal care from the records at Ranong Hospital and the Pak-Klong PHC. The data were for 2011–2014. In total 2,887, 3,035, 3,129, and 4,154 women received postnatal care at the hospital respectively in these years. While the overall
number of births (represented by the number of women receiving postnatal care in Ranong Hospital) has increased, some other changes over that time should to be noted.

Table 3.1 presents the numbers of Thai and Burmese women receiving antenatal care in the two clinics. The number of Burmese women receiving antenatal care at the hospital has more than halved, while at the same time the number receiving antenatal care at Pak-Klong Clinic has increased by 500 per cent. This related to changes in the local health service policy and the way antenatal care was provided for women from the Burmese community (Ratchaputi, 2015). From 2011 onwards, women were directed to use the community-based PHC and to only use the hospital in the case of risk factors or health complications. Simultaneously, the number of health professionals providing the service in the community-based PHC increased from two nurses to four, and two interpreters were employed. Staffing in the hospital-based antenatal clinic did not change. Therefore, a greater number of women either had to or chose to use the PHC clinic (Ratchaputi, 2015).

In the same period, only a small number of Thai women attended Pak-Klong PHC for antenatal care (20 in 2011, 2 in 2012, none in 2013 and 5 in 2014). Further, the number of Thai women using these public antenatal services decreased by over a third in this period. The managers suggested two reasons for this. First, Thai women are having fewer children on average. For example, in Thailand, the birth per 1,000 was 12.0 in 2009 and 10.6 in 2015 (World Data Atlas, 2018). Second, more Thai women are accessing private antenatal clinics in Ranong (Ratchaputi, 2015).

While the number of Burmese migrant women receiving postnatal care in 2011 roughly equalled the number of Thai women receiving postnatal care, from 2012–2014 the number of Burmese women receiving postnatal care exceeded the number of Thai women (The Postpartum Team Unit, Ranong Hospital) (Ratchaputi, 2015).
The data also indicate that the number of Burmese women using the two antenatal care services in 2011 far exceeded the number of Burmese women receiving postnatal care in that year. This suggests that many migrant Burmese women returned to Burma to have their baby or had a homebirth in Thailand (Ratchaputi, 2015). In the following years, it appears that most Burmese women receiving antenatal care in these Thai clinics also gave birth and received postnatal care in Ranong Hospital.

Table 3.1

*The Number of Migrant Women Who Came to Ranong Hospital in Two Areas, and Pak-Klong PHC During the Four-Year Period*

<table>
<thead>
<tr>
<th>Years</th>
<th>Maternity care</th>
<th>Antenatal care</th>
<th>Postnatal care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ranong Hospital</td>
<td>Pak-Klong PHC</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td>Thai</td>
<td>Burmese</td>
<td>Thai</td>
</tr>
<tr>
<td>2011</td>
<td>1673</td>
<td>2108</td>
<td>20</td>
</tr>
<tr>
<td>2012</td>
<td>1797</td>
<td>1369</td>
<td>2</td>
</tr>
<tr>
<td>2013</td>
<td>1886</td>
<td>1418</td>
<td>0</td>
</tr>
<tr>
<td>2014</td>
<td>983</td>
<td>891</td>
<td>5</td>
</tr>
</tbody>
</table>

In addition to collecting data in the healthcare settings, I also engaged with women in the community during my observations in the community. ‘Community’ refers to the districts or neighbourhoods in Ranong province, such as Sapanpla, where many Burmese migrants live and work. Areas where they are employed daily, such as markets or waterfront areas for fisheries workers, were included (see Figure 3.1).
Figure 3.1. Illustration of Burmese communities in Ranong, Pak-Klong PHC and Ranong Hospital.

3.6 Ethical Considerations

The first step in ethics approval was to seek permission to conduct the study from the Ranong Hospital and Ranong Provincial Public Health Office in Thailand (see English and Thai translation in Appendix A). Following this, ethics approval for the study was sought and obtained from the Human Research Ethics Committee of Western Sydney University (see Appendix B). Once ethics approval was received, the final approval to access the sites was provided by the Ranong Hospital committee and the Ranong Provincial Public Health Office in Thailand (see Appendix C).

Burmese women, particularly if they are illegal migrants, may have had concerns about participation. Most likely, women who were highly concerned about this would not agree to participate. Health providers may have held some concerns about having their practice observed by another and the implications of this scrutiny.
These discussions were approached sensitively in acknowledgement of the potentially confronting nature of the request.

Participation in this study was voluntary. Participants had legal worker status and were informed that they could withdraw at any time without providing a reason. An information sheet and a consent form was provided in Burmese for Burmese women participants (see Appendices D-F: D in English, E in Burmese and F in Thai), and Thai for Thai health provider participants (see English and Thai translation in Appendices G and H). The aim of a consent form is to clarify and record the terms of the agreement between the participant and researcher (Speziale, Streubert & Carpenter, 2011). Therefore, it was crucial that the study’s interpreters had a full understanding of the consent process and that each woman was given full information about the study. To ensure the Burmese women participants could be easily understood, the information sheet and consent form used to ensure informed consent was presented in their native language and translated by the interpreter.

Women were assured that all their information was confidential and their names would not be mentioned in the findings. Participation would not affect the care they received or their employment. Health provider participants were assured that the study was not about scrutinising individual practitioners. Rather, it was about capturing the experiences of the women and the health staff.

All data were re-identified and confidential and participants’ names were not stored with the data. Participants were provided with information about the study and a copy of the participant information, consent forms and the researcher’s contact details. A copy of the information and consent forms were kept in a central place for healthcare staff’s easy access.
Establishing and maintaining a relationship with participants during data collection is important when researching a vulnerable group and for gaining ongoing access. Allowing participants the greatest opportunity to talk comfortably and safely about their experiences facilitated the sharing of participants’ accounts of events and experiences.

3.7 Participants and Recruitment

Three groups of respondents participated in this study: Burmese women \( (n = 10) \), Burmese interpreters \( (lam) \) \( (n = 4) \) and Thai health professionals \( (n = 9) \).

3.7.1 Burmese women as key informants.

In this study, 10 Burmese women who were receiving antenatal care at either Ranong Hospital or Pak-Klong PHC were recruited as key informants. During recruitment, I was accompanied by one of two experienced Burmese interpreters. As I am a Thai-speaking nurse-midwife, a Burmese interpreter was crucial to assist with recruitment and data collection. When recruiting women attending the antenatal care clinics, initial contact was made by the interpreter, who invited the women to participate in the study. The women were provided with a colourful information flyer (see Appendix I). If women were interested and agreed to participate, the Burmese interpreter introduced and helped me communicate with the Burmese women to provide information and consent forms (in Burmese). If the woman could read in her own language, she was provided with the information and consent form and read this before agreeing to participate. In three cases, the woman could not read in Burmese; thus, the interpreter or a family member read it to her in Burmese. Women were given the opportunity to ask as many questions as necessary before being asked to sign the consent form, indicating that they understood the information provided and agreed to participate. In some cases, women did not agree to participate when first approached.
by the interpreter or the nurse-midwife in the clinic, but when they returned a week or two later for antenatal appointments, they had had more time to consider participating.

The 10 key informant women (five from Ranong Hospital and five from the Pak-Klong PHC) were asked to allow me to observe them during their interactions with health staff in the antenatal clinic. Additionally, depending on the time of the birth, to allow observation of them in the postnatal ward and to participate in interviews before and after the birth of their baby. I also sought permission to observe these 10 women as they participated in aspects of community life following the birth of their baby. The 10 women recruited to participate in this study had to meet certain criteria: They had to be willing to be voice-recorded during interviews and had to own a mobile telephone to allow contact after the birth to arrange the interview. If possible, they had to be able to speak basic Thai. To follow the women and interview them after birth, they had to agree to provide their contact details, such as telephone numbers and home address to enable contact for data collection. It was intended that women would be excluded from the study if they or their babies experienced antenatal health complications or post-childbirth complications. However, women were given the opportunity to remain in the study if that was their wish. None of the women or their babies experienced any complications; thus, they all remained in the study.

As part of the ethnographic research, on each visit to the antenatal clinics, around 50 to 60 non-consenting women were observed in the clinic reception area and waiting areas. This was necessary to observe the work of nurse-midwives and other health staff in both antenatal settings. Similarly, during participant observations on the postnatal ward, I typically observed 15–20 postnatal women and their family members interacting with each other, their babies and the staff. On any one day, this would amount to 40–50 people. In addition, Burmese people living in the Sapanpla
community were also observed; it is difficult to quantify the number of people observed, as these were extremely busy places. No demographic or interview data were collected from any of these participants; they were simply observed. It was not possible to obtain consent from the individuals. However, if asked by anyone in the setting, I explained that I was there as a researcher. This is common practice in ethnographic research (Liamputtong, 2013).

3.7.2 Burmese interpreters (*lam*).

Four Burmese interpreters (*lam*) were employed to work in Ranong Hospital and Pak-Klong PHC. The two interpreters in the Pak Klong PHC were employed by the Ranong Provincial Public Health Office in Thailand. Those working in the Hospital ANC were employed by the Ranong hospital. Two interpreters worked in PHC and two worked in the hospital (one in the antenatal clinic and one in the postpartum ward). I approached each of the four Burmese interpreters individually and invited them to participate in this study. As mentioned above, I had already employed an interpreter to assist with recruitment and data collection with Burmese women. Once I visited the antenatal or postnatal care areas, I introduced myself to the *lam* and provided information about this research, such as the aims and study participants. When they were fully informed of the steps in the research, they were provided with the information and consent forms in Burmese. They had the opportunity to ask questions and were informed that they did not have to participate, but were invited to if they would like to. The *lam* who agreed were asked to participate in an interview about their experiences of interpretation and working with Thai health professionals. They were also asked permission to observe interactions with Burmese women and Thai health staff (e.g., in an antenatal appointment). The interpreters had worked in the
hospital and PHC sites for a minimum of one year and were fluent in Burmese and Thai. All four agreed to participate.

3.7.3 Thai health professionals.

Thai health professionals were recruited from the two antenatal care clinics in Ranong, the PHC clinic and the hospital ANC and the postnatal ward in Ranong Hospital. There are 25 staff members in the maternity service and all staff were invited to participate. They were provided with the participant information statement and given the opportunity to ask questions before agreeing to participate. In total, 25 health professionals participated in the study; nine health professionals, including nurse-midwives, obstetricians and public health officers, agreed to participate in interviews. All staff working at the time of observations of interactions with Burmese women agreed to be observed (25 health providers). The managers of the health service also approved the observation of general activities and interactions in the antenatal clinics and postnatal wards.

3.8 Data Collection

In this study, data were obtained using the participant observation method in the antenatal clinics and postnatal ward, in the community and at key informants’ homes. In-depth face-to-face interviews with Burmese migrant women, health staff and interpreters were also conducted.

3.8.1 Participant observation.

Ethnographers use participant observation to collect data on individuals and groups in their natural settings (Liamputtong, 2013; Willis & Anderson, 2017). To understand the meaning of people’s everyday actions, interacting and participating with them is a distinctive research strategy that is very useful. Participant observation is the key methodological approach for ethnographic research (Liamputtong, 2013;
Reeves et al., 2013). Active engagement and participation directly in the setting captures study participants’ social meaning and ordinary activities (Hammersley, 2017). As such, field notes are a crucial means of data collection, particularly in situations of participant observation in which the researcher plays a central data collection role. Crawford et al. (2017) used 260 hours of participant observation to understand the context of nurse–parent interactions in a health setting. All details, such as staff folders, policy and medical records, were examined and described in handwritten field notes along with observations relating to interactions, personal reflections and responses to observations. In addition, they also conducted participant observations and semi-structured interviews with the participants, producing a rich and rigorous dataset (Crawford et al., 2017).

However, there are various levels of observation that researchers have adopted for participant observation. Gold (1958) provided descriptions of the nature of observer roles during participant observation. Gold positions observation along a continuum from complete participant, participant as observer, observer as participant, through to complete observer. Each role offers different perspectives on the group studied and raises different challenges for the researcher. Complete participants must adopt a role of ‘pretence’ as they immerse themselves in the community being studied without identifying their researcher status. This can lead to over-identification with participants, a lack of critical distancing and ethical implications.

The ‘participant as observer’ role is more transparent as the researcher can identify themselves to the study population. However, this role can lead to the researcher losing perspective and ‘going native’ (Gold, 1958; Unluer, 2012). The ‘observer as participant’ role allows the researcher to maintain a degree of ‘stranger’ distancing from the group, while still enabling interaction with participants to develop
rapport. The final participant-observer role is complete observer, in which the researcher maintains a more formal observational stance with minimal interaction with the community under observation (Gold, 1958; Whitehead, 2016). Researchers who engage in observation position themselves somewhere along this continuum to ensure that they find the right balance between observation and participation without becoming overly ‘aligned’ with one group or developing an over-rapport with another (Cudmore & Sondermeyer, 2007). Yet the researcher’s role is not ‘fixed’ during data collection. Rather, it can occur along this continuum depending on the aspect of data collection required (Pope, 2005).

In this study, data were collected through interviews and observations of women and health staff in the antenatal clinic at Ranong Hospital and the Pak-Klong PHC, and observations in the postnatal unit at Ranong Hospital. Interviews were conducted with pregnant Burmese women when they attended antenatal care in the PHC clinic or the hospital, in the postnatal ward and in the community. In addition, health providers were asked to participate in a one-to-one interview and some documentary sources related to the maternity services were examined.

3.8.1.1 Conducting participant observations.

I conducted participant observations for an eight-month period from early May 2015–mid-December 2015 in Ranong, where the Burmese community lived. In the first stage of the data collection, I conducted observations in the two antenatal clinic settings and in the community. In the second stage, observations occurred in the postnatal ward and in the women’s homes after they gave birth.

In this study, at times I was a complete observer. When observing in the local community and in the Burmese people’s workplaces (e.g., the fishery or food markets), I was a stranger to the participants, but spent time observing with very minimal
interaction with community members. At other times, I was an ‘observer as participant’ (e.g., when interacting with the women and staff at the Pak-Klong PHC and the hospital). This participation with women and health professionals provided me with a deeper insight into the experiences of life and maternity care for participants. It facilitated building rapport with women and health professionals and prevented an over-involvement, which might cloud the purpose and capacity to analyse the observational data.

3.8.1.2 Preparing for data collection at the health care clinics.

Introductory meetings with health staff of the Pak-Klong PHC and the Ranong Hospital maternity unit occurred prior to contacting any potential participants. A meeting and informal conversations at each site provided the opportunity for healthcare providers to gain an understanding of the purpose of the study.

To communicate with the Burmese women, I was accompanied by two experienced interpreters. Before the data collection, I had to train the interpreters to assist me with data collection. Liamputtong suggested that bilingual workers should be trained and employed by the researcher when researching migrant women (Liamputtong, 2010). Therefore, I spent considerable time orienting the two interpreters who worked with me in data collection.

The two female interpreters were experienced in working with Burmese people and Thai health providers. First, I requested their willingness to work with me to collect the data. Once they agreed, I explained the aims, objectives and methods of the study in greater detail. Second, I had to orientate the interpreters to the requirements of the recruitment process and the face-to-face interviews. The Burmese–Thai interpreters received instructions on the importance of interpreting my speech in Thai, word-by-word, to ensure accurate transcription of interview data (see Table 3.2).
I also stressed that when interpreting during interviews, the central meaning from the Burmese women should be maintained in the Thai interpretation. The interviews with the Burmese women were conducted in Burmese, supported by a Thai- and Burmese-speaking interpreter. I did not require these interpreters to work with me when I was observing the antenatal appointment between the Burmese women and the Thai health professionals because one of the employed lam was present during this time. Therefore, the interaction was translated to Thai for the health professional. The interpreters were also present when I observed the Burmese women in the antenatal clinic, the community and the postnatal ward.

Table 3.2

*The Steps of Interpretation During Data Collection*

<table>
<thead>
<tr>
<th>Interviews with Burmese women</th>
</tr>
</thead>
<tbody>
<tr>
<td>The researcher asked the questions to the women in Thai</td>
</tr>
<tr>
<td>The interpreter interpreted the question in Burmese</td>
</tr>
<tr>
<td>Burmese women answered the question in Burmese</td>
</tr>
<tr>
<td>The interpreter interpreted verbatim the response from the women in Thai</td>
</tr>
</tbody>
</table>

By orienting the interpreters to the objectives of the study, they were able to clearly understand their role as bilingual research assistants and accurately interpret interview data, thereby avoiding discrepancies caused by language barriers (Liampittong, 2010).
3.8.1.3 Observations in the antenatal clinic.

Ethnographic observations occurred one day a week in each antenatal clinic: on Mondays in the hospital antenatal care clinic and on Wednesdays at the antenatal care PHC clinic. The length of time allocated to the health providers to conduct antenatal care was around three to four hours per day. Approximately 60 hours of observation was undertaken. This was spent talking with health staff, participating directly in the setting and observing individual interactions between the nurse-midwives and the key women. When I was present during the clinic appointment, in the presence of a Burmese woman, the Thai health professional and the interpreter, I thought carefully about where I positioned myself to not intrude on the three-way interaction. However, the nurse-midwife typically asked me to sit next to her opposite the woman and the interpreter. Figure 3.2 illustrates this positioning.

<table>
<thead>
<tr>
<th>The hospital antenatal care clinic</th>
<th>Pak-Klong PHC clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outside building</td>
<td>Outside building</td>
</tr>
<tr>
<td>A: Waiting area, B: Staff working area.</td>
<td>A: Waiting area, B: Staff working area.</td>
</tr>
<tr>
<td>😞 Health staff 😊: Interpreter</td>
<td>😞 Health staff 😊: Interpreter</td>
</tr>
<tr>
<td>😞 This is me (the researcher)</td>
<td>😞 This is me (the researcher)</td>
</tr>
</tbody>
</table>

Figure 3.2. How I positioned myself in both ANC clinics.
As a healthcare professional observing in a familiar health setting, I had to be conscious not to slip into my usual health professional role and remember my status as observer. In the case of the health care ethnographies, the researcher, through participation, begins to act like an insider who is often a member of the health staff they are observing. I had to balance my position as a Thai nurse-midwife, who is to observe, and ensure my role as researcher was communicated to everyone at the clinics. Fortunately, the focus of the health professionals was interaction with the women and I was able to maintain an ‘outsider’ perspective.

3.8.1.4 Observations in the postnatal ward.

The second stage of the study started eight weeks later and involved observations in the postnatal ward, including observations of the interactions between health providers and postnatal women in general (not necessarily the women recruited as key informants), and when possible, the key informants who were interviewed during their pregnancy. The interactions between the health providers and the women were observed twice weekly for four hours each time in the postnatal ward—approximately 40 hours of observation. The focus of the observations was the postnatal environment, the activities undertaken by women, their family and health staff, and the interactions between the staff and women. These observations were recorded in my field notes. My status in this setting was ‘participant as observer’.

Here, I fluctuated between walking around and observing the nurse-midwives and health staff, the women and their families. At other times, I sat in the corner of the nurses’ station at the end of the ward. At these times, I had reading material with me, so it appeared I was reading while I was observing (see Figure 3.3). The participants (women, their families and staff) knew who I was and why I was there. Sometimes, the women or their relatives asked me questions and I would converse with them, if
possible, in Thai; otherwise, I had to rely on the interpreters to direct the women to the appropriate staff member. For example, frequent questions were, ‘what time does the doctor come to visit us?’, ‘when can I leave the hospital to go back home?’, and ‘how do I care for my baby’s belly button?’. 

![Diagram of hospital ward]

**Figure 3.3.** How I positioned myself in the postnatal ward.

### 3.8.1.5 Observations in women’s homes.

Opportunities were also sought to participate and observe the 10 women in aspects of their community life. When visiting the women after birth, I always had the interpreter with me, not only for language translation, but also because they were known in the community. The meeting time was arranged to suit the women and their families, and I always presented fruit for the family and a gift for the baby/children (e.g., clothes, dolls or toys). When family members, such as the woman’s husband and friends, were present during the observations or interviews in their homes,
conversations were recorded in the field notes with the permission of the women and the family members.

3.8.1.6 Observations in the Burmese community.

When I started data collection, I spent some time familiarising myself with the local community. I mostly went by myself and visited the fishery, markets, pier and other important community spaces, such as the temple and residential areas. I later went with the interpreters who were able to tell me a great deal more about community life. They encouraged me to participate in community events in the temple and took me to observe some weddings.

Typically, ethnographic research requires a considerable level of trust with participants (Liamputtong, 2013). It is difficult as a complete observer to gain the trust of people in the community without interacting with them. When walking around the villages, I tried to appear neutral and as though I was a member of community (e.g., wanting to buy food at the market). The people in the community could have been alarmed when I was observing. This was because there is a considerable number of illegal Burmese residents on Thailand–Burma border. These illegal residents are often vulnerable to arrests by Thai police. It is possible that while all the study participants were legal migrants, many community members or some family members of key informants may not have held a legal status.

I dressed neutrally, similar to other women, to feel comfortable and fit in. However, I still experienced some distrust from Burmese people in the community. From my observations at the Andaman Fresh Market, many Burmese people avoided eye contact with me. I saw the little children sitting beside their mother, who was selling fruits and flowers. I smiled at them and wanted to talk with them, but the mother appeared to mistrust me and turned away from me. I thought this may have been
because there were police patrolling. Most people ignored me. The Burmese interpreter explained that most Burmese people distrusted Thai people because they did not know what the Thai people wanted from the Burmese. For example, one Burmese tourist guide at Sapanpla came to question me, even though I was accompanied by a Burmese interpreter. He asked:

   Do you want to go to Burma by longboat? Where are you going? Are you a tourist? Why do you take photos? I do not want you to take photos because I am afraid that we may be troubled by the media because of your photography.

   However, this man did not dare make eye contact with me. He acted as if I was not there and instead talked to the interpreter. In response, the Burmese interpreter, who came along to help me, replied:

   No, nothing at all, just looking around. Do not worry, she is my friend. She is a nurse and is very interested about the experience of Burmese women accessing Thai maternity care. She is not a police officer. So, take it easy.

   The man was then satisfied and walked around to greet others but still did not meet my eye. The man stated that taking pictures could have negative consequences for him.

   After that incident, I always visited the villages with the interpreter, who was known in the community. I found it much easier to gain access to the participants’ community when accompanied by the interpreter, with whom the Burmese people were familiar. Having a known person with me was crucial to gain the trust of the Burmese community. One interpreter stated:

   If someone looking like a police officer comes by, they would be sort of frightened because they do not trust anyone. If I accompanied them on the visit,
they would know I am a Burmese. I told them that they did not need to be worried, they were safe, and we are now on friendly terms.

Likewise, I encountered similar problems when I went to the Chok-Dee Market with a Burmese interpreter who lived in the community. A female shopkeeper turned to the interpreter with a question in Burmese about who I was. I knew the question, as the interpreter interpreted for me:

It is okay, she is a nurse, same as the health staff from Pak-Klong Clinic. She just wants to know our community, and she is very interested in Burmese workers and Burmese pregnancy. Please, do not be afraid, she is not a Thai police officer or spy, so do not fear.

3.8.1.7 Recording the observations.

The observations in both antenatal clinics and the postnatal ward included observations of formal and informal interactions between the women and health providers, and everyday community life. I was particularly interested in how health providers interacted with the women, their communication style, the information they focused on, the activities they undertook with women, and more generally, in their workplace. I also noted use of non-verbal body language. I observed how the women responded to health staff, their facial expressions and what they said or perhaps did not say. These activities were observed and recorded in a structured observation tool, as well as field notes when appropriate, or as soon after the event as possible (see Appendix J). The observation tool was informed by the work of Spradley (2016) (see Table 3.3).
Observational dimensions | Field note exemplars
---|---
**Space—Physical layout of the places** | There were rows of seats in front of the registration desk, where the women wait. The hospital clinic had 12 seats and the PHC had 20–30 seats. Women sitting in these seats would not speak with each other; they just stared ahead and waited. I realised I had not taken much notice of this as this is typical of antenatal clinics in most Thai hospitals. However, what surprised me was the number of women in PHC who preferred to sit on the floor so they could speak with each other rather than sitting in a row staring ahead. I did not observe this in the hospital clinic.

**Object—The physical things that are present** | The entrance to both clinics has a banner or sign stating the opening hours of the clinics and when the Burmese clinic is scheduled with an interpreter. This is in Thai and Burmese. There is also a poster inviting pregnant women to use the prenatal care. These posters are illustrated with smiling pregnant women. This created a welcoming feel.

**Actors—Range of people involved** | On any one day in the ANC, there could be 40 women waiting to see staff. It was rare that I saw the women’s husband’s staying with them at the clinic; sometimes women brought their children with them. Some women sat together on the floor so they could speak with each other. The health staff in the PHC seems relaxed and would casually call women to the registration desk, then to the room for assessment etc.
<table>
<thead>
<tr>
<th>Observational dimensions</th>
<th>Field note exemplars</th>
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<tbody>
<tr>
<td><strong>Activity</strong>—A set of related activities that occur</td>
<td>Postnatal ward: Today the ward was busy. Most women had at least one relative with them all day. The relatives were mostly talking with the Burmese mother, or nursing the baby while the mothers slept. Women’s visitors stood beside the women and some helped the women become comfortable or care for her baby. Some women breastfed their baby and some were talking with their relatives.</td>
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<tr>
<td><strong>Act</strong>—Single actions and group actions people undertake</td>
<td>Two women have been waiting since early morning but had not received ANC yet. At 1.20 pm, the midwife asked the women, ‘What are you waiting for?’ One of the women could understand some Thai and replied ‘We come for antenatal care. We do not know why the health staff kept us waiting. I do not know what we are waiting for, but the person in pink [the interpreter] told us to wait’. The health staff interacted with the postnatal women in soft tones as they informed the women about what they were doing. The nurses were friendly, smiling as they provided care to women and demonstrated techniques such as bathing the newborn and cleaning the umbilical cord and eyes. The women responded positively to these interactions. They appeared to listen intently to the nurses, nodding their head and holding eye contact with the staff.</td>
</tr>
<tr>
<td><strong>Event</strong>—Activities that people carry out</td>
<td>A doctor came in to check on the baby in the postnatal ward; he greeted the women with a Thai Southern accent (informal communication) and talked in a friendly way without using the interpreter.</td>
</tr>
<tr>
<td>Observational dimensions</td>
<td>Field note exemplars</td>
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<tr>
<td>Time—The sequencing of events that occur</td>
<td>Today I have drawn a map of the ‘patient flow’ in the clinics. It seems that the women are on a conveyor belt or being processed and at the same time, they have to wait for ages for appointments. They move from area to area and from staff to staff. There must be a better way to organise the service.</td>
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<tr>
<td>Goal—Things that people are trying to accomplish</td>
<td>It was good to talk today with the two interpreters in the PHC clinic. They love their job and are very enthusiastic. They told me that they were very motivated to help their community; they felt they could make a difference, particularly encouraging woman to come for antenatal care.</td>
</tr>
<tr>
<td>Feeling—Emotions felt and expressed</td>
<td>Another occasion today when I heard a nurse-midwife telling a Burmese mother that she should be sterilised after this baby because they should not have any more than two children. The woman looked stunned that the nurse-midwife would say this to her; she did not say anything and had no further eye contact with the staff member, but she looked upset.</td>
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</table>

During the fieldwork in the antenatal clinics, postnatal unit and in the community, I played the role of participant-observer, aiming to disappear into the background as much as possible. The ‘busyness’ of the environments helped me ‘blend’ in. In each setting, the antenatal clinic and postnatal ward, many people were present daily; some were visitors of the women and others might be visitors such as students and their teachers. During the observations, I engaged in informal conversations, through the interpreter as necessary. This allowed me to ask additional questions about events as they occurred.
3.8.2 Interviews.

Interviews are a common method in ethnographic research (Gobo & Marciniak, 2016; Liamputtong, 2013). Well-conducted in-depth interviews allow the researcher to explore with participants the complex experience of finding ‘reality’ in interview accounts (Gobo & Marciniak, 2016; Silverman, 2010).

3.8.2.1 In-depth interviewing method.

The in-depth interviewing method is commonly used to examine the meanings of participants’ beliefs and actions (Serry & Liamputtong, 2017). It is one of the most effective methods of data collection in a variety of research methodologies and can potentially provide insightful participant understandings of attitudes, perceptions and motivations (Given, 2012; Serry & Liamputtong, 2017). In-depth interviewing is suitable for data collection in qualitative research, such as grounded theory and ethnography, but it provides limited opportunity since it relies on recalling an experience within the timeframe of the interview. In-depth interviewing allows each participant to provide in-depth knowledge on the topic under investigation and detailed accounts of their experiences (Given, 2012; Goldman & Swayze, 2012).

Additional questions may be asked of the interviewee, but they feel more comfortable and free to talk in the interview, during which the conversation oscillates between the researcher’s directions of the topic and the participant’s account (Given, 2012). In-depth interviewing involves direct, one-on-one engagement with individual participants. It is commonly conducted face-to-face or through the telephone. Information can be gathered in various ways using questions on the continuum between structured and unstructured interview schedules (Johnson & Welch, 2014). The researcher can retain control over the direction and content discussed and probe to expand on discussion points (Johnson & Welch, 2014; Serry & Liamputtong, 2017).
For instance, Azaare and Gross (2011) used semi-structured interviews with nurses to explore the nature of leadership styles used by nurse-managers. In their study, interview questions were ‘open’; for example, they started with ‘what’ and ‘how’, and were conducted face-to-face (Azaare & Gross, 2011). In-depth interviews are recorded, as they would be too time-consuming to document in field notes. Interviews should be transcribed, organised, analysed and reported (Johnson & Welch, 2014). Johnson and Welch (2014) suggested when organising semi-structured interviews, the researcher should provide a time suitable for both interviewers and interviewee, a private location and inform the participants about the time required of them. To ensure consistency in interviewing, reliance on the in-depth interview can be combined with other methods like observations and documents. This is because the researcher and the participant are limited by the participant’s recall and ability to compose detailed discussion during interviews (Goldman & Swayze, 2012).

3.8.2.2 Interviews with Burmese women.

A total of 20 interviews were conducted with the 10 Burmese women. Face-to-face interviews were conducted with five Burmese women in each antenatal care setting (Ranong Hospital and Pak-Klong PHC). Ten interviews were collected with women in pregnancy. The interviews conducted in the antenatal clinics took place in a private space in the presence of an interpreter. Each interview was between 30 and 60 minutes long and depended on the availability of the woman. In the antenatal clinic, women could wait for one to two hours for an appointment. Therefore, most were happy to be interviewed during this time. In addition, as these women returned to the antenatal clinic fortnightly from 32 weeks and weekly from 36 weeks, I had the opportunity to follow-up with them and ask further questions about their experiences,
plans for birth, postpartum care, and their planned return to work and childcare arrangements.

These 10 Burmese women were interviewed again following the birth of their baby. These interviews occurred in the women’s homes or community when the babies were between two and six weeks of age. Each interview was 30–60 minutes long. One woman was interviewed in the postnatal ward. To arrange these interviews, I had telephone contact with the women via the interpreter. At this time, some women also talked about their experience. These telephone chats were around 20–30 minutes long.

The interview questions were open-ended and explored Burmese women’s perceptions of becoming a mother, their experiences of pregnancy, birth and the postnatal period, and their views of their healthcare needs. They were also asked about their experiences of maternity care, including their relationship with the nurse-midwife and other health staff, their access to maternity care and the factors that they perceived facilitated or hindered their access and use of maternity care services. Women were asked to suggest improvements for the maternity services. Interview questions and additional prompts are presented in Tables 3.4 and 3.5. The women were asked to provide their basic demographic details such as age, length of time in Thailand, employment status, marital status, number of other children and living arrangements.

Table 3.4

Antenatal Interview Questions for Burmese Women

<table>
<thead>
<tr>
<th>Antenatal interview questions for Burmese women</th>
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<tbody>
<tr>
<td>How do you feel about becoming a mother?</td>
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<tr>
<td>What were your first thoughts when you found out you were pregnant with this baby?</td>
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</tbody>
</table>
Antenatal interview questions for Burmese women

How have you been feeling during the pregnancy (physical and emotional health)?
Is there anything you are particularly concerned or worried about?
How has the pregnancy affected your work and other aspects of your life?
Why did you decide to come to this antenatal clinic for your pregnancy care?
How did you find out about the health care here in Ranong?
How do you travel to your antenatal appointment?
What is your perception/experience of the care you have received at the clinic or hospital?
How do you feel about the interactions with health providers?
Can you describe any practices or beliefs that are important for Burmese women during pregnancy or birth (e.g., special food, body care)? Are you or will you participate in any of these practices?
How do you plan to feed your baby?
Who is providing you with support in your pregnancy?
When you leave hospital with your baby, where will you be living and who will provide you with support?
Do you have any suggestions for how antenatal care can be improved?

Table 3.5

Interview Questions with Women After Birth

Interview questions with women after birth

Can you tell me about your birth?
Who cared for you during labour and birth?
Did you have any family with you?
Interview questions with women after birth

What is/was your experience and thoughts about the postnatal care you are receiving/received in Ranong Hospital? (If the woman has had a previous baby in Burma, how does this compare with care you received with your previous baby?)

What has been most helpful about your care in hospital? Or what have you liked most about your postnatal care?

Are there any aspects of your care that you are not happy with/pleased about?

Can you tell me a bit more about that?

How are you feeding your baby?

If breastfeeding (most will be), how is breastfeeding going?

What help do you need with breastfeeding?

Are there any specific postnatal (traditional Burmese) practices that are important for your health or that of your baby?

Have you been able to practice your cultural traditions in Thailand?

If not, what is preventing this?

Field notes were also made during and after interviews. These described how the women reacted and responded to questions about their experiences and perceptions of maternity care, as well as my thoughts and reflections on the interview process, particularly the use of the interpreters. These interviews were conducted in a sensitive manner, maintaining eye contact, being respectful and allowing the woman sufficient time to consider the questions. The interviews were digitally recorded and transcribed, first into Thai and then transcribed into English. Field notes were transcribed in Thai and then into English.
3.8.2.3 Interviews with Burmese interpreters (lam).

Four village health workers (VHWs) worked as healthcare interpreters for Burmese women receiving antenatal care in Ranong Hospital and Pak-Klong PHC. These interpreters agreed to participate in this study and two agreed to work with me outside their normal working role to conduct the interviews. Individual interviews were conducted with four interpreters (lam) at a convenient and private location, either at the PHC, the hospital or in the community. The four lam were formally interviewed in Thai, three times across the data collection period. The face-to-face interviews ranged between 30–60 minutes, while telephone interviews lasted 15–20 minutes. I also gained additional information during regular interactions with the four lam.

The interview questions gathered basic demographic details and the experiences of the Burmese interpreters while working with the Thai midwifery team and specific aspects of the work of the interpreter in the antenatal clinics and ward. I interviewed them using questions like: ‘How did you come to work as an interpreter and what motivated you?’; ‘Could you describe your role as an interpreter and do you have any other duties?’; ‘How do you support Burmese women in pregnancy and/or in the postnatal ward and how do you work with Burmese women?’; ‘What challenges do you experience in your role?’; ‘What are the barriers that Burmese women experience in using maternity care?’. The interviews covered the interpreters’ experiences of working with the Thai maternity services.

3.8.2.4 Interviews with health professionals.

Nine health professionals were interviewed. These interviews were conducted at a convenient and private location either in the Pak-Klong PHC or at Ranong Hospital. Each interview was between 30 and 60 minutes long and depended on the availability of the health professionals. For the women, interviews were audio-
recorded and transcribed first into Thai and then English. Health staff were asked to provide basic demographic details at the start of the interview including their age, professional background and training, and years working in their current role. These interviews explored the perceptions of health staff of the needs of Burmese women and their experiences providing maternity care to this group of women (see Table 3.6).

Table 3.6

*Table Questions for Health Professionals*

<table>
<thead>
<tr>
<th>Interview Questions for health professionals</th>
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<tr>
<td>Please, tell me about your experience of working with/caring for Burmese women in pregnancy and/or in the postnatal ward after birth.</td>
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<td>In your experience, are there any particular difficulties or problems that Burmese women experience in pregnancy or after birth (physical, emotional or social issues)?</td>
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<tr>
<td>In your experience, have you noticed any particular Burmese traditional practices that Burmese women use either in pregnancy, or during birth or after birth?</td>
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<td>How are Burmese women facilitated to practice their cultural traditions?</td>
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<tr>
<td>How do you communicate with women who do not speak Thai?</td>
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<tr>
<td>Do you have access to an interpreter?</td>
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<td>If so, can you tell me how you work with an interpreter?</td>
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<tr>
<td>What are the barriers that Burmese women experience in accessing maternity care?</td>
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<td>What would help Burmese women access antenatal care?</td>
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<tr>
<td>What suggestions do you have for improvements in maternity care for Burmese women?</td>
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<tr>
<td>Have you ever provided any help or support for Burmese women outside your working role, in another context?</td>
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</table>
Field notes were also made during and after these interviews. These described how the health staff reacted and responded to questions about their experiences and perceptions with maternity care, as well as my thoughts and reflections on the interview process, particularly the use of the interpreters.

3.9 Data Analysis

All interviews were audio-recorded and transcribed for data analysis. The qualitative data generated from the one-to-one interviews and field notes were analysed using thematic analysis. All transcribed interviews, field notes from observations and participant observations were entered in NVivo (Version 11) to accommodate a thematic analysis of the data. All participants’ names were changed to protect anonymity.

3.9.1 Translation and transcription of data.

Translation and transcription of data were crucial processes in this study, not only because thematic analysis relies on rich textual data to develop inductive themes, but also because of the accuracy of the data obtained. The planning around transcription and translation was crucial in preparing for data collection. It was time-consuming to generate all data translation and transcription, which are essential in ethnographic research.

As mentioned in Section 3.8, I was accompanied by an experienced interpreter for most of the data collection period. This included when I observed everyday events and activities in the study settings, including in the Burmese community during the interviews with the women. The interviews with the Burmese women were conducted in Burmese and supported by a Thai-and Burmese-speaking interpreter. In accordance with this position, when I interviewed the women, I asked the questions in Thai and the interpreter translated the questions to Burmese. The woman responded and
answered in Burmese; their meanings were then interpreted to me in Thai by the interpreter. This was crucial for conducting cross-cultural qualitative research through the lens of interpreters (Liamputong, 2010) in a cross-language study (MacKenzie, 2016).

In my planning of translation and transcription, an orientation of interpreters was needed to prepare them for translations of data from Burmese into Thai (see Section 3.8.1 and Table 3.2). Interpreting between two languages, Burmese and Thai, requires a balance between cultural and language understanding and interpreters’ proficiency (Larkin, Dierckx de Casterlé & Schotsmans, 2007).

Once the recordings in Burmese were translated into Thai, I had a second bilingual interpreter listen to the recording to check that all information had been precisely interpreted. All interviews and field notes from observations were transcribed into Thai for data analysis. I only translated these data into English to represent the verbatim quotes of participants. Translations from Thai to English were checked by a bilingual expert (Reeves et al., 2008) and were originally conducted by a speciality English teacher with assistance from the language centre at Surat Thani University, Thailand.

3.9.2 Thematic analysis.

There are several approaches to ethnographic data analysis. Thematic analysis is one of the most common approaches used to analyse individual ethnographic datasets (e.g., observations and interviews) (Braun & Clarke, 2006). Nursing researchers increasingly use qualitative thematic analysis as a descriptive qualitative approach to allow for interpretation of themes. Thematic analysis, according to Braun and Clarke (2006), is used to analyse both individual ethnographic datasets (observations, interviews) and to triangulate findings across datasets. Thematic
Thematic analysis is an iterative process used to code concepts and identify categories or themes from the data (Braun & Clarke, 2006). The process of analysis includes several steps. First, I organised and prepared data for analyses, including the transcription of interviews, participant observation data and field notes. Next, I read and re-read all transcribed interview and observation data to become familiar with or immersed in the data to generate initial insights. This, together with the translation and transcription process, assisted me to identify meanings, patterns and issues that were of most interest to the study questions. It also helped me formulate ideas for preliminary themes. Following this, I coded all data, coding interesting features of the data systematically across the entire dataset, using key words and phrases from the participants as appropriate to label codes or subthemes. I collated codes into potential themes, gathering all data relevant to each essential theme. I also reviewed themes for assessing what worked in relation to the coded extracts, and defined and named these themes. During the ongoing analysis process, I constantly asked questions of the data: ‘What is this piece of data referring to?’; ‘What is this woman thinking while she is waiting to see the midwife at the primary health care clinic?’; and ‘What does this say about barriers to accessing maternity care?’. I then compared and contrasted data across the preliminary subthemes or broader themes to identify linkages and relationships between the themes and subthemes. Finally, I determined the suitable themes to present the findings (see Table 3.7).
Table 3.7

**Stages of Thematic Analysis**

<table>
<thead>
<tr>
<th>Stages of thematic analysis</th>
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<tbody>
<tr>
<td><strong>Stage 1</strong> Organising</td>
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<td><strong>Stage 2</strong> Familiarising</td>
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<td><strong>Stage 3</strong> Identifying meanings</td>
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<td><strong>Stage 4</strong> Coding themes and subthemes</td>
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<td><strong>Stage 5</strong> Refining themes</td>
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<tr>
<td><strong>Stage 6</strong> Interpretation</td>
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**3.9.3 Rigour.**

The term ‘rigour’ refers to the quality of qualitative enquiry since it can be ‘trusted’ as the passage of evaluating the findings or insights of the qualitative data (Houghton, Casey, Shaw & Murphy, 2013; Johnson & Welch, 2014; Yin, 2016). It also refers to the strictness in judgement and conduct and is used to ensure trustworthiness in qualitative research (Houghton et al., 2013). The term
trustworthiness has to be used to guarantee that the successive steps in a research project have been conducted with scrupulous attention to detail (Johnson & Welch, 2014; Yin, 2016). Qualitative researchers must be competent in selecting appropriate data collection methods. The quality of research data is dependent upon the researcher’s competence to acquire the necessary high-quality data (Johnson & Welch, 2014) and their capacity to analyse that data (Liamputtong, 2013). In qualitative research, numerous approaches are used to ensure trustworthiness of the findings. In this study, triangulation of data sources (participant observation, interviews and field notes) and prolonged engagement during fieldwork (Green & Thorogood, 2013; Houghton et al., 2013) enhanced rigour.

Further, to enhance rigour, I had many meetings with my supervisors and discussed preliminary and developed themes. We discussed my role in data collection, working with the interpreters and engaging in the Burmese community. I had the opportunity to present my findings at international conferences and to my student colleagues in student group meetings. These interactions helped me to refine my results and consider the impact of the findings. I also reflected on my own position in this study.

3.9.4 Reflexivity.

In undertaking this ethnographic study, it is important to consider and clarify the relationship between the researcher and participants. The sensitivity of the topic and the healthcare settings are factors that are associated with power relations in the field (Finlay & Gough, 2008). It was crucial for me to have an awareness of the healthcare settings and recognise the nature of the social interaction between the participants and the researcher that influenced the data interpretation (Finlay & Gough, 2008). Personal reflections are considered part of the rigour of a study and the research
process (Liamputtong, 2013), as they offer a glimpse into the researcher’s ability to interpret. I needed to offset my own bias, since I am a Thai nurse-midwife and nursing educator. I had worked in Thai hospitals providing postpartum care for women and this is an area that I also teach at a university. I have two children, both born by caesarean section. Thus, my position as a nurse-midwife, educator and mother may potentially influence or even interfere with my ability to collect and interpret the data. My experience in the postpartum ward and my experience as a mother meant that it may have been easier for me to develop a rapport with the Burmese women.

The research setting was similar to environments in which I have worked as a nurse-midwife, both in the hospital and the community clinic. In this sense, I was an insider-researcher, which contributed to my ability to enter the ‘field’ and be accepted by potential participants, especially my regular presence on both the antenatal and postnatal ward. An insider-researcher has to overcome the problems related to being a member of a group when collecting data as a participant-observer (Unluer, 2012). Other authors have reported that although there are many advantages of the insider-researcher position, there are also some disadvantages (Burns, Fenwick, Schmied & Sheehan, 2012; Simmons, 2007; Unluer, 2012). One advantage was that I could gain access easily and people accepted my presence readily. When I told my colleagues that I planned to do this research on Burmese women accessing maternity services in the PHC and the hospital, my nurse-midwife friends reacted positively. In fact, my colleagues in nurse-midwifery helped me gather information about the number of births in the area and attendance at antenatal clinics and postnatal care. I was also welcomed by other health providers during the data collection process. However, my relationship with health provider participants was still professional and I did not interfere with their work. Rather, I could observe practice without being obtrusive.
In contrast, there were some disadvantages of being an insider-researcher, which became apparent as the project progressed. Some of these have been documented by Unluer (2012): ‘overlooking certain routine behaviours’; ‘the participants may tend to assume you already know what they know’, and ‘closeness to the situation hindering the researcher from seeing all dimensions of the bigger picture while collecting the data’ (p. 6). As I observed the interaction between the health staff and the women, I felt able to relate to the nurse-midwives’ discontent with the system and the inefficiencies. I also felt an ardent desire to assist them with simple tasks. For example, on the extremely busy day at the PHC clinic, I wanted to assist staff to clean a caesarean section wound when the postnatal woman came for a check-up. I had to closely monitor my insider status while maintaining my researcher observational role. Simmons (2007) reflected on her experiences as an insider-ethnographer in her employing organisation, in which she was drawn into assisting participants (e.g., helping patients undress for examinations during her fieldwork), which presented a dilemma, as the role of insider-clinician and outsider-researcher differed. Unluer (2012) stated that the researcher must take serious precautions to prevent slipping into the clinician role to maintain the systematic continuity of data collection. I resisted the temptation to slip into the clinical role and maintained my stance as a researcher. These self-aware dynamics led me to ensure that I approached the study with sensitivity to the needs of women and health providers. For example, I carefully considered how I would dress for the observations. In particular, I ensured that I was not wearing a uniform during data collection as a uniform can be a symbol of power (Wisanskoonwong, Fahy & Hastie, 2011). Instead, I wore simple clothes that did not draw attention to me.
While I am an insider to health professionals in healthcare settings, I was an outsider to the women, as they were from Burmese communities. Burmese people did not know me and did not know why I was in their communities. Burmese communities were new places to me; I did not have expertise or prior knowledge of these, especially the workplaces involved in the villages. Hence, I was an outsider to the Burmese women and their families. People might perceive me as someone who came to buy food in the markets, or as a tourist when I was visiting the pier (see Section 3.8.1.6). I was able to be a complete participant-observer by engaging in appropriate social activity and distancing myself from the nurse-midwife position.

Gaining the trust of the Burmese community was not easy, I worked hard to become familiar to them. I discovered that because I came to observe their community weekly, they seemed more familiar with me later than they did when I first came to this community. The women I met at a fresh market near the clinic said:

I know who you are. I had seen you came to the primary healthcare in the last few weeks. I had seen you speak to the health officers here, so I know that you have good intentions.

As stated previously, I am a mother of two children, which meant that I was able to feel deep empathy for the Burmese women who were parenting at distance. I had been leaving my children and my hometown in Thailand to study abroad in Australia. While studying in Australia, I thought often of my children and family and felt homesick and missed them. This gave me an understanding of how the Burmese women were feeling when their children went to Burma to live with family. I found myself relating in an empathic way to the women and their stories of being a mother and of working hard in low-skilled jobs. In particular, I felt an acute sense of tension when the women were a long way from their children, families and homeland. For
example, I asked the women during fieldwork, ‘How do you feel about becoming a mother?’ and ‘How do you plan to feed/care your baby?’. I had really thought about the questions and I was mindful of the time I was studying in Australia. I too was feeling concerned about my children: who was taking care of them, taking them to school and so on? This highlighted the importance of acknowledging the different roles and challenges we faced as women: for me as a ‘researcher’ and ‘mother’, and for the Burmese women, as a ‘worker’ and ‘mother’.

3.10 Conclusion

This chapter has explained how the underpinning framework of social constructionism and ethnography informed the data collection and analysis of this study. The methods—face-to-face interviews and participant observations of the interactions between the health staff and the women, and observations in the clinics, postnatal ward and community—have been described. In addition, this chapter also identified the strategy for translation and transcription of all data and the thematic analysis applied to the transcripts. The ethical issues were also highlighted.
Chapter 4: Being a Burmese Migrant Woman Living and Working in Thailand

4.1 Introduction

This chapter is the first of four to present the findings of this study. It describes aspects of the daily lives of Burmese migrant woman living and working in Thailand. First, it outlines the sociodemographic characteristics of the 10 key informants in this study, including the reasons they migrated to Thailand. Second, drawing primarily on the field notes of community observations and interviews with the 10 Burmese women, the Burmese interpreters and the health professionals, it describes the participants’ living spaces, lifestyles, traditional ways of life and modes of transports. The working environment is also presented to understand how it may affect women’s health and wellbeing in pregnancy and motherhood. Finally, it describes how many Burmese parents become transnational parents, as the imperative for employment means that many women and men decide to send their young children to Burma to be cared for by grandparents and other family members while they continue earning an income in Thailand.

Chapter 5 draws primarily on the interview data with 10 key informants to describe their experiences and perceptions of becoming a mother in Thailand and their access to services. Chapter 6 reports on the perspectives and experiences of Thai health professionals providing maternity care for Burmese migrant women. It draws on the data from interviews with Thai health professionals and the observations of the interactions between health professionals and the women. Finally, Chapter 7 is the last findings chapter. It examines the role of Burmese lam and their accounts of supporting maternity care providers as interpreters.
4.2 Sociodemographic Characteristics of the Burmese Key Informants

Ten Burmese women were key informants in this study. At the time of the interviews, the women ranged in age from 23–32 years. Eight were born in Burma and two were born in Thailand but had spent all their childhood years in Burma. They all belonged to the ethnic group from Burma known as Burmese and practised Buddhism, the main religion in Burma. The main language spoken at home was Burmese, but six of them could speak a little Thai. Regarding education, two women had completed primary school, two had finished secondary school, five had enrolled but not completed primary school, and one participant had not received any formal education. All women indicated that they could read and write some Burmese, but it appeared likely that at least four women had limited literacy skills. One woman (May) indicated that she had learnt some reading and writing from family members.

Six of the 10 key informants migrated because their husbands were already working in Thailand. The other four came with or because other family members were living in Ranong province and had been working for many years. Six of the 10 couples lived with their families, including their parents or their relatives. The remaining four couples lived together, with no other family members or friends living with them. However, each of these four couples had many friends and relatives living nearby in the same community or village (see Table 4.1).

The participants were a mix of long-term and newly arrived migrants wanting to secure permanent residency in Thailand. The 10 women had worked for between one and 10 years in Burma and were currently employed in Thailand in fish processing, food sectors, seafood factories and domestic work. All participants have been living and working in Thailand for at least 2–17 years.
Table 4.1  

Demographics of 10 Burmese Women Becoming Mothers in Thailand  

<table>
<thead>
<tr>
<th>Women</th>
<th>Age</th>
<th>Level of Burmese education</th>
<th>Length of time living in Thailand (year)</th>
<th>Number of people in house</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tata</td>
<td>26</td>
<td>Secondary school</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Ning</td>
<td>26</td>
<td>Secondary school</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Meena</td>
<td>29</td>
<td>Some primary</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Neenee</td>
<td>32</td>
<td>Completed primary</td>
<td>17</td>
<td>4</td>
</tr>
<tr>
<td>Neeza</td>
<td>23</td>
<td>Some primary</td>
<td>12 (Born in Thailand)</td>
<td>2</td>
</tr>
<tr>
<td>Mint</td>
<td>24</td>
<td>Some primary</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Teena</td>
<td>27</td>
<td>Completed primary</td>
<td>10</td>
<td>7</td>
</tr>
<tr>
<td>May</td>
<td>31</td>
<td>No education</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Yunin</td>
<td>25</td>
<td>Some primary</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>Yusoo</td>
<td>23</td>
<td>Some primary</td>
<td>7 (Born in Thailand)</td>
<td>6</td>
</tr>
</tbody>
</table>

Note: The names used above are pseudonyms.

4.3 The Main Driver for Migration

The 10 Burmese key informants migrated due to both ‘push and pull’ factors. As discussed in Chapter 2, the primary push factors related to political instability in Burma, where the Burmese socialist regime and dismal economic performance of the Burmese government, meant that living standards were poor. During the interviews,
key informants mentioned that they and their families had sought a better life. Maloo, a Burmese interpreter working in the antenatal clinic, stated:

The push by economic and political difficulties at our home in Burma and decades of war and militarisation has resulted in social and economic devastation. So, we had no alternative economic opportunity at our home, only poverty, and we are concerned about human rights. What should we do? Just wait for death? Hence, many Burmese had sought migrant in neighbouring countries.

May, a Burmese woman, also described the economic hardship in Burma as her reason for coming to work in Thailand:

There were no jobs in Burma. There were jobs that pay too little to make a living. The soil was not abundant. Even growing vegetables to eat would cost too much money since the vegetables need fertiliser or they would not grow.

Simultaneously, there were pull factors: primarily, a growing economy with employment opportunities that motivated people to migrate to Thailand from Burma. All the women and their husbands came to Thailand in search of work. Teena asserted that once she found employment in Ranong, she was able to send money home to Burma:

It was not easy to find jobs in Burma and living in Burma was really hard; that was why I and my relatives decided to come to work in Thailand, as there were much more job opportunities here and I could earn much better to send money back my family in Burma.

A statement from Mint, a Burmese woman, clearly illustrates the significance of job opportunities in Thailand:
Particularly the opportunities offered by in the increasing labour practices in Thailand caused us to migrate here for work. Our relatives told us that there were labour shortages in specific areas in Thailand. So, we were employed to work in industries, and mostly we worked in the seafood export industry where a large number of migrants work.

4.4 The Migration Journey

Migration occurred in one of two ways. First, four of the women came to Thailand through migration brokers. These four key informants paid a broker for a work permit, including payment to certain officials for passports. Many women faced issues related to registration fees and encountered system abuses that made it very expensive to gain documentation. Neemoe, a Burmese interpreter, explained:

As many Burmese migrants lack knowledge about how to apply for Thai work permits, we have to pay for brokers who can help us to gain the rights of migrant worker in Thailand. However, we still encounter problems that were many abuses in the system. Many Burmese were overcharging and the payment of additional fees to middle-men that is often harassment. If we cannot afford to pay, the employers would pay for us and then deduct this from their employees’ wages in monthly instalments. Many of them have difficulty with daily costs.

The women stated that the brokers must be paid money directly or have their payments deducted from their daily wage, including any additional expenditure or costs incurred by their employers, who also paid the brokers to hire migrant workers as labourers:

When I first came to Thailand in search of work with my friends, I had to pay a lot although I had neither jobs nor any cards. I just came with an agent who
charged me THB 10,000 (AUD 333.50) for hiring a long-tail boat to take me here. I had debts. To make a work permit and a medical insurance through the help of my employer, my income was deducted in monthly installments to my employer to cover those costs. (Mint, a Burmese woman)

The other six women came primarily because their husbands were already working in Thailand and some family members had lived and worked in Ranong province for many years:

I came to Thailand with my sister. Our parents had been living and working in Ranong for many years. So, we did not need to connect with any agents as our parents knew the process about how to arrive here. It was not difficult since we travelled by boat at this pier. (Teena)

All women in this study came to Ranong province in southern Thailand by a long-tail boat from Burma. They travelled to Sapanpla pier—the entrance to Thailand (see Figure 4.1).

*Figure 4.1. Travelling by long-tail boat at Sapanpla pier.*
4.5 Living in Ranong: Lifestyle and Traditional Ways of Life

This section discusses the accommodation or housing of Burmese women and their families, and the lifestyle of the Burmese women, living in Ranong. The daily life of the Burmese participants was based on their traditional practices and cultural beliefs. For example, each Buddhist holy day, the key informants and interpreters took fresh flowers when they went to worship at the temple. They believed that doing good deeds would create positive karma for themselves and to the lord Buddha.

4.5.1 Living conditions: Housing.

Most participating women lived in a small house or a room in Sapanpla. In Sapanpla, there were many Burmese villages and most participants lived in the village of Pla-Kem. Translated literally, Pla-Kem means ‘salty fish’. Previously, the land on which the village was built was used by Thai people to dry fish and to prepare salty fish. It was also known among Burmese people as ‘near immigration checkpoint-village’ because it was located near the immigration point. This was considered a more desirable place to live. Neemoe, a Burmese interpreter, lived in a townhouse in Pla-Kem.

In my observations, Pla-Kem had two types of dwellings: small houses and small townhouses. Most were wooden houses covered with galvanised iron. There were around 100–150 of this type of small house. It was a heavily populated area, but the environment was quite green with trees all around. The roads in the village were dirt roads with many holes. It was muddy and damp when it rained. There were two entrances to the village. Cars could not pass through the village, so they all parked on a main street just outside one entrance to the village. On the other side of the village was the entrance to the port.
Between two and seven people from one family lived in the same house. There were also spaces for washing, bathroom and kitchen duties, all in the same area. Every space was used, making it extremely crowded. Teena, a Burmese woman who lived with her family and shared the rent in a small house, said:

There are only two small rooms in our family living together, which includes my father, mother, husband, sister and a little nephew. Just my elder sister lives in another province. We help each other with paying the rent.

The small rooms that comprised each of these dwelling spaces were only separated by a wooden partition and the bathrooms were communal. It was dark, humid and the sun could not shine in. The room was also covered in a large quantity of black coal powder (see Figure 4.2). The women stated that they preferred to tolerate these poor conditions, as this accommodation was provided free by employers; they had to make a monthly payment for water and electricity, at a fixed rate of THB 500 (AUD 17). May, a Burmese woman who lived with her husband in this coal warehouse, also explained:

For single workers, Burmese labourers would be staying in the shared room, which was separated by genders. The accommodation was free but the utility bill for the fixed rate of THB 250 (AUD 8.5) per a Burmese labourer. For a couple like I and my husband, we preferred to live in a single room. Although no rental charged, we must pay for water and electricity supply for TBH 500 per month. Living here, it is likely to poor condition as living in the dark, no sun, very humid, a lot of dust coal, and crowded. But it is better than the others because it is no cost for rental and transport.
Figure 4.2. The small rooms in the coal warehouse.

One participant lived in a more temporary dwelling space, which resembled ‘storage accommodation’, as it did not appear to be either a small house, townhouse or combined shop.

4.5.2 Religion and cultural practices.

All the women in the study were Buddhist. Buddhism has a central place in their lives and influences all aspects of daily life. They took the fresh flowers to the temple to worship and to their homes, where they created a small place of worship for Buddha. When I visited their homes, I saw beautiful fresh flowers in a vase that they maintained. They believe that if the flowers wither, they would perform poorly in life, fail to meet expectations, experience bad luck, or lack peace of mind. This practice is similar to Thai Buddhism. Neemoe, a Burmese interpreter explained, and asked me:

Although we [Burmese workers] have financial hardships, we paid for a bunch of flowers to pray for worshipping to the Buddha. We believe that good things would be turned to us. Are you Buddhist? [I said ‘Yes, I am’]. Did you do the same as us? [I replied ‘Yes. I did’].

Women wear the long sarong, which demonstrates respect to places such as the temple, which they likely value for the maintenance of their souls. Women are not
permitted to wear a short skirt or dress because it is considered culturally inappropriate. When I first met the women when they were waiting for antenatal care at the PHC, they were wearing a sarong dress. Their husband and relatives were dressed similarly. When I visited their homes, they were also likely to wear a sarong. The sarong worn by women is called *Htamain*; for men, it is called *Pasoe* (see Figure 4.3). However, when at their workplaces, they wear practical clothing such as trousers and shirts, which are more convenient when working.

*Figure 4.3. Left:* Researcher with Burmese girls in their community. The girls wore *Htamain*. *Right:* Burmese man wear *Pasoe*.

### 4.5.3 Dietary practices.

The typical diet of Burmese migrants living in Ranong is similar to Thai food. Rice is a staple eaten with each meal. Vegetables are easily accessed and meals always contain vegetables such as eggplant, morning glory, tomato, onion and other Asian greens, herbs and spices like coriander, ginger and chilli. I observed that the families would cook a large pot of food, such as a vegetable curry or a spicy papaya salad, in the morning and this would be eaten for all meals that day. Most Burmese people like eating oily rice and food (see Figure 4.4). I noted that when I visited the Burmese market, there were many oily foods and many Burmese bought it to cook at home. Burmese also add a great deal of sugar to their cooking.
Figure 4.4. Burmese food cooking with oil observed in the Burmese community.

Many Burmese people like carbonated soda drinks or sweet drinks, such as Sprite and Coca-Cola. In particular, Burmese workers like to drink Red Bull or other energy drinks, as they believe it enhances work agility. After drinking, they describe feeling refreshed and awake and ready to work again. During visits to their homes, Burmese woman appeared to be excited when they saw me. In one case, when I arrived at a woman’s home her father tried to find cushion for me to sit on and then gave me a bottle of energy drink, Red Bull. Neemoe, an interpreter, explained, ‘Burmese people believe that these energy drinks are the best for welcoming guests to their home’.

It was also common to see Burmese people chewing ‘betel quid’. Several substances are combined to make a particular betel. The ingredients for this chewing betel are mixed on the betel leaf and a small stick quid is scraped through the white quicklime, which is liberally daubed over the leaf. Next, ingredients like sweet liquid, a few green seeds and shredded tobacco are added. The leaf is then carefully folded into a small packet and enclosed in a small cellophane bag. For consumption or chewing betel nut quid, people put in their mouth and slowly suck it. The quicklime
breaks down the ingredients quickly, leaving a pleasant but bitter spearmint-like taste in the mouth. Mint, a Burmese woman, said:

I like chewing betel nut as chewing betel nut is better than using candy.

The key informants suggested that chewing betel leaf helped to clean their teeth. However, some women did not practice this. Neemoe, an interpreter, told me about chewing betel:

I hardly use the chewing betel nut because I feel embarrassed. It looks dirty when I was talking with the health officials, I had no confidence talking with them if I chew it.

4.5.4 Mode of transport in daily life.

In general, many Burmese people use a bicycle for their daily transport to and from work and within their community. This is the most economical way of travel, although due to their lack of money, some have no light on the back of the bicycle. This has led to accidents and is a cause of death among Burmese. Neemoe, an interpreter shared her experience of using a bicycle:

Most Burmese workers use bicycle like a daily transportation. It happened very often that they got crashed by car and died, but the suspected people cannot be found since it happens at night. They just drive away and no-one is interested in that case. Last week, one of my friends rang me and told me that she was caught because there is no night light on her bicycle. I did not dare to help her since my bicycle has no night light either. But finally, I went to help them. The police officer said that we have to buy and install night light on our bike for safety, otherwise next time we will be caught again and need to pay the fine.

When the Burmese community want to travel further afield, they use a local minibus, known as a Songteowin Thai. Many local taxis pass by the Burmese villages
into Ranong town. The cost of the local taxi is THB 15 (AUD 0.5) per person for the whole route, but taking a round trip with a minibus costs TBH 30 (AUD 1). Some Burmese people use a motorcycle taxi, as it is faster, but the motorcycle taxi is more expensive—about THB 20 (AUD 0.7) a person per time.

4.6 Working Environment

All the women in the study were employed or working as labourers. Most worked in seafood processing and domestic work. The women’s monthly incomes were between THB 3,000 and THB 6,000 (AUD 100–200) (see Table 4.2), but they experienced heavy workloads, poor sanitary conditions and sometimes they to work long hours.

Table 4.2

*Employment and Monthly Incomes of the Women and Their Husbands*

<table>
<thead>
<tr>
<th>Women</th>
<th>Current employment status</th>
<th>Work prior to pregnancy</th>
<th>Husband’s occupation</th>
<th>Monthly incomes for a couple (in THB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tata</td>
<td>Unemployed</td>
<td>Frozen food factory worker</td>
<td>Construction worker</td>
<td>2,000–6,000</td>
</tr>
<tr>
<td>Ning</td>
<td>Temporarily employed</td>
<td>Waitress</td>
<td>Cook</td>
<td>3,000–6,000</td>
</tr>
<tr>
<td>Meena</td>
<td>Unemployed</td>
<td>Fishery worker</td>
<td>Fishery worker</td>
<td>2,000–5,000</td>
</tr>
<tr>
<td>Neenee</td>
<td>Unemployed</td>
<td>Cleaner</td>
<td>Untrained mechanic</td>
<td>2,000–5,000</td>
</tr>
<tr>
<td>Neeza</td>
<td>Temporarily employed</td>
<td>Waitress</td>
<td>Motorcycle taxi driver</td>
<td>4,000–6,000</td>
</tr>
<tr>
<td>Mint</td>
<td>Unemployed</td>
<td>Fishery worker</td>
<td>Construction worker</td>
<td>3,000–6,000</td>
</tr>
<tr>
<td>Women</td>
<td>Current employment status</td>
<td>Work prior to pregnancy</td>
<td>Husband's occupation</td>
<td>Monthly incomes for a couple (in THB)</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------</td>
<td>-------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Teena</td>
<td>Unemployed</td>
<td>Fish processing</td>
<td>Deep-sea fisherman</td>
<td>3000–6000</td>
</tr>
<tr>
<td>May</td>
<td>Casually employed</td>
<td>Coal factory worker</td>
<td>Coal factory worker</td>
<td>2,000–4,500</td>
</tr>
<tr>
<td>Yunin</td>
<td>Temporarily employed</td>
<td>Food factory worker</td>
<td>Deep-sea Fisherman</td>
<td>3,000–6,000</td>
</tr>
<tr>
<td>Yusoo</td>
<td>Unemployed</td>
<td>Fishery worker</td>
<td>Farm worker in rubber plantation</td>
<td>2,000–5,000</td>
</tr>
</tbody>
</table>

### 4.6.1 Fishery workplace.

Based on my observations, most markets in the pier and central market were run by Thai people and staffed by Burmese workers; most customers were Burmese. This central market and pier area housed the fishing industry: two fishmeal factories and a shipyard area where the fish and seafood were dried on the ground.

There was a very strong smell of fish and the floor was wet and slippery with rotting carcasses of fish and shellfish. Many types of fish lay piled on the floor. Here, the market people laid out the fish for the day, washed it on the ground and left it there to dry. Burmese workers sorted the fish into baskets by size, type and quality and then determined what price to ask. Slippery and wet areas made the environment look dirty from all the food waste across the floor (see Figure 4.5). There appeared to be equal numbers of young workers (between 18 and 24 years) of both sexes, older workers (over 40–50 years), but no children.
Figure 4.5. Burmese working in Sapanpla fishery.

Figure 4.5 illustrates the nature of the work in the fishery and market. Meena, a Burmese woman, works in Sapanpla fishery:

I work in the fishery. I mainly remove the squid ink, which is black water, out of the squids. Sometimes, I have to be a heavy porter. The employee pays us based on the weight of kilogram (kilogram of squid). The more we do, the more we earn. I’d earned THB 400 a day at maximum or TBH 200 at minimum. I work every day; I usually take one or two days off a month.

Besides working in the Sapanpla fishery, some women worked in the fresh markets located in Burmese communities in Ranong province.

4.6.2 Working at the food markets.

There were many markets in Burmese communities such as Andaman Fresh Market, Pak-Klong Fresh Market and Chok-Dee Market. They seemed a central place for Burmese to gather and shop for food. I observed that around 500 Burmese people came to the Andaman market each day, including traders and purchasers. The market
was very crowded. It looked like a flea market but there was a large variety of goods, typically presented outdoors, including fresh food, second-hand goods and new items.

Pak-Klong fresh market was outdoors and built on a rough dirt road. There were many potholes and the road was bumpy with a large hole spread over a wide area. Sales and market stalls were set up along the roadside and this caused traffic jams during the day when the flea market was crowded with Burmese shoppers. I communicated with some traders, as most could speak Thai. They told me that this was the final week of month; thus, fewer people come. Towards the end of the month, people have less money because workers receive their income at the end of the month. The markets are significantly busier early in the month. The Chok-Dee Market, in the centre of the Burmese community, had a real ‘buzz’, with Burmese socialising and eating with their family and friends. The market building looked run-down and old. There were three public coin telephone booths that worked, but looked shabby.

Two women in this study were working at the fresh markets at the time of the research, but all key informants had worked in these markets at some time since arriving in Ranong. Employment at the fresh market was typically casual; they prepared and cooked the food and served customers. Many of the women and their families who primarily worked in the fisheries also worked casually in the market. This work was seasonal depending on the availability of food.

Another contributing factor to the poverty of the participants was the expectation that they would send money or remittances to their family in Burma:

Now, I am pregnant I cannot work hard like before. We have to save money as much as we can first since we need to pay for the living cost every day and send money back to my family in Burma every month. But now, we do not
carry much money anymore because I have no job anymore and my husband is the only one who is working. (Tata)

We have so many expenses that make us not have enough money for living. When I have not been pregnant yet, I had some money to send to my children in Burma. But since my pregnancy, the money is not enough as we need to pay for living. (May)

4.7 We Send Our Children to Burma

The participants described the typical situation for young children born to Burmese migrants living in Thailand. Key informants explained that they wanted to keep their children close and care for them as babies, but as their children reached school age, they preferred to send them to live with family in Burma. It is common for Burmese children to be sent to study and live in Burma. The children are then raised by their grandparents or close relatives while their parents stay and work in Thailand to earn money and send remittances to their family in Burma every month. When the children reach employment age, they return to Thailand to find jobs. Most participants had positive perceptions of child-rearing in Burma, as they believed their children were better off: safe and secure. Thus, the parent could work without being worried about their children:

For our children, need to be safe that will be good for them and we hope they can take well in education and may have a good job in the future. We do not want they work hard here the same as their parents. We send money back to family in Burma every month to earn as much money as possible and then return to Burma. (Neemoe, a Burmese interpreter)

Neenee also described sending their children back to Burma:
My sister-in-law had two children and she sent them back to live with their grandmother and study in Burma. Our children will have good opportunity to live closely with their relatives in Burma, and we were also trustful. For me, when my children will have to study in a school, they would be sent to their grandmother in Burma too.

During the observations conducted at the Burmese market, I had an impromptu interview with a Burmese woman who had been living in the town for six years. She had two children, aged four and one years. She took her first child shopping in the market and spent time buying the necessary food to cook dinner for the whole family to eat together. Her family included her husband, sister, brother and sister-in-law, and four children, including her children and her nieces and nephew (Field note: 5 May 2015).

I: Who is taking care of your youngest child?

The woman: My older sister is caring for her.

I: Your child who is four years old to goes kindergarten or not?

The woman: Yes, he goes to kindergarten in this community but he is going to be sent to live with his grandparents in Burma.

I: Can I ask why you choose to send him there? There are many Thai schools for everyone including Burmese children in Ranong.

The woman: I know, but I have to work. As soon as I was pregnant, I took time off from work until now, it’s a long time to stop working. For education in Burma, I think that is very important and a good idea if our children live with our grandmothers. Importantly, they will be safe and sound. My older sister and other relatives, everyone has to work. They do not have enough time
to take care of their children. However, we have to send some money to them every month.

Further, the main reasons for studying in Burma were that although there are many Burmese schools in Ranong, there is a mismatch in socio-economic status, cost, illegality and insufficient care:

It is not easy, as we have a lack of education about communication with others people in Thailand that it is better for studying in Burma we do not want any problems about living and working here. Therefore, our children will be happy in Burma having education in our homeland. (Mint)

Some women mentioned the benefits for the child of studying in Burma:

When my son becomes four years old, I will take him to study in Burma because there are quite many good schools in Burma. However, I will work here in the same place and will send money to support him every month.

(Teena)

Two of the mothers had their children living in Burma while they had a new baby in Thailand. One gave birth in Thailand and looked after the baby herself until the baby was four years old. This child was then sent to live with his mother’s aunt in Burma, largely for study reasons:

Most of the Burmese children are supposed to grow up and study in Burma. My son is seven years old. I actually sent him to study in Burma since he was four years old. He currently lives with his grandmother. She helps me take care of him. Living and studying in Burma is better as the school fee is cheaper than in Thailand and it is a good opportunity for him to live with his grandmother and other relatives in Burma who can take care of him well. (Teena)
May, another mother, had two children born in Burma. May left the children with her relatives in Burma so that she could return to employment and earn an income to remit every month. These mothers had a newborn born in Thailand while they were working and living in Thailand:

My two sons live well with their grandmother in Burma. I have to send money to them every month. Now that I have a baby, this baby will be born in Thailand.

Many Burmese people are permitted to travel back and forth between Burma and Thailand to visit children and family members. It is customary for Burmese women to take their new babies back to Burma to visit family but not often, since visiting is based on their opportunities to earn more money back home, or take a pause from their work. Thus, it took a long time for mothers to visit their children in Burma. These mothers maintain contact with their children in Burma while working in Thailand. Teena stated, ‘I do, we talk with each other on the phone and I can see my son in the Facebook every day’. Conversely, May did not have a mobile telephone and had to wait for the school break when her children came to live with her for a while. In her interview, she stated:

Our children live well in Burma with their grandmother. I rarely contact them because I have no phone, as it is broken. I had to borrow the phone of my neighbour in case I needed to use it. Ever since I came to work here two to three years ago, I only visited home once. However, it is better for the children in Burma to wait until the summer break before my mother could bring them here to visit me. If we visit Burma, then we would lose the opportunity to work. It is better for them to come during school break and stay for a while, so everyone gets to be together and gets to see their little brother.
Additionally, two Burmese interpreters (*lam*) in this study, both mothers of two children, had sent their children to live with their grandmother. Both mothers had left their children for at least two years, but maintain contact and visit their children more than three times a year. Neemoe, a Burmese interpreter, added:

> I have two sons but now they are studying in an elementary school in Burma and they stay with my aunt. I just went to my home in last month, going by boat and by bus to get my home. I had many days off for holidays. So, I had a good opportunity to spend many days at home. Now I miss my children a lot.

Although the women have financial hardships that prompt them to work away from their homeland and family, they try to maintain contact with their family, support their children and be the best mothers they can.

Many Burmese women endure poor living conditions and difficult circumstances. However, they were generally positive about living and working in Thailand. They are able to earn more than they would in Burma and most could earn money for their daily lives and send money to their families in Burma. Maloo stated, ‘I think anyway, working and living in Thailand is better’, while Yusoo, a Burmese woman, said, ‘I entered Thailand for living in a better life’.

### 4.8 Conclusion

This chapter has presented the main reasons for key informants’ migration to Thailand. It has also described their living conditions, employment context and continuing relationship with family in Burma, particularly if their children live in Burma. Field notes of the community observations and interviews with Burmese women indicate that the Sapanpla community is poor. Burmese people work in manual jobs, requiring a low level of skill and earning a low income. Living conditions and housing are basic, but there is clean water. The key informants appeared to
continuously adapt to their situation, and generally believe they have a decent quality of life, or at least a better life then they would in Burma. I observed the desire that some Burmese had for sweet things to boost their energy and sugar levels and for chewing betel nut. The impact of these working conditions on women in pregnancy is discussed in Chapter 5.
Chapter 5: Protecting My Baby

5.1 Introduction

This chapter describes the perceptions and experiences of the 10 Burmese migrant women who were key informants in this study as they became mothers in Thailand for the first or subsequent time. The analysis revealed the women’s perceptions of health and wellbeing during pregnancy, their health-promoting practices and their experiences accessing and using Thai maternity services. The findings presented in this chapter are based on analysis of the interview data collected before and after birth, either face-to-face or by telephone, and observations of interactions between women and health staff during antenatal visits and in the community. Analysis of the interview data and field notes from observations are supplemented by relevant data from the interviews with health professionals and Burmese interpreters (lam).

The analysis revealed three major themes and several subthemes that explicate Burmese women’s experience of becoming a mother and accessing Thai maternity services: ‘Becoming a mother’; ‘Protecting myself and my baby’; and ‘My family will help me: The role of informal support’. Figure 5.1 illustrates this analysis.
5.1.1 Becoming a mother.

Becoming a mother in Thailand was the first major theme identified in the analysis of the interviews with key informants. Five subthemes emerged through the analysis: ‘Excitement and love’; ‘Fulfilling my role as a woman’; ‘The more children, the stronger the family’; ‘Love at first sight’; and ‘Wanting the best for my baby’. These are discussed in Sections 5.1.1.1–5.1.1.5.

5.1.1.1 Excitement and love.

All the women described being happy and excited about the news that they would become a mother for the first or subsequent time. Pregnancy evoked feelings of love for their baby, their other children and families. One woman explained how much
she already loved her unborn baby and her capacity for sharing her love among her children:

When I knew that I was to be a mother of two children, I have attention to have children. I love her since she was not born yet. When I have another child, I will love them equally. (Meena)

Participants who were pregnant for the first time were particularly excited. For example, Yunin stated:

I am very happy and excited. I really want to have a baby. It has been a year [since] I got married and I never have birth control. I want to have two children. Five women were having their second or subsequent baby and were also happy. Three women stated they were perhaps a little less excited than they had been with their first child. However, these women were happy to be having a new baby:

I felt very happy. This is my second pregnancy. My first pregnancy, I was really happy and felt more excited. As for the second pregnancy, I am still glad but feel less excited than before. But anyway, now I am happy now to have another child. My first child came to earth as it is my intention to have a child. I really want to have children. (Neenee)

Even if the pregnancy was unplanned, the women remarked that they and their husbands were happy:

Even though I knew that it was going to be hard, my life with the baby made my life happy and our family happy. The oldest girl is now four-and-a-half years old. Our second child is one year old. Both two children are girls. I did not use birth control and I ended up being pregnant. I love all of my daughters. (Yusoo)
A couple of the women were confused as to how they had become pregnant, despite taking precautions:

I did not know that I was pregnant as I could not remember the last time I had a period. I really did not know. I am still kind of confused because I take contraceptive pills regularly, but I just forgot to take it sometimes. That led to my pregnancy. I felt shocked at first after knowing I will be a mother. Then I decided to take care of myself better because I actually wanted to have a baby. (Ning)

Yusoo was surprised she was pregnant because her husband works away from home and she only had sexual intercourse once. However, after learning that she was pregnant, she wanted to keep the baby:

This was not intentional, but I did not use birth control because I did not think I was going to be pregnant, as my husband was working in another province and we were not living together. We slept once together, and I got pregnant. That is okay though. I have the love for this baby as much as my first pregnancy. When I found out that I was pregnant then I was very excited and happy. My husband was happy when he found out as well.

5.1.1.2 Fulfilling my role as a woman.

Becoming a mother provided the women with pride and happiness. This was mainly because becoming a mother permitted them to fulfil their role as a woman:

When I know that I was pregnant, I could not wait to see my baby … It actually did not matter that I would get a son or a daughter as long as the baby was my child. I am thankful for my baby enhanced me proud of becoming baby’s mother. My role of woman was fulfilled. (Neeza)
Women described a sense of fulfilling the role of womanhood and wanting to be a good mother:

I feel blessed to be a mother. If I were not pregnant, I wouldn’t be able to fulfil my life as a woman. My son made me so happy and I have to do my best on taking care him well. (Tata)

As becoming a mother was an important role for women, Teena described being excited about having her first baby: ‘I am very happy from the time that I knew I was two months pregnant. I want to have children’. Meena also described:

I felt happy and excited. The baby brought the opportunity to fulfil my role as a woman and to be loved and to love someone without any conditions.

5.1.1.3 The more children, the stronger the family.

Having many children was important to the Burmese participants (both key informants and interpreters), as this created a strong family. Ning stated, ‘Our family wants to have many children. I have many relatives to help me raise them’. Teena added, ‘Now, I am pregnant and being a mother of two children, my family is so happy’.

Children were an important part of their life and made them and their family happy:

We all are so happy, the whole family. We mean that families with children would be a happy family. Burmese people want lots of babies, as it makes our family happy. (Mint)

Some relatives of the Burmese women who were present during the interview also contributed. Meena’s mother stated, ‘Burmese are more likely to have many children because we believe that the more children, the stronger the family’. Teena’s sister commented, ‘Burmese people want many babies, as it makes our family happy’.
However, this was also so that their child or children will help them in older age. May suggested, ‘My family will raise our children to be a good person, and when they are grown enough, they would turn to help their families’. For Yusoo, becoming a mother was a means of securing a stronger relationship with her partner:

I had my first baby when I was 17–18 years old. I was very young then but I wanted the baby because I was afraid my husband would abandon me. At the time, he was leaving me. My friends said if we were to have the baby together then my husband would not leave me. My husband has steady monthly income.

He loves his kids very much.

Given the importance of family and having many children, the women became distressed about any suggestion from the Thai health professionals that they should consider sterilisation. During fieldwork, I noted several occasions when staff suggested this. For example, one nurse-midwife, Pimpa, advised a Burmese woman, ‘Why did you get pregnant again, it is dangerous for your age? If you haemorrhage, it will risk your life’. Neemoe, an interpreter, translated the woman’s response stating, ‘She wants to have more children’. Neemoe also added her own experience. ‘I have only one son, I still want a couple more. I do not want to be sterilised either.’

5.1.1.4 Love at first sight.

Feelings of love and of being a mother were almost instantaneous for women at birth. Neeza stated, ‘After the delivery, it was just indescribable. It was so emotional. I felt excited and afraid all at once. However, I got the feeling of motherhood at that time’.

Ning also described the feeling of love when she saw her baby for the first time:
I was so happy when I knew that I gave birth and was safe, and my baby was safe. First of all, I desired to see my baby and first seeing her at that moment made me feel very happy. I am even more delighted when I saw my baby. I was so emotionally happy, and I love her so much.

Tata had a caesarean section. While she felt some pain after the operation, seeing her baby was almost an immediate cure:

Once I saw my beautiful newborn baby, I felt so relieved and happy that he was safe. Most of all, my son was safe, I will take care of my baby myself and breastfeed my baby and the baby can feel my love from my embrace.

Mint had three miscarriages in the past. She was very worried about her baby’s safety. After the birth, she stated that she now knew the feeling of a mother’s love, and intended to cherish every moment with her baby:

The birth of my baby is imprinted in my memory. During the pregnancy I was concerned I would lose the baby. When my baby was born safe and strong, I was extremely happy to see her. I did not care if I would die in the future because now that I can hold her and hug her, that is all. I will focus on at the present time and will take good care of her.

5.1.1.5 Wanting the best for my baby.

The women discussed the responsibility of motherhood and took this very seriously. All spoke of wanting to care for their baby in the best way possible. They also focused on the future. As discussed in Chapter 4, the women and their husbands migrated to Thailand to seek a better future for themselves and their family. They discussed in detail the actions they took to care for their babies and children to protect them from any harm:
I think that being a mother involves great responsibility. I always think about how to make my children have a better future. I will give them everything that we find is good. Even now, I have no work anymore, but I think all the time that I have to do my best in my role as a mother. (Neenee)

Even though we are working very hard and long hours and I am tired, I will do this because I have the strong intention to bring up my children with no fear and that they are protected and have good food and good education. (Meena)

Caring for their child also meant that as the children became school aged, many participants would decide to send their child to Burma for their education. In the antenatal and postnatal interviews, this was already on their minds:

I will take care of my children as long as they are old enough to study in school. When my child grows up, no-one can help me take care of her, because I have to work. I will send her to live with my relatives in Burma. (Neenee)

I will take care of my baby the best I can here in Thailand. When he grows up (around four years), I will send him to study in Burma because we are Burmese and our families live in Burma who can take care of him well. Thus, we would better take our children to grow up in our home country. In my mind, it would better for our children they will be safe and protected. (May)

These benefits were reiterated by others, who asserted that their children would be safer and they could work without worrying about their children. However, they also acknowledged that they would miss them:

I think that it is very important and a good idea if our children live with our grandmothers. Everyone has to work. They do not have enough time to take care of their children. However, we have to send some money to them every month. (May)
Only one participant indicated that she would like to send her child to a government supported school in Thailand which offered Thai, and Burmese as well as English lessons to both Thai and Burmese students. This was because most of her family lived in Thailand and they could support her well:

I love my daughter so much. I want my daughters to live with me. The oldest one is six years old. She does not go to school yet. I think I will send her to the Burmese school here [in Ranong province]. In the past, we might have to send them to Burma, but now most of us work here in Thailand. My relatives would support me to care our children here. We probably do not have to send her to Burma. (Meena)

Wanting the ‘best for my children’ included breastfeeding. During pregnancy, the women participants planned to breastfeed. Their perception was that breastfeeding was the best food for their babies. Neenee said, ‘I will take care of my baby by myself and will breastfeed my baby as natural milk is the best’. Several women also described breastfeeding as being more than providing food for baby; it includes a loving touch. Neeza described:

I want my baby to be healthy. I will breastfeed; that would make my baby strong and healthy. I will also like hugging my baby if breastfeeding him. That would make me feel happy.

Tata also intended to breastfeed:

I think that I will take care of my baby and breastfeed my baby, which is safer and the baby could feel my love from my embrace.

After birth, all the women were positive about breastfeeding, describing it as the best food for the infant. The women believed that breastmilk would assist the baby to be happy, strong and healthy. The baby would sleep well and feel the warmth of
love from their mother. Women were keen to continue breastfeeding when they returned to work:

Breastfeeding is the best. Our baby will be strong and healthy and not be sick easily. If we breastfeed our baby before bedtime, it can make the baby sleep well. I want to breastfeed my baby every meal and every day during my maternity leave. If it is the time I must go to work, I will breastfeed him after work and before bedtime. (Yunin)

Some women managed to express breastmilk and feed their babies for six months, despite returning to work. Some second-time mothers disclosed that in the past, they had breastfed for a long time, approximately two to three years:

I breastfed my first child for two years. Breastfeeding is very good and nutritious. I have a plan to breastfeed my second child until the baby is two years old. I will take care of the baby by myself and will not go to work until my baby grows enough. (Teena)

In summary, this theme demonstrates that becoming a mother was central in the lives of Burmese women in this study. The participants held positive views of becoming a mother—excitement, happiness and love. They aspired to achieve the best for their babies and children and wanted to care for their children in the best way possible.

5.2 Protecting Myself and My Baby

Burmese women expressed concern about whether their baby would be born safe and well. During the pregnancy, they worried about this and described what they had done to ensure the safety of their unborn baby. They discussed self-care, which included eating healthily. They also engaged in a range of traditional practices and attended antenatal care provided by the Thai health services. Many women also
worked less in pregnancy and some stopped working altogether. This importance of ‘protecting myself and my baby’ was also reflected in the postnatal period when the women discussed engaging in both Thai maternity care and a range of traditional practices keep themselves healthy and to protect their baby. Two themes comprise the major theme—Protecting myself and my baby. The first theme, ‘Taking care of myself’ comprised several subthemes.

5.2.1 Taking care of myself.

Burmese women focused mainly on ‘taking care of myself’ to protect their babies. Three subthemes emerged: ‘Following the advice of elders’; ‘Balancing the demands of work’; and ‘Coming to antenatal care makes me and my baby well’.

5.2.1.1 Following the advice of elders.

Women mentioned that they must take care of themselves to protect their infants. Meena stated, ‘When I knew that I am about to be the mother of the second child, I decided to give all my attention to my children. I have had a strong desire to protect them’. Rigorous exercise was avoided, as the women believed it could lead to a miscarriage; most participants indicated that consuming healthy food was important for their health and that of their baby:

I think I should do my best to take care of my baby and make him or her safe and strong. I want to eat healthy food; although, I sometimes do not want to eat anything. However, I have to eat for my child. (Tata)

Meat is expensive in Thailand and many women could not afford it. However, they consumed a great deal of fish because either they or their family worked at the fish markets and obtained fish at no cost. Female relatives and neighbours also advised that some foods should not be eaten or should be restricted in pregnancy. For example, some women cautioned against the consumption of eggplant as it could cause
‘prolonged labour and more pain’ (Ning). Fermented food, such as pickled fish and sour pork, were believed to cause problems for the baby and mother. Neenee remarked:

I just avoid eating spicy food. If I eat too spicy, I am afraid that my baby would have some health problems after birth; it may be uncomfortable and hot and have a stomach ache. I just do not want to face the situation of seeing my baby sick.

The women also followed the advice of older women and consumed a specific ingredient contained in herbal tonics (Lay-Say in Burmese), as they believed that could help women feel more comfortable and nurture their pregnancy:

In Burmese culture, we were advised by the elderly women that cooking of herbs or foods with added special tonics ensures pregnant women feel fresh, it helps relieve gas in their stomach, and feel well. We should follow them. (Neenee)

During community observation, one participant described the herbal tonic as ‘a special recipe used by Burmese’. She asserted that the tonic contained mixed herbs with an alcohol base (Field notes: 17 June 2015). However, none of these Burmese women were prepared to disclose the tonic ingredients or the amount of alcohol in the base. According to the women, only Burmese people would be able to learn about the ingredients. Meena stated:

It is only made by Burmese as the substance is made with mixed herbs and liqueur. I cannot show you since you are not Burmese. It is only Burmese people. It is Burmese traditional medicine.

Maloo, a Burmese interpreter, explained that the tonic was believed to relieve flatulence and discomfort during pregnancy:
They like to take some kind of tonic. It is Burmese medicine, it is clear, but it has bubbles and tastes like soda pop. They buy the tonic from the drugstore. The tonic they take is so salty it is almost inedible. They drink it anyway; they say it has calmative effects that make them feel relief from the gastrointestinal gas; they drink it because they think it is good. They take the tonic and tell the others it helps relieve the discomforts caused from the fetus growth. It is normal for them to buy and drink it.

Another interpreter, Neemoe, said:

This tonic is normally taken with one spoon or two before a meal to make appetiser and stimulate our appetite. Pregnant women who are near to give birth like taking it (Field notes: 27 November 2015).

The Burmese interpreters indicated that they advised the pregnant women not to drink the tonic. Neemoe explained:

It is strictly prohibited to be taken by pregnant women, but we do know many of them still drink it. I tried to stop them from consuming the tonic as it can make their baby sickly; for example, they can be jaundiced or have seizures but most of the Burmese women do not agree.

Some of the women had an abdominal massage since they believed that this would make them more comfortable. May and Yunin used abdominal massage and stated that their friends or Burmese elderly people had suggested this traditional practice. Massage was provided by the local healer, who had extensive experience in massage. Therefore, they believed that abdominal massage would be beneficial for pregnancy:

After I had gone for the massage, I did not have abdominal pain at all. I think it will be good for my baby, too. Many of my Burmese friends have done that
before as well and most of them said that they felt good, because the local
healer has a lot of experience in doing so. (May)

Elderly women always tell us to get an abdominal massage during our
pregnancy as well. The local healer can help people in giving birth. She
massages our abdomen and makes an appointment to do it again so that the
baby can be healthy and make pregnant women feel good. After the massage,
the baby will move much more. I did twice and felt so good. (Yunin)

In contrast, some were afraid to have an abdominal massage because they were
worried that it may harm the baby. Teena consulted a healer to have a massage but was
concerned that it could harm the baby:

Someone goes to the folk healer to get oil massage on their belly. They said it
can make you feel relaxed and have no colic. The folk healer applied herbal oil
on the belly and then started pressing on it around, and pressed tightly under
the breast in order to help breech baby turn head down. But I felt scared when
I saw it. I was afraid to do that. They said if we did that we would feel
comfortable and it is not dangerous. But I did not dare to do it anyway. I was
afraid that my breech baby would get harm as they are not a real doctor but just
an old man healing people with local wisdom.

5.2.1.2 Balancing the demands of work.

The participants faced the decision of whether to continue working in
pregnancy for the income or to stop work because the heavy manual work posed a risk
to their pregnancy. Six of the 10 women stopped working when they became pregnant
to ensure a safe pregnancy. Due to financial hardship, four women had to continue to
work.
The women who stopped working did so for a range of reasons, including concern about the baby’s health, fear of miscarriage and family commitments. They indicated they had their husband’s support in this decision. During their pregnancy, these women remained at home, caring for children of other family members and doing household chores. Mint had experienced three miscarriages. She and her husband believed it was better to stop work for their baby’s safety:

I avoid lifting anything because I am afraid that my baby is going die. I had worked when I had those three pregnancies; however, I have not been working since I have got pregnant this time. My husband said I should not work hard since he does not want our baby to die.

Veena, a nurse-midwife, recognised that Burmese women did heavy manual work and believed, as a consequence, that some experienced pregnancy complications:

Most of them who come for antenatal care also have to stop working. That might cause some troubles to their work. The Burmese also have higher rates of pregnancy failure and weak newborns than the Thais. This is because many women work hard, lifting heavy objects in fishery like seafood buckets that may cause an abortion.

Several women had to continue working during pregnancy for financial reasons, including sending remittances to their family in Burma. Others had debts and some wanted to earn for the new baby. Despite their tiredness in pregnancy, they continued with their physical work. Yunin stated:

It is a hard work. I go to work even when I have been pregnant for two to three months. I have to work as much as I can. We have to save money for taking care of our baby.
Some women negotiated with their employer to undertake lighter duties and shorter hours:

As I have a pregnancy, now I finish work earlier. I work from 8 in the morning to 2 in the afternoon. The pay decreased from THB 300 to THB 200 a day. I do not want to work hard anymore. (Neeza)

Women also knew that their employment was precarious because of their pregnancy. A main driver for continuing to work was fear of being replaced in the workplace:

When I had my first pregnancy, my employer dismissed me, as there were restrictions on pregnant workers working overtime. I did not want to lose my income, but I did not have a choice. I sought another job with lighter work, but work is hard to get for pregnant women. (Meena)

Bua Ae, an interpreter, also remarked that the working conditions of pregnant women are tough and often, they do not receive a full wage. She added that women did not want to tell their employer about their pregnancy:

It affects their work; their employer will hire others who could work much stronger than pregnant women do. So, when women are pregnant, they do not dare tell their employer as they are concerned about reducing or losing their income.

5.2.1.3 Coming to antenatal care makes me and my baby well.

Alongside the traditional Burmese beliefs and practices, participants also attended Thai antenatal services. Almost all participants attended antenatal care in the second trimester of their pregnancies, on average between 16 and 17 weeks gestation. However, one woman, Tata, was 10 weeks pregnant when she had her first antenatal visit:
The first time I attended the antenatal clinic, my pregnancy was still in the first trimester. I did not get anything checked but the midwife gave the mother-baby book to me in the Burmese version—that was very useful for guiding me to take care that my baby will be healthy. (Tata)

They believed that nurse-midwives and other health professionals would provide them with information and education to keep themselves and their baby safe and well:

I just want my baby to be safe. I think, coming for antenatal care, doing what they say and having the tests and treatment that are safe and secure can make me well. Having nice and kind midwives and Burmese interpreter working here is also superb. (Yunin)

The health staff could be the good consultants and help me with it if I have any problems. Thus, I want to access antenatal care as fast as I can. I want to come for the antenatal care check-up every time. (Mint)

**Accessing antenatal care**

Most Burmese women were referred directly to the PHC for antenatal care. In general, Burmese people living in this area were only referred to the hospital in the event of pregnancy-related risk factors or health complications. In this study, I purposively sought five participants who were attending PHC and five who were attending the hospital. Therefore, it was interesting to hear their differing perspectives on where they decided to seek care and how they went about this. Most of the women were familiar with the clinic and knew other Burmese women who had received antenatal care there and were happy with the service. This word-of-mouth played a crucial role in women’s decision-making about antenatal care:
My sister who has two children also came here [PHC] for the prenatal care service. It is convenient and the place is not located far from home. My aunt and my sister used to come here, and they said it is very good. The health providers are nice and there is interpreter provided to help with communication. We can feel free to ask whatever we want to. (Yunin)

My sister-in-law who used to be an interpreter at the PHC clinic suggested I should come here [PHC]. She told me to let her know if I need any help getting an appointment. (Neenee)

Alternatively, Tata received advice from a friend that the hospital was the best place to receive antenatal care:

My friend suggested me to come here (Ranong Hospital). She told me that this hospital looks after the patients very well. I should have antenatal care here instead of going to any other places because of their good service and hospitality. My house is located near the hospital. It is very comfortable and does not take a lot of time to get here.

Some women chose to attend the hospital as it was more convenient for them or they believed they would receive better care there. For example, Mint believed that ‘the hospital provided the best antenatal care in this province’. One participant had miscarried three times. For two of those pregnancies, she attended the PHC service. She stated that she had not missed any appointments, yet she still lost the babies. Therefore, for this pregnancy, she wanted to access the antenatal care clinic in the hospital, as she thought this was best for her pregnancy:

For the first two, I went to Bai [PHC]. For the third one, I changed my mind and went to Somjai [PHC], but unfortunately, I still lost my baby. I therefore intentionally come to this hospital since I think it would be better. (Mint)
One of the women had attended antenatal care at PHC clinic during the first and the second trimester of her pregnancy. For the third trimester, she decided to seek care with a doctor in a private clinic who had performed her previous caesarean section:

I actually had the extra antenatal care service in a private clinic, not at the primary health care. I am pretty old and used to give birth through operation before. I would like the same doctor from my last pregnancy to deliver me. He is very good, so I can get recovered soon. (Neenee)

Planning for birth

Most of 10 participants emphasised the importance of the consumption of healthy food, and planned to have a vaginal birth. They believed vaginal births were safe:

I would prefer a natural delivery. It would hurt less and is safe. My friend said that a caesarean section hurts more. I did not want to deliver through the operation, as I thought it might be very painful and my baby would not be that safe, just my opinion. I really wanted to give birth naturally. (Neeza)

After giving birth, Neeza was no longer concerned:

I actually feel better since I knew I could give birth through the normal way. Finally, my baby was delivered safely. We were safe.

Tata focused on what would be the best birth to ensure her safety:

I had a natural delivery when I had my first child, and I had given birth safely. For this delivery, I want to give normal birth that is the best safe for delivery. I do not wish to a caesarean section that may affect my health. I had a natural delivery of my first child. Why wouldn’t I be able to have normal birth for this child?
Barriers to accessing care

Although all the women in this study had attended antenatal care regularly, not all Burmese women living in Ranong province attend antenatal care. Women’s health insurance status was crucial to whether they could access care. Women without a health insurance card sought care later because they were charged for the services. May said:

I did not have a health insurance card at that time because I was waiting for a renew card. If I come here [PHC] for any antenatal care, I have to pay everything by myself. I do not have enough money.

Bua Ae, an interpreter, also emphasised:

Without the health insurance card, Burmese women have to pay full cost for attending antenatal care. Although many women want to receive antenatal care to care for their health when being pregnant, some of them could not afford since they earn less than the cost. Therefore, they started antenatal care late until they received the health card.

The interpreters and Thai health professionals shared that many Burmese women do not use antenatal care either at the PHC or the hospital. Some women attended only for the delivery or attended irregularly since they believe that pregnancy is natural; thus, antenatal visits at the hospital or PHC are unnecessary.

Maloo, an interpreter, shared her experiences:

Not all Burmese women use antenatal care, I would say there are many of them came here [PHC] just one time before delivery to want us to send them to the hospital for giving birth. They see pregnancy as normal and there is nothing for them to be scared.

Chaiyut, an obstetrician, added:
Some women believe that getting pregnant is natural. They do not come to the hospital unless it is really necessary. No antenatal care visits; some come only for the delivery.

Some Burmese women also give birth at home with a local midwife or traditional birth assistant because these women believe that pregnancy is natural. Sopa, a nurse-midwife, stated:

Some think their previous births were fine without antenatal care and they give birth at home. They see pregnancy and birth as normal and there is nothing for them to be beware of, as their last pregnancy had no problems at all. They think giving birth is not dangerous and they can give birth by themselves.

5.2.2 Protecting my baby from evil spirits in pregnancy and after birth.

Burmese women believe that evil spirits could harm them and their baby during pregnancy and after birth. They protect their pregnancy in several ways. For example, the women were told that wearing a brooch or amulet on maternity clothes would ward off evil spirits and protect their baby from stillbirth:

Once I leave the home then I have to stick pin on my clothes so the bad spirits do not harm me or my baby. But we do not have to put it on at home. (Yusoo)

However, Yusoo did not participate in this practice because her mother perceived that they had become modernised, like Thai people:

The Burmese believe they protect from bad things, from bad spirits. I’m not concerned about it. My mum told me most Thai people don’t do that. She said she is modernised. So, I didn’t pin the amulet.

Further, there were activities that women were not allowed to engage in during pregnancy, as they might affect the baby or result in a miscarriage. For example, the
women believed that they could not cut their hair during pregnancy, and at night time, they must tie up their hair:

    Elderly people told us we should bind our hair properly before going to bed. If we leave our hair down or messy, it seems like bad spirits can come stay with you or you may have nightmares or even can harm you and your baby. (May)

    Women were discouraged from going out at night and had to avoid things that might make them sad. For example, they should not watch horror movies and or anything that frightens or shocks them:

    My mother told me pregnant women are not allowed to go out at night or go to a funeral, as it is not good or safe for our children. (Neeza)

    After delivery, according to Burmese culture and tradition, particular foods are encouraged to restore the women’s health and wellbeing and to stimulate breastmilk production. Teena remarked:

    Women who had just delivered a baby needed to eat hot food to aid in postpartum recovery. My mother and some elders in the neighbourhood told me to eat some ginger and banana blossoms, as those foods could induce lactation. I believe them.

    According to traditional beliefs, women would consume Gotu cola, a kind of plant or herb that contributes to the retraction of the uterus and the healing of the perineum. Gotu cola soup is a traditional food used to reduce abdominal pain, the expulsion of lochia and drying out of the womb. In the observations of the community, I noted that the women’s relatives cooked the herb mixed with Gotu cola for the women. Mint’s sister displayed the soup pot. The soup looked like clear vegetable soup with seasoning powder; there was no meat. Mint added, ‘It is the soup for the post-delivery mother. Black pepper and the Gotu cola leaves enhance my breastmilk.
The Burmese cook it and eat it every day after the delivery’. We also noted during our visit to Meena’s home that her husband had cooked for his wife. He showed us the food and explained:

It is fried pork. It is a nourishing food for the post-delivery mother. The Gotu cola soup with fish makes the body strong and produces natural breastmilk. The mother can recover fast this way. I cook for her every day during postpartum recovery about 45 days after delivery.

During the postnatal period, the women’s relatives assisted in taking care of the newborn. Women participated in a range of traditional practices that were perceived as having positive outcomes for babies and mothers. Rituals included shaving the baby’s head and putting a knife under the baby’s mattress or cradle. For example, when we visited Mint in her home during the postnatal period, we noted that she had placed a big knife under her baby’s mattress. She stated:

Any kind of knives will do, just make sure it is sharp. Scissors are fine, too. It is a Burmese cultural belief. If you put it under the baby’s mattress, the evil spirits would not be able to do the baby harm. It protects the baby from evil things. The Burmese put it under the mattress or cradle until the baby can walk. Once the baby grows up, we would not have to do it anymore.

However, Neenee did not follow this practice as she felt it was unsafe:

It is believed to keep the baby safe. However, I was afraid that it would be more dangerous if my baby fell off the cradle and was stabbed by the knives. It would be even more dangerous if the baby rolled over on the scissors. The hospital staff told me that it could be dangerous if I was not careful. So, I thought that I would not need to put the knives under the cradles.
Smearing black soot from the bottom of the pot onto the infant’s forehead, to prevent evil ghosts from harming the baby was another Burmese cultural practice. Black soot was believed to protect the baby when the baby leaves the house. Teena explained:

The soot keeps away the bad spirits and prevents them from doing the baby harm. If I do not do that, I would not feel at ease. The baby might come back home and get sick. Most Burmese do this. I think it is better to follow the belief. It makes me at ease.

Teena seemed to doubt the value of this practice, but appeared soothed by it.

One of the most unusual practices disclosed was the preserving of the baby’s umbilical cord. This was considered important for the women, as they believed it could restore the baby’s health during illness if the baby was fed some preserved cord:

This is the Burmese belief. If I get to keep my baby’s umbilical cord, it will give me a peace of mind when my baby is sick. I will be able to scratch some pieces out of it to feed my baby and make the sickness go away. (May)

Neemoe, a Burmese interpreter, added, ‘I did that, too. I had kept both my children’s umbilical cords, just in case they got sick. Most of us did this’.

5.3 The Role of Informal Support

The concluding section of this chapter describes the support women received during their transition to mothering. All the Burmese women mentioned the involvement and support they received from their husbands, families, relatives and employers.

5.3.1 Support provided by the baby’s father.

All key informants spoke positively about the role their husbands played in supporting them during pregnancy and after birth. Husbands were also present during
some home-based interviews after birth or during observations on the postnatal ward. The women all indicated that their husbands were happy about the pregnancy and that these men wanted to work hard to support their family and help care for their baby and children. The main income of the family was earned by the husband. Mint mentioned the valuable support she received from her husband:

My husband often told me to have a rest after work. He took care of me very well. He was so glad that we will have a baby. Before giving birth, he had me stop working and stay home. He did not want me to keep working hard anymore.

The women’s husbands often came to the antenatal appointment, particularly the first appointment. Tata said, ‘The first time I accessed antenatal care, my husband came with me’. May also described that her husband always brought her to attend antenatal care: ‘My husband takes me here [PHC] by bicycle. We came here very early in the morning’.

From the women’s perspective, their husbands cared for them well and were good fathers. The women stated that they helped to earn money to raise and take care of the baby. One father, who was at the home when I came to interview Tata, stated:

I am very happy. I will do my best in taking care of her. Since I knew I was to be father, I told myself that I will work harder to earn money as much as I can and make sure that my wife always stays healthy. I was very worried when she had bad morning sickness. At that time, I thought she could not work anymore, so I told her to stop to work so that it would not be dangerous for her and our baby. It is my responsibility to take care of her as a role of husband and father. (Tata’s husband)
It was not possible for the husbands to be with their wives during labour and birth. Therefore, the fathers of newborns typically visit their wife straight after the baby’s birth:

My husband is so nice to me. I rang my husband to tell him that I was near to labour, so my husband hurried to come up to me. He took days off to take care for me because I had a lot of pain after the birth through caesarean section. He took care of me very well and he could take care of me until I went out from the hospital. (Tata)

When the women were resting after birth, their husbands supported them emotionally and provided physical care. Neeza stated:

My husband takes care of me and our baby very well. He thought that I had been pregnant for a long time that caused me fatigue, so he wants to pay something back to me and take care of me as best as he can. (Neeza)

Neeza stated that her husband was happy to clean the house and to cook for the family.

The women described the role of a father and husband as providing love, attention, care and protection. When I visited Meena’s home, I observed that her husband was cooking for her and caring for their children. I interviewed him about the role of a father:

I love my wife and my children so much. She’s my wife and I’m her husband. We have to take care of each other. For my children, I’m a father. I have to do my best as a father. Mostly, I cook food for her. She had just had a baby. She is not strong enough. It’s fried pork. It is a nourishing food for the post-delivery mother. I can’t breastfeed the babies, but I can feed the babies’ mother foods that enhance her breastmilk. I don’t know how important it is. I only know that
I should be a family’s leader. I have to earn money for the family. For that part, I work. To help taking care of the children is also my duty. To help my wife is also a duty. I love them. (Meena’s husband)

Mint also described the role her husband played in practical tasks, such as washing and housework:

My husband did not let me work hard. He was afraid I would get sick. He also wanted me to spend all my time taking care of our baby. He woke up at 5 am in the morning to clean the diapers, the baby’s clothes and mine. He did all the housework before he went out to work. He started working at 8 am and finished at 5 pm. Today is Sunday, but he does not stop working. He wants the money for our baby. (Mint)

Further, Neenee’s husband paid for extra care during the hospital stay; he offered the VIP room to his wife. He wanted to support his wife the best way he could:

I asked her to have one more child. She said yes to me, so in return, I must be a good husband. I am happy to pay money to make her stay comfortably in the VIP patient room. It is quite expensive but good quality of service. I think it is worth spending money for me anyway.

5.3.2 Support provided by the family and relatives.

Besides the support from baby’s father, the women had the support of family members such as mother, mother-in-law, siblings and sisters-in-law. Neenee, a mother of two, was escorted by a family member when she attended antenatal care, particularly for the first visit. ‘The first time I came here [PHC], my sister-in-law brought me to this place’. Neenee’s many relatives supported her to care for her children. Following the birth, her mother-in-law, who lived in Burma, came to look
after her grandchildren. Neenee’s sister and sister-in-law also helped to care for her children:

My husband’s mother and sister helped me to take care of my baby and after my child was one month old, they went back to Burma. They used to help me take care of my first child for the whole month.

Family support extended to the provision of postnatal care in the hospital. Female relatives stayed overnight to ensure the women had all their needs met:

My mother and my siblings helped me. My sister has a child, a four year old, so my relatives help me well. After the delivery, my sister was able to take care of me at the hospital because she could speak Thai quite well. She stayed with me and gave me support, suggestions and helped me in everything. (Neeza)

Women also learnt about breastfeeding, infant care and important traditional practices from their relatives:

My mother taught me how to breastfeed and care for my baby, as she has known from her experiences as a mother. (Teena)

Moreover, my sister came along and suggested to me how to take care of my baby properly. She helped me with what I was not able to do, as I did not have experience. For example, my baby was crying as I think he got hurt, so she came to apply herbal balm to my son and then he got better. (Neenee)

Besides taking care of the baby, mothers, mothers-in-law or female relatives offered breastfeeding advice:

On the first day after I gave birth, I did not have milk for my baby, and she cried at night a lot. My mother-in-law and my aunt advised me to breastfeed her every two or three hours that stimulated milk flow well. My baby then slept well. (Yunin)
During pregnancy, the women were already planning how they would balance work and caring for their children after the birth. The length of time between having their baby and returning to work varied from two months to 12 months and depended upon their employers and the support of family and relatives. For financial reasons, May planned to return to work two months after birth. She indicated that she was still able to look after her baby, as she lived in her workplace. Six other women intended to return to work when their baby was between three and six months old. Three women did not plan to return to work until their babies were 12 months old:

When my baby is three months old, I will have to ask my mum to help taking care of her. This is because I want to go back to work since my husband earned too little income. I am afraid we do not have enough money to pay for food and rent. (Mint)

If it is the time I have to return to work, my mother-in-law would also take care my child since she stays near us. She has helped taking care of our first child while we had to go out to work. (Meena)

5.3.3 Support provided by employers and friends.

Women in this study also received support from their employers and friends. Despite difficult working conditions and low pay, it appeared that some women had close relationships with their employers. Ning relied on many of her friends:

My Burmese friends who are the good consultants and can also help me with it. If I have any problems, I think, they can help me somehow. I think, after giving birth, I will have my Burmese friend teach me how to take care of the baby. My friends working at the same place as me, they are also kind and helpful to me. We have the same employer I mentioned, so they can come along to help.
They described the ways their employers supported them during pregnancy. For example, some employers allowed the women to take days off to attend antenatal appointments and some helped by driving them to the antenatal care clinic, including when it was time to give birth at the hospital. Ning’s employer accompanied her to an antenatal visit and helped her communicate with the nurse-midwife and other staff. The employer was also present during the interview and said:

It is raining. I saw her waiting for the rain to stop but it did not. That is why I decided to take her here (antenatal care clinic). I told her husband that once she bleeds, has labour pain, please come call me, I will take her to the hospital.

(Ning’s employer)

Ning also explained how her employer had offered to take her an appointment:

My employer used to take me to the hospital for antenatal appointments. When I gave birth in the hospital, she drove me there and stayed with me at the hospital. She is so kind. She helped me care my baby, took care of the food and helped to clean my body.

May’s employer paid her hospital fees:

The employer paid for us. When I had labour pain, he took me to the hospital and he used his car to pick me up and paid for the fees. He said it was okay, it was the duty of the employer to take care of the employees under their responsibilities.

Chapter 4 described the practice of families sending their preschool-aged children to live in Burma, where they are cared for by relatives and attend school. In pregnancy, the key informants were already planning for the baby to go to Burma. As previously described, this practice is based on the trust that their family will care well for the children and that their children will be safe and receive appropriate education.
This practice enabled the women and their husbands to keep working in Thailand, earning money for their families.

5.4 Conclusion

The Burmese women and key informants in this study held positive views of motherhood and wanted to take care of themselves and their baby to the best of their ability. This included following traditional practices and attending antenatal care. Negotiating the demands of earning an income and protecting their unborn baby sometimes led to unhealthy practices, such as consuming herbal tonics to increase their energy and improve work performance. Accessing antenatal care was a positive health-seeking behaviour noted in this community; however, it was not available to or accessed by all women. The women described a high level of family and other social support and this appeared to be central to their positive views of becoming a mother as a migrant living in Thailand.
Chapter 6: Providing Maternity Care for Burmese Migrant Women: The Perspectives and Practices of Health Professionals

6.1 Introduction

This chapter focuses on the perspectives and experiences of Thai health professionals providing maternity care for Burmese migrant women in Ranong. The data presented in this chapter draw primarily on the observations of the interactions between the health professionals in the antenatal clinics and postnatal ward, and the interviews with the nine health professionals. However, data from the interviews with the Burmese migrant women (key informants) and Burmese interpreters who worked in the Thai health services are also included. Four major themes emerged from the data: ‘We treat everyone equally’; ‘Being processed’; ‘Complying with directions’; and ‘Being cared for’.

In Figure 6.1, the themes representing the perceptions and practices of Thai health care providers are presented. The observation data and interviews with Thai health professionals conveyed that care occurred on a continuum from ‘being processed’ to ‘being cared for’. When staff focused on the processes and rules, Burmese women were expected to comply with their directions. When Thai staff were more caring, they appeared more flexible and treated women equally.
Figure 6.1. Four major themes representing the perceptions and practices of Thai health staff caring for Burmese women.

6.2 We Treat Everyone Equally

Generally, the Thai health professionals spoke positively about the Burmese women they cared for, emphasising that they aimed to provide the same level of care to all women and their babies. This view is illustrated in quotations from Soraya, a nurse-midwife working in the maternity services, and Veena, a nurse-midwife in the postnatal ward:

Actually, it is not different from what we do with Thai women. We basically take care of all the postpartum mothers the same way. (Soraya)

Burmese women have the same equal rights to receive medical care as the Thais. The medicines and the treatments are the same. They are treated under the same standards with the Thais. (Veena)
Health providers stated that they made the women feel welcome even though they could not communicate with them. The main objective of healthcare providers was safety and quality during antenatal care:

From my point of view, there were many women who came for antenatal care in the hospital. We also need the same outcome standards for our care, no matter the women are Thais or Burmese. What we expect is not only to provide the safe birth for Thai mothers and babies, but also for the Burmese, too. They have got to be treated the same way. (Penjai)

Despite this positive perception, the practices of these health professionals varied depending on whether they were working in the time-pressured antenatal clinic, or what appeared to be the more relaxed environment of the postnatal ward. The analysis of the observation data suggests that antenatal care in both the PHC clinic and the hospital was akin to a production line, in which women were ‘being processed’. In this context, there were strict rules governing when and where women were required to attend. At times, there was less tolerance of certain cultural practices or beliefs. Lack of familiarity and miscommunication meant that Burmese women either complied with health professionals or ignored their directions, partly because they could not understand them. In contrast, the environment in the postnatal was more relaxed, and the staff appeared compassionate and caring.

6.3 Being Processed

There appeared to be strict rules governing where Burmese women attended for antenatal care. In general, all women who were well in pregnancy were expected to attend the Pak-Long PHC clinic. Women who had health complications or pregnancy risks were directed to attend the antenatal clinic at the Ranong Hospital. However, there was some flexibility based on where a woman lived. If she lived close
to the hospital, she was permitted to attend the ANC at the hospital, but this was rare as most women lived in Burmese communities close to the PHC clinic—the main reason that the PHC clinic had been established. It became evident that many women preferred to attend the ANC for their pregnancy care because they had a shorter waiting time. This resulted in an elevated level of frustration expressed by both staff and women.

Several subthemes emerged from data related to ‘being processed’: ‘They have to go to the PHC service’; ‘They must wait’; and ‘Organising patient flow’.

6.3.1 They have to go to the PHC service.

In Ranong, women were directed to use the antenatal care services at the community-based PHC clinic and were only referred to the hospital clinic if they had risk factors. Penjai, one of the nurse-midwives, explained the policy:

Recently, we have improved the system and spread the workload to the PHC. The ANC in the hospital provides care for women who live in the area nearby, except for cases with risk in which the women need assessments and treatments at the hospital. Otherwise they have to go to the PHC near their house instead. Some women continued to access antenatal care at the hospital, but the nurse-midwives insisted that they use the PHC clinic:

They [Burmese women] think that hospital is the best place. They would persistently come here for the service. I will serve them only for the first time, but I kept telling them to go to PHC near their house instead. I tell them that I will not serve them next time. (Pimpa)

Penjai went on to say that they have difficulty explaining this restriction to the women:
Some of them keep coming to the hospital. I always send them to the PHC anyway. I have to make them understand that they will receive the same service.

However, from the women’s perspective, these rules were ‘too strict’ and five participants argued they had worthy reasons to attend the hospital rather than the PHC clinic. Meena stated, ‘It should be the same standard. I can access antenatal care at either the hospital or the PHC’. The hospital clinic was recommended to them by other Burmese people who told them it was the best maternity care for women and others emphasised its convenience. Yusoo was determined to go to the hospital for antenatal care as she had family responsibilities and she was told by others, ‘The service system is good and with less pregnant women’. She knew that the hospital might deny her, stating, ‘I lied to the staff that my place was in the market nearby, so she allowed me to have antenatal care here’. Neeza indicated she was able to travel to the hospital clinic by herself: ‘The hospital is closer. I can come here myself. It takes me just a few minutes to get to the hospital’.

However, when Tata attended the hospital clinic, she was less fortunate. The nurse-midwife she encountered in the clinic was strict about the rules, informing her that she could not attend the hospital clinic and must go to the PHC. This resulted in Tata missing two antenatal visits because she did not feel confident meeting another group of staff:

My first ANC was in the hospital but a midwife did not permit me to continue accessing ANC in the hospital. However, although the ANC in the PHC is located near my house, I was afraid to attend the PHC. I just worry about communication so that I came to the PHC for ANC clinic a bit late.
Four of the women had experienced antenatal care in both the hospital and PHC clinics. Meena mentioned that the nurse-midwives at the hospital clinic appeared to be stricter than the nurse-midwives at the PHC:

All health staff here [PHC] seem to be easier to talk to one by one. I can tell them whatever I want to have or speak. At the hospital, the staff spoke very fast and did not ask me whether I understood or not. The nurse-midwives also caused difficulty for me to speak or consult any problems, as they seem very strict.

6.3.2 They must wait.

During the observations, it was not uncommon to see 30–40 women waiting in the hospital antenatal clinic, sitting outside the PHC clinic, or on the veranda or floor of the PHC clinic. This was captured in the field notes and in antenatal care clinic photographs (see Figure 6.2).

*Figure 6.2. A long waiting line at the antenatal clinic.*

Observations recorded in my field notes included entries about the long waiting line at the clinic. For example, field note entry 20 May 2015: ‘There were many women waiting for antenatal care. Despite it being a busy day, only three health staff (including an interpreter) were working’. One day, while observing at the PHC, one of the women waiting asked the Burmese interpreter about me and the reasons for my presence. She wanted to know if I might be able to provide her antenatal check-up so
she did not want to wait a long time. The interpreter replied that there was only one examination room, one set of equipment to check the fetal heart and that she ‘had to wait’. Some women decided to leave the clinic and return home before their appointment. This demonstrates why some women did not want to keep attending appointments and stopped accessing antenatal care. I noted the following in my field notes (8 June 2015):

Two women have been waiting since the early morning but had not received ANC yet. At 1.20 pm the midwife asked the women, ‘What are you waiting for?’ One of the women could understand some Thai and replied, ‘We come for antenatal care. We do not know why the health staff kept us waiting. I do not know what we are waiting for, but the person in pink [the interpreter] told us to wait’. It appeared that the two women had come in the morning for their first antenatal appointment but were told they had to wait for the afternoon session. Eventually, the midwife called the women who could speak a little Thai because the interpreter had not returned from lunch.

This situation was common. Women came in the morning and had to wait their turn. Language barriers, particularly when there was no interpreter present, meant they often had to wait despite arriving early. At times, women made the decision to leave the clinic without having their appointment. For example, Meena missed an antenatal appointment because the day she came, there was fewer staff working:

I missed an antenatal visit last time because I came to the PHC and there were a lot of women waiting there, but on that day the clinic had only two staff [one midwife, one public health official and one interpreter]. I could not wait so I decided to go back home.
6.3.3 Organising patient flow.

In Thailand, the Ministry of Public Health provides guidelines on the services that must be offered antenatally. However, the organisation of the service, including staffing and processes, is determined at the local level by each hospital or PHC clinic. These decisions are based on the hospital / PHC clinic protocol and sometimes the preferences of the health staff, and are dependent on the resources available, including the number of nurse-midwives, availability of interpreters, and space, rooms and equipment (e.g., sphygmomanometers) available.

On visits to the Pak-Klong PHC clinic and hospital, I observed the way antenatal care was organised and mapped the process of care in my field notes. This appeared to be important because it helped explain why women were waiting and demonstrated the nature of the theme ‘being processed’. Figure 6.3 demonstrates how patient (woman) flow was organised at the antenatal clinic at Ranong Hospital (i.e., A → B1 → C → D → B2). This clinic care is provided by two nurse-midwives and one Burmese interpreter. I observed that when women first arrive at the hospital clinic, they wait outside the building to be called by one of the staff (zone A in Figure 6.3). On average, women wait for 15 minutes in zone A. When it is their turn, a nurse-midwife or interpreter will call their name. The woman then follows the staff member and interpreter into zone B1, where they will register the woman and ask basic administrative questions, such as their name (see Section 6.4.3), their address and if they have previous children. The nurse-midwife consulting the woman will also conduct assessment and screening tasks, such as taking her blood pressure. This part of the appointment takes two to three minutes.

The woman is then directed to move inside the hospital ANC, where the same nurse-midwife will conduct the second part of her antenatal check-up (zone C). In zone
C, the nurse-midwife listens to the fetal heart, but this is typically done without the interpreter, as the interpreter continues to work with the nurse-midwife in zone B1. The second stage takes about four to five minutes. If the woman did not speak any Thai, I noticed that the nurse-midwife used non-verbal communication, such as signs to indicate all was well with the baby. However, sometimes the interpreter was called to assist in zone C. I noticed that this occurred most often if the nurse-midwife was concerned that the woman did not understand about observing fetal movement.

The last part of the process occurred inside the hospital building (zone D), where women received information and health education from the same nurse-midwife. The education focused on the need to take the prescribed iron medication, the hazards of sugary drinks and the need to rest and reduce the amount of paid work in the last month of pregnancy. The interpreters assisted with this, but were often engaged with other women in zone B. Therefore, the nurse-midwife managed this with the use of health information pamphlets translated in Burmese. The education session was short, lasting around to two to three minutes. When this was complete, the women returned to zone B2 to book the next appointment.
Figure 6.3. The process and patient flow in the antenatal clinic at Ranong Hospital.

Figure 6.4 shows the process of antenatal care in the PHC, where care is provided by two small teams. Each team comprised a nurse-midwife and an interpreter. Similar to the hospital antenatal clinic, the woman moves from A → B → C → D → E.
Figure 6.4. The process and patient flow in the antenatal clinic in the PHC.

The nurse-midwife and interpreter from Team 1 call a pregnant woman waiting in zone A outside the building for registration and screening in zone B. After they are finished in zone B, the woman is then directed inside the building to another waiting area (zone C), where the nurse-midwife and interpreter from Team 2 conduct the antenatal check-up. The final part if the process is in zone E, where the woman receives health information and education from the nurse-midwife and interpreter in Team 2. This is provided in the same way as in the antenatal clinic at the hospital and takes between two and three minutes.

What was most interesting in the PHC was the opportunity that staff created for ‘communal’ education or education by chance. I noticed and recorded in field notes that the nurse-midwife and interpreter in Team 1 provided information and education
to the woman while registering her and taking her blood pressure. However, this was
done in a way that it was also directed at all other Burmese women waiting in zone A
for their appointment. For example (Field notes: 10 June 2015), I observed on several
occasions a nurse-midwife telling a woman that her blood pressure was high and then
turning to the group of waiting women and saying (see Figure 6.5):

This is not good; your blood pressure is too high ... [turning to other women]
... do you know why your blood pressure is high? The woman just smiled ... it
is high because you are eating too much salty fish and you put too much salt in
your cooking.

Figure 6.5. The examples relate to the health staff providing information and education
for the woman and then turning to the group of waiting women at the antenatal clinic.

6.4 Complying with Directions

The Burmese interpreters indicated that most Burmese women were willing to
comply with advice from Thai health professionals. Neemoe emphasised:
They love their babies so much. They believe and follow whatever I and health providers suggest them to. They seem to focus and cooperate well as far as I have seen. They do whatever they are told to do.

However, some women mentioned that they were not always compliant with the directions of the nurse-midwives and other staff:

I did not take any medicines such as iron and folic acid which I received from the antenatal clinic because these pills made me want to vomit and lose my appetite. (Meena)

It appeared some women were confused about folic acid, for example, describing it as a special pill for good health and energy. Neemoe, a Burmese lam, commented:

Folic acid should actually be taken only one pill a day, but some women double it as they think it can nourish and energise them more if they take it many times or a lot.

Neemoe also stated that the Burmese women did not always understand the health information they were given, despite the interpreter’s many explanations and clarifications:

I clearly explained it, wrote it in Burmese, and the midwife told them everything, but they just did not follow the guidelines and suggestions. Some women did not know how to take the medicine (folic acid and iron). Some say they just do not want to take it.

6.4.1 They keep doing what they want.

Some individual health professional participants indicated that the Burmese women did not always comply with their advice or directions. For example, in the health education sessions, the nurse-midwives and interpreters encouraged the women
to eat well and advised them against sweet and fatty foods. During fieldwork, I observed the Pimpa, a nurse-midwife, advising a woman, ‘You should not eat so much oil and sweet things because you have gained too much weight and you could get diabetes. It is dangerous for you and the baby’. She then handed the women information in Burmese. The woman just nodded and turned away to put the brochure in her pocket (Field notes: 11 May 2015).

Additionally, the nurse-midwives also expressed frustration when the Burmese women, particularly those with health problems or complications, ignored health professionals’ suggestions. For example, one of the nurse-midwives examined a Burmese pregnant woman, measured her blood pressure and weighed her. The nurse-midwife said with frustration:

You have gained too much weight that you have diabetes disease during pregnancy. You should not gain more than 27 kg, but you gained 30 kg. You have high blood sugar levels as well because you are overweight. It is dangerous for both the mother and the baby. Do you know you that? You should avoid sugary food and eat a balanced diet and attend antenatal care regularly. (Pimpa)

The woman merely smiled and remained quiet.

Pimpa repeated to me that some Burmese women ignore what they are told to do in relation to antenatal care education:

Regarding taking prenatal education, Burmese women seem to only take the information they want and they ignore the rest. They sometimes took only a few bits of the information we gave them. In fact, in general they keep doing what they want and ignore what they were told to do.
Pimpa then added another example, stating that she had often emphasised to the women about hygiene during pregnancy, but was annoyed that they never washed their hair:

Many Burmese women have very long hair and they usually apply ointment on their hair, but rarely clean it. Some of them are poor hygiene. This is why I have to tell them many time about if you do not want to cut your hair, you should tie it to be easy for care your hygiene.

Yusoo, one of the Burmese women, explained why she did not always comply with the health staff in relation to hair care:

Even if the nurse provided the best care and information for me in pregnancy, they are quite strict, for example, they told me to cut my long hair. The nurse said it was hard to wash or I should tie my hair up and not let it grow out. So today, I have them in a braid. I believe that cutting the hair while pregnant is harmful. Burmese people believe this way. I did not tell the nurse this, but I have it tied up well. I understand that the nurse does not understand Burmese tradition.

In the field notes, I also noted the example of a 42-year-old Burmese woman who attended the antenatal clinic at the hospital. This woman had three children and several health complications. The nurse-midwife read the pregnant woman’s profile and discovered she was a high-risk case. This nurse-midwife explained to me:

Do you know? Burmese women have not only a lot of children and were so poor, but also some of them have high-risk diseases. In this case, you can see this woman has diabetes mellitus, hypertension and ischemic heart disease. From her chart recorded, she had also dementia, was on aspirin, methyldopa,
enalapril, etc. However, she still wants to have another baby and has not been using contraception. (Penjai)

6.4.2 They are not confident to speak.

Despite the availability of interpreters, lack of confidence to discuss directions from nurse-midwives and other health providers meant that Burmese women might not follow the instructions or comply with them, despite not fully understanding them. Six of the Burmese women participants could speak some Thai, but were not confident that their Thai was sufficient for talking with the health providers:

I could understand Thai, but I only speak a little Thai. I am not so self-confident. It is a problem to me. The PHC, there is a Burmese interpreter helping me. (Yunin)

Although in both clinics the interpreters were employed to assist with communication, some of the pregnant women were embarrassed to ask questions and most were not confident in talking with the health staff, even via an interpreter:

In the hospital, I did not know the health providers and there was no interpreter in the antenatal clinic, so I did not dare to ask a question. (Meena)

Some women were embarrassed to ask questions and most were not confident in talking with the health staff even if via an interpreter. Maloo, an interpreter, had witnessed Thai staff becoming upset with Burmese women if they could not understand what the staff asked them:

Sometimes the staff asked the women, but they could not understand. Sometimes the staff were a bit upset. That was why some women do not have the courage to ask. They would prefer to have the interpreter speak for them.
The interpreters believed that their role was particularly important because many Burmese women did not have the confidence to ask or speak with the health professionals:

The Burmese women usually go ask the interpreters since they do not have the courage to ask the nurses. The interpreters can answer the questions and communicate to us. (Sudjai, a nurse-midwife)

Teena stated that she would often say ‘Yes’ to someone, despite not having understood the question. ‘I could not remember how many times I used to say “Yes”. I did not know what the health providers talking with me as I did not understand.’

Neemoe, an interpreter supported these Burmese women:

Me too, although I am an interpreter, I am Burmese. Formerly, before I worked at PHC, I used to say ‘Yes’ because I could not speak Thai very well. Just say ‘Yes, yes’. [All laughing loudly among Burmese women].

These communication challenges were made even more difficult when women experienced staff who were strict, inflexible and uncaring.

6.4.3 Use only one name.

Due to their circumstances, some Burmese women used different names in different contexts, which caused difficulty in the antenatal clinic in recording their profiles. Often, the name of their health record did not match the name on their passport. This meant that the Burmese women could not access antenatal care services. Health professionals expressed frustration at the use of multiple names, as it was too difficult to ‘process’ the women. This was demonstrated in a conversation documented in the field notes (8 June 2015):

Midwife: ‘Why did you change your name?’ (looking serious and maintaining a long period of eye contact with the pregnant woman).
Midwife (shaking head): ‘Choose just one name, the one according to your passport’.

Burmese woman (via interpreter): ‘I cannot remember my name. Sometimes my employer calls me this and I am called a different name at home. The name in the passport is so long that when I came into register, I could not remember it’.

Midwife (with serious expression and hint of anger): ‘That is why you have so many patient cards, too many names for one person. Okay! I will not ask anymore. Next time, use only one name. Got it! I do not want to give you another card. You never understand and never fix it’.

Midwife (to me): ‘This woman has had several name changes. These women they have no knowledge about anything. All they know is about having babies, but they have no idea about registration. When we do not have the right information, I cannot provide them with service’.

6.4.4 Wash off the powder.

In general, some Burmese women apply thickly coated powder on their body to prevent dry skin. This is believed to have both therapeutic and beauty benefits. During observations of interactions in the hospital, I noted that the Thai nurse-midwives disapproved of this practice. They understood that this was a traditional Burmese practice but dismissed it because they could not see any benefits. Penjai, a nurse-midwife, explained:

I will not do anything if they do not wash off Burmese powder since the powder will mess the bed up.

Pimpa, another nurse-midwife, added:

The injection cannot be done since the whole body is covered with powder.
Conversely, in the PHC clinic, the staff did not complain about the use of the powder:

That is okay because we understand their culture. If they required an injection that day, it was only wiped the area needed. The instruments are then cleaned after use, so any powder is removed. (Sudjai)

6.4.5 It’s about time you were sterilised.

Staff appeared to be of the view that once a woman had two children or was 30 years of age or older, she should not have any more children, and pressure was put on the women to agree to sterilisation. For example, in this encounter below, the nurse-midwife seemed irritated that the woman was pregnant. She took the woman’s blood pressure and said:

Where do you live? Next time, go to the PHC clinic. Today, I will get your blood tested and you will have to come and get the result on the 2nd of June, got it?

The woman did not answer; she listened to the interpreter, who explained in Burmese and nodded. It was noted that she looked worried. At this point, the nurse-midwife turned to talk with me:

The situation is worse with older pregnant women. When it is suggested to get sterilised, almost all of them decline. They said they could not make the decision themselves, so they needed to talk with their husband. They did not know contraception. I could not understand. I had seen all kinds of Burmese women, they cooperated and were willing, but once it came to sterilisation, there was hardly any positive response.

Teena, one of the Burmese women, described how fearful she was when the nurse-midwife raised the issue of sterilisation:
The midwife at the hospital asked me how many children I have got. I told her
I have already had one. She said to me, ‘Then let’s have you sterilised after this
delivery’. I told her I did not want it because I have just had two children. When
I said so, she looked angry. I was terrified. I do not understand why she had to
be angry and annoyed with me. Then, the midwife said angrily to me, ‘What!
You have two children already and you are almost 30 years old. It is about time
you were sterilised. Why are the Burmese so stubborn? Do it, have the
sterilisation. Sign! Sign the consent now’.

The nurse handed me the letter of consent to sign. I told her that my mum did
not want me to do it since she still wanted one more grandchild. But she was
angry and said, ‘It is you who will die, not your mother. You are the one who
get pregnant, not your mother? What is with her?’ I was so terrified. Did she
have to say so? Why did she have to be that harsh? I was in tears. She insisted
that I had to sign the consent. She said that the expected date of confinement
had passed, so I would not be able to have a normal delivery. I might have to
have a caesarean section and I could be sterilised at the same time. I was
terrified that I would get a caesarean section and also sterilisation. She spoke
in a threatening manner that she would not get me the delivery paper unless I
signed the consent. I told her I had to make a phone call.

Then, I called the interpreter who worked in the PHC where I got my antenatal
care. I told her that the nurse did not speak nicely at the hospital. She forced
me to have the sterilisation. I am only 27. I had a natural delivery with my first
child. Why would not be able to have more children? I begged the interpreter
and the other health providers at the PHC to speak to this nurse for me. I begged
them to tell her not to force me to get the sterilisation. The interpreter told me to relax, but I cried a lot.

Anyway, luck was on my side. When I was worried and cried a lot, I had the labour pain and gave a natural birth. I did not have the caesarean section, so I did not get the sterilisation. Now I had already given birth safely, I will definitely not have the sterilisation. However, I am still worried. What if I have to see that nurse for the next pregnancy? She would not be satisfied and would not provide me care services.

One of the nurse-midwives explained the reasons for having sterilisation that focused on the mother and baby’s health:

They are old. They might not have knowledge or ideas about contraception. Some of them have been pregnant many times and they are quite old having underlying disease; however, they deny taking sterilisation. You know what I am talking about? We suggested that since they are too old and have many children; getting pregnant is dangerous for both mother and child. Unfortunately, they kept denying taking sterilisation and she had got pregnant again shortly afterwards. (Pimpa)

6.4.6 Do not cry: Alone and unsupported in labour and birth.

The hospital policy strictly prohibited relatives from entering the labour room. Ning described being afraid and scared with negative perceptions because she was alone:

The labour room looked scary. There was no-one I knew. My relative could not be in the room. I was afraid and I screamed loudly. A health provider scolded me and complained about me. I could not understand what she said,
but I felt that it was a scolding, not a word of comfort. However, the other health providers were nice.

Yunin did not believe that she was well cared for by the health providers during delivery. She talked about being frightened of childbirth and described her birth experience in a negative way:

In the delivery room, I had a very strong pain. I could not bear it, so I cried out. I remembered a nurse coming to scold me. She told me, ‘Do not cry. Crying will not make the pain go away. Be quiet, do not make a loud noise, it is a nuisance’. I could not stop crying, so she slapped me. I tried to stop crying loud. I cried until I passed out. I was unconscious. I woke up again shortly and cried. This time, I finally gave birth successfully. I recognised that I was really terrified and sad since I was scolded.

However, women justified the care obtained from health providers because they had a positive outcome. Both the women and their baby were safe:

When I saw my baby, the anger just disappeared. I knew that the health providers tried to help me deliver. I understand that. Nevertheless, they provided great service. I am a Burmese, but they allowed me to have Thai antenatal care and delivery here. Many nurses were kind and helpful. I would rather want to thank them. (Yunin)

6.5 Being cared for

In contrast to the situations in the antenatal clinics, it appeared that the atmosphere and interactions in the postnatal ward, and the nursing staff, were more flexible in their approach to care. The Burmese women looked happier and husbands, family and friends were able to be with the women on the ward. The following field note captures the atmosphere in the postnatal ward:
The health staff interacted with the postnatal women in soft tones as they informed the women about what they were doing. The nurses were friendly, smiling as they provided care to women and demonstrated techniques such as bathing the newborn and cleaning the umbilical cord and eyes. The women responded positively to these interactions. They appeared to be pleased that the health staff were happy to advise them even though they could not speak Thai and had to use the Burmese interpreter. They appeared to listen intently to the nurses, nodding their head and holding eye contact with the staff.

In the postnatal ward, the Thai staff spoke in the local dialect (southern Thai dialect). This is a more informal Thai language than the Central Thai language and it appeared that some of the Burmese women were able to understand this dialect. Sopa, a nurse-midwife, explained:

If we talk with them using the southern Thai dialect, rather than using the Central Thai language, the women are happier because the local dialect is more informal, as though we are talking with close friends or our family. If the Burmese women have been living here a long time they know some of the local dialect, and this makes them feel more comfortable with us.

In interviews, the nurses and other health providers working in the postnatal ward, spoke in a compassionate and respectful way about the Burmese women. Soraya, a nurse-midwife, stated:

In the postnatal ward, we take care of them the same way we take care of the Thais. I do not feel we are different at all. I used to hire a Burmese woman to be a nanny for my daughter. I do not have any problems providing the services for Burmese women.
Some staff indicated that their perceptions of working with Burmese women had changed over time and they were happy to support Burmese women and believed that the maternity service should address their needs. Sopa, a nurse-midwife, explained:

When I first came here, I did not want to talk to them [Burmese women] because we could not communicate. Recently, I have more empathy. The longer I work, the more I want to help them. I want to be kind to them and take care of them like the other women. I listen to them more. Our job is to provide maternal and child care services. We have to do it with our hearts.

Soraya described the economic hardship and language barriers that many Burmese women experience: ‘I know it is not easy for them to live in Thailand even though they have a job, but their life and the way they live is really hard’. Staff member Patumtip described her role in providing support and education for women on the postnatal ward:

Many of the women have had little education and they have difficulty understanding us. We have to teach and explain things to them and repeat this. We will show them until they can really follow our instructions. It is my responsibility to care for mothers and babies. I am happy to put my heart into doing a good job.

The following field note also demonstrates the way nurse-midwives provided care for women in the postnatal ward. In this observation, one Burmese mother asked Sopa, ‘I am worried I have no milk and my baby will be hungry’. The mother looked worried. Sopa responded, coming closer and explaining through an interpreter:

Please, do not worry because it is common for a new mother in the first day after delivery, the milk may not come yet. However, breastmilk may take a few
days to come in. What you should do, you just take care yourself by drinking water, consuming healthy foods, and please do not stress. Just breastfeed every two or three hours even though no milk yet, but it will be coming soon. Please, trust me.

It was also evident in the postnatal ward, that the staff were not concerned about the Burmese women using powder on themselves or their babies. For example, in one observation, the grandmother put Burmese powder on the baby’s body. Soraya, a nurse-midwife, smiled at the grandmother and said, ‘It is alright to apply the powder but just be careful to avoid applying on the umbilical cord or the baby’s eyes, but for other areas that would be okay’. When the baby cried loudly, this grandmother held and rocked the baby and sang softly to her. Soon the baby fell asleep. The nurse-midwife observed this and said to the grandmother, ‘You are a good mother and a good grandmother as well’.

Field notes describing the interactions between the women and health providers on the postnatal ward included displays of empathy. The nurse-midwives were friendly as they provided care to women and informed the women, women’s husbands, families and relatives how to care for the newborn. For example, health staff demonstrated the technique of bathing the newborn and cleaning the umbilical cord and eyes via the Burmese interpreter. The purpose of demonstration was to enable the women and women’s family to take care of their baby when they returned home. The women and their families seemed happy to follow advice from the health staff. They nodded their head in response and made eye contact with the staff, indicating reciprocal understanding.

All women were provided with information about caring for their baby after discharge from the hospital. The nurse manager also prepared information pamphlets
for the women covering topics like infant vaccination and postnatal follow-up. This information was mostly provided by an interpreter, unless the woman understood some Thai. The nurses provide the information step-by-step to ensure the women understand.

It also appeared that staff in the postnatal ward did not have the same concerns about family size and the need for sterilisation. One doctor in the postpartum unit demonstrated her empathy and caring regarding the women’s decision about sterilisation:

From my experiences talking with Burmese women, many women believe that there are going to be many problems following the sterilisation. They are afraid that they would get weak and would not be able to work hard, have less sexual needs and have family problems. They deny the sterilisation because of these reasons. (Jasmine)

6.6 Conclusion

This chapter explored the health professionals’ experiences of providing maternity services and care for Burmese women. The health professionals stated that they treated all women equal to the Thais. The organisation of services meant that women were processed in the antenatal care clinic, and thus, had to wait a long time for their appointment. This appears to be why some women do not comply with health staff directions. Women were expected to attend the antenatal clinic they were allocated, regardless whether they preferred to go to the other clinics to avoid a long wait. They were expected to follow all advice from the health professionals, even when they contradicted cultural practices. Burmese women were not confident to speak up, and some women were coerced into procedures they did not want, such as removing the powder on their skin. There were some situations in which miscommunication led
to confusion and refusal to follow advice. Moreover, the Thai health staff became frustrated at times with Burmese women (e.g., during the registration process when women used multiple names). It was also evident that some staff held strong views about Burmese women as mothers and were critical of their desire to have more than two children. In contrast, the care in the postnatal ward appeared to be more compassionate and supportive.
Chapter 7: The Role and Perceptions of Burmese Interpreters

(lam)

7.1 Introduction

This chapter focuses on the role and perceptions of Burmese interpreters (lam) in providing maternity services for Burmese migrant women. It describes the Burmese lam’s accounts of supporting the Burmese migrant women during maternity care with Thai health care providers. The data presented in this chapter are derived mainly from interviews with the interpreters and Thai health professionals, supported by data from the observations, interviews with the women and observational data conducted during the fieldwork.

Three major themes emerged in the analysis that captured the role and experiences of the Burmese lam: ‘More than an interpreter’; ‘Challenges in sustaining the role’; and ‘Working for our community’. Figure 7.1 illustrates the subthemes under the overarching theme: The role and perceptions of Burmese interpreters (lam).
More than an interpreter
1. Being a communication aid
2. Doing healthcare work

Working for our community
1. 'I love my job': I am treated well
2. Helping women and our community

Challenges in sustaining the role
1. On-the-job training
2. Poorly paid

The Burmese Interpreter

Figure 7.1. The Burmese interpreter role.

7.2 More Than an Interpreter

The Burmese interpreters (lam) described two core components to their role: ‘Being a communication aid’ and ‘Doing healthcare work’. Collaboration between the interpreters and the healthcare team facilitated this role.

7.2.1 Being a communication aid.

The *lam* described their primary role as ‘facilitating communication’. Bua Ae explained that her role as a *lam* was the mediator, or the link, between the woman, the midwifery team and the healthcare system:

My duty is to interpret accurately. The women cannot ask the midwives by themselves nor can the midwives ask them any questions. They speak different languages.

Access to a *lam* was crucial for nurse-midwives. One nurse-midwife, Veena, described the unsatisfactory situation prior to employing interpreters:
I used to work without interpreters. The Burmese told me they did not understand. We needed to ask for help from their friends or the other Burmese who understood Thai. But they were temporary interpreters for us.

Nurse-midwife Sopa claimed that employing interpreters was necessary since health staff needed to know women’s health conditions and backgrounds to provide individualised care:

We cannot directly talk to them [Burmese women]. We need the interpreters to ask and provide information for us. In case they have any questions, we have the interpreters interpret everything for them to make them understand. The interpreters work to pass on the information and we had to provide health care services to them.

Patumtip, a nurse-midwife, cited that using interpreters decreased communication problems in providing health care:

The benefit of having interpreters helping us is that communication problems have decreased. She can help us a lot and is the key person to solve the communication problems.

One obstetrician reiterated the positive benefits of working with interpreters:

I think we have a lot of benefit about working with interpreters. We have the interpreters to help the women. Our interpreters know about interpretation and health education. I think this is good. The interpreters’ origin is Burmese. (Chaiyut)

The lam also played a crucial role in the Burmese community, as described by Maloo, the longest serving lam:

Sometimes, when the midwives visit their houses, they [Burmese women] do not pay much attention. They doubt the advice of the midwives and do not
cooperate. I have to go with them because the Burmese know me well. They are happier if the interpreter and the midwifery team visit them together.

As a communication aid, the lam is required to clarify information and meaning, not just interpret:

Sometimes the Burmese do not speak clearly. When I am not sure what they say, I will tell the midwife not to write it down since I am not sure what the woman has said. I have to ask her again before I let the midwife write it down so that the information is correct. (Maloo)

7.2.2 Doing healthcare work.

In addition to their role as a communications aid, the lam also undertook healthcare-related tasks. This appeared to be an expected, but undocumented, aspect of their role. During observations, it was evident that the lam were familiar with the routine in the maternity services and could anticipate what the nurse-midwives needed to do. Typically, this involved organising the paperwork for clinic appointments, booking appointments with women, and assessing and screening women’s health. For example, collecting urine specimens and gathering information about their previous pregnancies and births. The lam were also observed collating documents for the women’s health records. For example, they organised the documents for each woman’s baby book and if any information was missing, they asked the woman the relevant questions, added this to the documentation and informed the nurse-midwives. The lam appeared keen to reply to mothers’ questions, such as ‘What will happen in my antenatal check-up?’ and ‘When will I be having my ultrasound?’. The lam explained the procedure and made hospital appointments for the woman. Maloo explained this aspect of her role:
When the Burmese ask me questions, I will give them the answers right away if I know it. If I do not know the answers, or if I am not sure, I will ask the midwife first.

When a woman arrived at the antenatal clinic, Neemoe, an interpreter, explained that she would ask the woman about her medical history and prior pregnancies and births, and at times would take a reading of her blood pressure:

We have to be at the desk when the women attend for antenatal care. We take their blood pressure, record their vital signs and screen for women’s health issues. Then, we inform the midwife. Sometimes we help the midwife prepare a dressing for C-section wound care.

In the postnatal ward, the lam also undertook healthcare tasks. Based on advice from the nurse-midwives and the lam’s observations of the nurse-midwives’ work, Ingdao described the education she provides for Burmese mothers:

I have to educate the mother after birth. I teach her to bathe her newborn and inform her about postnatal hygiene. I teach the mothers to clean the eyes and the umbilical cord of the newborn.

Often, the lam also acted as a counsellor for women. Maloo remarked:

We provide counselling sessions for the women. That is for their baby’s sake too. I talk to them. Sometimes they came to ask me without asking the midwives. I work as a counsellor with them. I try to make them understand so that they are not hard on themselves as mothers. I tell them to take good care of themselves.

The lam also described the work they did in their village, providing basic health education to people about children’s vaccination, MCH and healthcare for preventive infectious diseases (diarrhoea, dengue fever, malaria and tuberculosis):
Last weekend I came here with the Thai midwife to provide health education to the Burmese people. Some people in this village have had diarrhoea, and some of them were referred to the hospital because of food poisoning. Most Burmese workers have poor living and working conditions. They have not had any health education. Thus, we have to educate them about how they can avoid consuming contaminated food. (Neemoe)

7.3 Challenges in Sustaining the Role

All lam participants agreed that there were challenges in sustaining the role of the lam, but also many benefits. The main challenge for both lam and the midwifery team related to the lack of formal training and the need for the lam to learn ‘on the job’. This could be difficult because the lam were not necessarily literate in Burmese and sometimes spoke limited Thai. The lam also received a low salary, resulting in a high turnover of lam as they looked for a better paid job.

7.3.1 On-the-job training.

The lam had not received any formal training to prepare them for their role. Therefore, the responsibility for training was placed on the midwifery team. The ‘on-the-job’ training was provided by Thai nurse-midwives, who demonstrated tasks and coached interpreters. Penjai, a nurse-midwife, explained that following the initial training, they also needed to monitor the lam’s performance:

Once the interpreter is skilful enough and ready to perform her duties effectively, we will let her work freely, but we have to occasionally evaluate her work performance.

Sometimes the nurse-midwives sought feedback from the Burmese women who spoke Thai to confirm what had been said by the interpreter. However, in the busy antenatal clinic, or postnatal ward, there was often not enough time for the nurse-
midwives to check on the work of the *lam*; they had to trust that the information the *lam* provided to the women was accurate. Veena explained:

> We are very busy, and it is a waste of our time to have to check on the work of the *lam* and to ensure that they have interpreted accurately all the time. We have seen them work. We know they understand the system and what is required. We consider their work is satisfactory.

Penjai, a nurse-midwife, also praised the trusting relationship that existed between the interpreters and nurse-midwives:

> Sometimes, we told them to interpret a short sentence, but the interpreters spoke so long sentence. We had no idea if they added up something, or it was because the sentence had to be long in Burmese. We had to trust them because we worked together.

However, some nurse-midwives indicated that they were not entirely confident with the *lam*. Sudjai, for example, did not want the *lam* to ask the women questions in the antenatal clinic until she had consulted the woman first:

> The interpreters like to ask the women the questions and give us the answer before we have started the conversation. Sometimes, they give us the answer although the woman has not said anything yet. Some questions are leading questions which are not supposed to be asked.

Only one of the interpreters who worked in the hospital antenatal clinic could read and write in Thai and the nurse-midwives placed significant trust in her. Some nurse-midwives reported that it was difficult or problematic if the interpreter was not literate in Burmese:
I do not know who accepted her for this job as she could only speak the Burmese language. This lam is still very young and has little experience and she cannot do a lot of the work required. (Patumtip)

7.3.2 Poorly paid.

In the Burmese community, the lam were held in high esteem compared to those who worked in the fishing industry or as labourers. Despite this, the salary of an interpreter is lower than that of a labourer; it was approximately THB 5,500 (AUD 184) a month. Salary is determined by the hospital administration in this province. Patumtip, a nurse-midwife, empathised with the economic position of the lam and believed that they deserved a higher income:

At present, the hospital has hired its own lam without support from the provincial public health office. Thus, their salary is pretty low. We support and help them as much as we can, as we know they may be sensitive about the low income and that can be very emotional for them, and they can feel neglected. They often have financial problems since the salary is low but they actually work well and help us.

According to the health professionals, the low salary resulted in a shortage of Burmese interpreters. Sopa, a nurse-midwife, stated:

The lam receive a low salary so it is better for them to get another job that is better paid. The lam we hire need to be trained. We want a skilled interpreter. But the salary is so low, we feel sympathy for them. There is barely anybody who wants to do the job.

Patumtip added, ‘If they take a day off due to sickness or, any other purpose, their salary will be deducted’. The lam were often paid late, resulting in financial...
hardship. Some lam spoke of having to find an extra job or part-time work to support their family. Bua Ae stated:

Today is almost the middle of the month; I still have not received my salary. It is alright at that moment since I have some savings from working with the obstetrician at the clinic. It provides a good wage and I can support my family.

7.4 Working for our Community

Despite the challenges, the lam indicated that they wanted to continue to work in this role. They described the benefits for the Burmese community, themselves and their families, particularly in gaining new skills and knowledge.

7.4.1 I love my job: I am treated well.

Most lam described their role in positive terms:

I love this job. I am very happy. I am pleased that I am able to offer correct information to the women. Some Burmese women are not comfortable to talk to the midwives by themselves and I am happy to help them. (Bua Ae)

Maloo described the strong relationship she had with the nurse-midwives:

It is nice. All the nurse-midwives are friendly. They trust me. When I have any questions, I can ask them. I can talk to them all. They are generous. We have been working together for a long time and we understand each other.

The nurse-midwives supported this:

We have been working together happily. We consider their work satisfactory and they act responsibly. There is no problem, we trust them. (Veena)

The nurse-midwives and the lam were observed to be friendly and relaxed with each other during the lunch break. The relationship between some of the nurse-midwives and the lam extended to social relationships. The nurse-midwives reported that sometimes, they visited the interpreters in their homes on the weekend. They spent
time with them, shopping and sharing meals. Bua Ae described not only being supported by the nurse-midwives when working in the clinic, but also that two nurse-midwives had supported her financially:

Those two midwives are nice. I can tell them everything. For example, once I was anxious because my salary had not been paid yet. One midwife said that she would lend me some money. Both of them were generous.

The new skills learnt on the job helped the lam increase their income. Some took on additional work with the obstetricians at the private clinics when they were not working in the clinic or hospital or on the weekend. For example, Ingdao stated:

This job also gives me the opportunity to earn additional income from other sources. On Sunday and Saturday when it is my day off, I can also work in the private clinics. It can earn me more income and stability.

7.4.2 Helping women and our community.

The lam wanted to assist the Burmese community. They understood the challenge of living in a new country, the language barriers, and the physical and mental health problems that many Burmese migrants experienced:

I understand Burmese women. As far as I know, many of them come here without any work permit. Some of them come illegally. When the Burmese women are sad, I am sad too. I am also Burmese. I do not want them to suffer. Many of them ask for help. Some of them are unemployed and want to get a job. They come to me to talk. (Maloo)

Maloo had been working as a lam in the PHC clinic for over 15 years. She described the reward she received from helping women in her community:

I am willing to help them as much as I can. I am hired to do that, and I like to do my best to help. I could find another job and earn more money, as I have
been living here a long time and can speak Thai well, but I love my job and I like to make Burmese patients feel better.

Maloo also described how worked hard, but felt she had to continue working to assist Burmese women. She likes to help her people and has sympathy for Burmese workers:

I cannot cure their physical illness. But what is hardest to cure for us human is the mental illness. I do what I can. Someday, I cannot stop interpreting. My body was fine, but my mouth was exhausted. It is my job. I am an interpreter and I have to do my job.

Neemoe described how she was happy to help the nurse-midwives so that the Burmese women would feel comfortable to access maternity care:

A lot of Burmese women come here [PHC]. When they have a baby, they are afraid to communicate in Thai. But here, they do not need to be worried since there are two Burmese interpreters.

The focus on helping their community was evident in story offered by Maloo, who shared her experience in supporting a pregnant woman:

One woman’s husband had cheated on her and she could not sleep. I asked what happened and I had to comfort her and talked with her. She would not have talked to me if I went straight to her and asked what happened. I had to approach her slowly and encourage her. I had to remind her that she was pregnant. She had a baby in her body. She had to take care of her health and her baby.

The trust in the lam allowed the Burmese women to ‘just talk’. Maloo recognised that sometimes just talking with women was sufficient to make them feel better, ‘Sometimes, just a talk can bring relief. I give them my phone number. I don’t
mind them phoning me’. Neemoe viewed positive aspects as not only work-related; they can gain trust to advise the women and be available to talk:

When talking with the Burmese women about their problems in both physical and psychological health, they listen to and trust me. I am very happy that I am somehow able to give them advice and suggestions.

Bua Ae stated:

Some Burmese women are happy when they see me. They feel more comfortable to talk and they can reach me immediately, they do not have to wait for an appointment.

The Burmese women appreciated the access to the lam. All women mentioned that because of the availability of the lam, they were comfortable accessing the antenatal clinics:

I was afraid to go out to anywhere. I was afraid to talk with obstetricians or midwives. But now I know that here there is a Burmese interpreter assisting Burmese women to communicate with obstetricians and midwives. The interpreters here are very kind and friendly. This is my third time of the antenatal care here, I feel good coming here. (May)

Mint, a Burmese woman, felt comfortable communicating with health providers because of the access to interpreters, who helped her understand the maternity care:

The interpreters are very nice. We can talk to each other in Burmese, which makes me not worry. Burmese people in our community know them well, as many of us used to access the clinics and told me that do not worry about communication since the clinic provided the interpreters.
One nurse-midwife emphasised that the lam enhanced the care the women experienced:

Our interpreters are Burmese, so the women feel more comfortable to ask them for help. The women know that there is somebody who can help them. They are not comfortable to talk to the midwives by themselves. (Sopa)

It also appeared that the lam provided ‘unofficial’ healthcare and advice to women in the community who were illegal migrants. For example, one lam helped a Burmese woman and her family access a nurse-midwife who was prepared to support homebirth. Due to her illegal status, this woman had not had any antenatal care. Pimpa, the nurse-midwife, stated:

I have assisted in childbirth for a Burmese woman living near my house. The lam told the woman how to find me. Her husband asked me for help and then I helped them. They were safe both the mother and baby but later on, I sort of forced them to stay in the hospital for a night to ensure that they both safe.

This finding has highlighted two essential roles for the lam: interpreter and healthcare worker. The obstetricians and nurse-midwives displayed effective communication skills, worked appropriately in a team and the lam appeared to work well with the midwifery team. The women also reported positive experiences with the lam.

7.5 Conclusion

This chapter highlighted the crucial role that Burmese interpreters (lam) played in these Thai maternity services. Two key components were identified in the role: healthcare interpreter and healthcare worker. These dual roles brought several challenges, including lack of clarity around role boundaries, limited training and low remuneration. Despite the challenges, the lam believed their presence encouraged
Burmese women to attend antenatal care. Despite the low pay, they described benefits for themselves, including ‘on-the-job’ training. Community trust in the *lam* meant that Burmese women and families sought their advice within the community. This study demonstrates the important role that migrant workers play in collaborating with midwives to ensure access to maternity services in MICs.
Chapter 8: Discussion

8.1 Introduction

This chapter presents an overview of the study’s findings and discusses the findings in relation to the SEM and extant literature. The findings have explicated the experience of a small group of Burmese migrant women becoming mothers for the first or subsequent time in Thailand. Importantly, the study also explored women’s experiences of maternity services in Thailand and has articulated the role of the interpreter (lam) in these services. The beliefs and practices of Thai health professionals caring for Burmese women were also examined. Ethnographic methods were used in this study and included observation of interactions between women, health professionals and interpreters (lam), individual interviews with 10 Burmese women, four Burmese lam and nine health professionals. Observations in the community, antenatal clinics and postnatal ward in general were important in understanding the living and working conditions for Burmese women and the health services they access.

8.2 Overview of Key Study Findings

The 10 women and four interpreters came to Thailand because of economic hardship in Burma. They sought a better life for themselves and their families by gaining employment in Thailand. All worked as labourers in low-skilled jobs with low incomes, and working and living conditions were poor. My observations in the community recorded the daily lives of Burmese people. People in the community, including my participants, appeared to be well connected with each other, with constant interaction in the workplaces, market and in their homes, although less so in the antenatal clinics. The sense of community was strong for the women and
interpreters I interviewed. In my observations, I also captured the daily stresses of women and families and the potential impact of manual labour, poor diets and substandard housing with limited ventilation and lighting.

The sense of connection to Burma remained strong, even for those who had been living in Thailand for 20 years. These Burmese migrants did not live far from their home country. Indeed, some were able to visit family regularly, as it was only a 60-minute boat ride. As in many international communities, participants were motivated to work hard to meet remittances to their families in Burma. They also were comfortable with, or accepting of, the idea that their children would return to Burma for schooling and would be cared for by grandparents or relatives.

This study has captured both the enjoyment and challenges of pregnancy and the early postnatal period for migrant Burmese women living in Ranong province. The Burmese women appeared happy to be pregnant and demonstrated an intense desire to take care of themselves and their baby in pregnancy. This included following traditional practices and attending the antenatal clinic if able. Negotiating the demands of earning an income and protecting their unborn baby led to unhealthy practices, such as consuming energy drinks and herbal tonics to improve wellbeing or provide energy. Accessing antenatal care was a positive health-seeking behaviour noted among participants. However, it was not accessed by all women. Similar to the antenatal period, after the birth, the mothers wanted the best for their baby, and engaged in a range of traditional practices to protect their baby from evil spirits.

A key finding in this study was the prominent level of social support that these 10 women had from partners, family and employers, and how this appeared to ease their transition to motherhood in a new country. Another important finding reported in
this paper was the desire to maintain culture, which required the women to send their young children to Burma for their education.

Overall, the health providers offered positive views about their experiences of interacting with Burmese women. However, the feeling of ‘being processed’, with women having to wait many hours for check-ups, and the lack of recognition of cultural values in the antenatal services, was evident. The organisation of the service appeared cumbersome, with potential for improvements to enhance the flow of women through the clinics. This may have been a major barrier to some women accessing antenatal care. In contrast, the care provided in the postnatal ward appeared more caring. The atmosphere in the postnatal ward and the interactions between health staff and the women appeared collegial, with health staff displaying a more flexible approach to care. The Thai staff spoke in the local dialect, which was a more informal Thai language than standard Thai. This made the Burmese women feel more comfortable with Thai staff. Important lessons for health service improvement emerged from this study.

This research is one of the first studies in LMICs to examine the role of healthcare interpreters in a maternity service. The theme ‘more than an interpreter’ captured the dual roles of the Burmese interpreters as both a communication aide and an extra pair of hands—someone able to undertake healthcare work in the busy antenatal clinic and postnatal ward environments. This dual role brought challenges, including lack of clarity about role boundaries, limited training and low remuneration. However, it is also important to highlight the benefits that ensued for the interpreters themselves and the broader community. The lam identified the individual and family benefits as gaining new skills and knowledge, helping women and their community in communicating with Thai staff, and helping the Burmese people feel comfortable to
access health care. The interpreters believed that their presence encouraged many Burmese women to attend antenatal care. However, the *lam* received no formal training and learnt healthcare-related tasks ‘on the job’, at times leading to unclear role boundaries.

Based on the thematic analysis of the rich qualitative data captured in this study, the key findings of this study have been mapped onto the SEM presented in Chapter 2 (see Figure 8.1).

![Social-ecological model of factors influencing Burmese migrant women’s experiences as mothers](image)

**Figure 8.1.** Illustration of the multifactorial nature of Burmese migrant women’s experiences of becoming a mother in Thailand.

Figure 8.1 illustrates the multifactorial nature of Burmese migrant women’s experiences of becoming a mother in Thailand. Aspects of the model are also based on observations of the community and interviews with interpreters and Thai health staff.
In this way, the diagram illustrates the factors that influence the experience of the broader community of Burmese migrant women, not just the women in this study.

Section 8.3 outlines the key findings under a number of heading: ‘Being a good, responsible mother’; ‘The central role of social support’; ‘Thai maternity services and the role of interpreters’; and ‘Engaging with the Thai health professionals and health services’.

8.3 Being a Good and Responsible Mother

The Burmese women in this study, including the four interpreters, did not use the term ‘good mother’. However, they articulated and enacted characteristics, attitudes, beliefs practices and aspirations that characterise notions of the ‘good mother’, both in South-East Asian and other cultures. The notion of being a good mother was reflected in their unanimous positive response to pregnancy, even if unplanned. All the women expressed in interviews their joy or happiness at becoming or being a mother, none were ambivalent. However, motherhood also brought significant responsibilities. For example, participants demonstrated their ardent desire to protect their baby, which included looking after themselves in pregnancy, their responsibility to adhere to particular cultural practices, and engaging in antenatal care provided by the Thai maternity services. They also had to provide for their children to ensure their education, preferably in Burma, and to maintain the Burmese culture for their children. While they did not always follow the advice of family and health professionals, they rarely spoke out about this. Rather, they simply nodded and decided to follow their own instincts.

In many studies of motherhood, women from diverse backgrounds subscribe fully to the discourse that presents motherhood as something always joyful and welcomed (Benza & Liamputtong, 2017; Etowa, 2012; Liamputtong, 2006; Shafiei et
Mothers mostly, or at least ostensibly, described being happy and excited about their pregnancy. They spoke of feelings of love for their baby, their other children and families. In celebrating motherhood, it is rare for any woman to be able to talk about the ambivalence or exhaustion they may feel (Benza & Liamputtong, 2017; Etowa, 2012; Liamputtong, 2006; Shafiei et al., 2012; Tsai et al., 2011).

For many migrant women, the transition to motherhood can be more difficult because of the migration experience, disconnection from family, limited financial resources and limited access to maternity services (Finlayson & Downe, 2013; Higginbottom et al., 2014). Authors have commented on the double identity or double burden of learning to be parents and citizens in the host society (Liamputtong, 2006; Merry et al., 2017; Raffaetà, 2016). Liamputtong (2006), in her research with South-East Asian migrant women living in Australia, explained that the women faced unique challenges in their mothering practices due to limited access to resources, variations in child-rearing practices, language barriers and lack of support during pregnancy and motherhood. Migrant women tended to have responsibility for the household and care of family members, including the need to earn an income to raise their children (Liamputtong, 2006; Tsai et al., 2011). In performing these roles, mothers report an overwhelming sense of tiredness. However, many migrant women, including the women in this study, felt that being a mother is a normative part of women’s roles, and their children filled their lives with happiness and satisfaction, and enhanced acceptance into their family (Benza & Liamputtong, 2017; Etowa, 2012; Tsai et al., 2011).

The Burmese women in this study also reported a sense of responsibility to ensure their children became good citizens and maintained traditional and cultural values. Benza and Liamputtong (2017), who studied Zimbabwean women in Australia,
noted that migrant women enacted their mothering roles by nurturing and teaching their children how to be good and responsible learners in society. This meant these mothers were socially conscious and strived to be good mothers by developing a sense of moral and social responsibly in their children. A study by Tsai, Chen and Huang (2011) indicated that South-East Asian women residing in Taiwan perceived themselves as responsible for raising children to be productive citizens and emphasised their role in maintaining their children’s health and wellbeing by providing sufficient food, shelter, safety, care and love.

To achieve these goals, the woman in this study had already planned for their child to return to Burma when they were of school age. These practices of transnational parenting ensured their children learnt to speak their own language and know their own culture. Further, they ensure ongoing connection and social support with family members still in Burma. Other studies suggested that migrant mothers may also be concerned about raising their babies in a strange land away from familial care providers in their homeland (Liamputtong, 2006; Naidu, 2013). Migrant mothers from Ghana, in a study by Naidu (2013), worried about children losing touch with their culture while living in a new country. Migrant mothers want their children to be closer to traditional values by raising them in home countries with their families (Benza & Liamputtong, 2017; Naidu, 2013). For instance, Zimbabwean mothers taught their children how to learn and appreciate Zimbabwean culture and language, even though they gave birth in Australia (Benza & Liamputtong, 2017).

Research has consistently indicated that migrant women experience higher levels of postnatal depression (Firth & Haith-Cooper, 2018; Schmied et al., 2017). Canadian researchers O’Mahony et al. (2013) examined factors that influenced postnatal depression, citing the impact of structural inequalities on the health of
migrant women and their access to appropriate care and treatment. O’Mahony et al. (2013) and Merry et al. (2017) identified difficulties in gaining employment, low-paid work resulting in financial difficulties, unequal treatment or discrimination in the workplace and the dependence on employers as factors that limiting the control that women have over their lives and care of their family. These authors report that this experience ultimately affects how women cope, typically viewing their feelings as something they simply have to bear, rather than seeking help from a health professional.

In contrast, the Burmese migrant women in this study did not demonstrate or speak of being depressed or feeling down. This may have been because they described having solid social support (see Section 8.5) and appeared to be part of a strong community. It may also have been because as research participants, in front of other community members such as interpreters and Thai health staff, they wanted to put on a happy face (Hochschild, 1979; Reid, Schmied, Sheehan & Fenwick, 2014). I also observed that many Burmese women waiting in the antenatal clinics did not look so happy. However, this may be due to the long wait and their anxiety about returning to work.

8.3.1 Being responsible—looking after myself and my baby.

The women felt a responsibility to attend to their health and wellbeing in pregnancy and to their baby’s health following birth. This was supported by comments by the interpreters and health staff. In most studies of migrant motherhood, women view themselves as responsible for their baby’s health. During pregnancy, they are focused on consuming healthy food and attending to cultural precautions around diet and rigorous activities or vigorous work that may cause a miscarriage (Etowa, 2012; Liamputtong et al., 2005). Women want to seek the best support to ensure a safe birth
(Nilsson et al., 2010). This concern continues following birth. For example, Shafiei et al. (2012), described new migrant mothers’ desire to learn baby care from health professionals and to breastfeed to be good mothers. Engaging in traditional practices, seeking antenatal care and balancing work commitments were important for mothers and appeared to be one way they demonstrated or presented themselves as being responsible.

8.3.2 Engaging in traditional practices.

The Burmese participants appeared to confidently combine beliefs and practices from Western medicine, embedded in the Thai health system, alongside traditional Burmese practices to maintain a healthy pregnancy (see Chapter 5). The literature demonstrates that many women living in LMICs access both Western healthcare while simultaneously adhering to traditional practices (Diamond-Smith et al., 2016; Raman et al., 2016b; Sein, 2013). A synthesis of qualitative studies by Raman et al. (2016b) identified that spiritual, supernatural and religious beliefs influence pregnancy and birth practices in many regions of Africa and Asia, particularly to reduce or prevent harm to mother or baby.

Cultural and spiritual practices related to pregnancy and childbirth were also reported by Sein (2013), who identified numerous practices or restrictions that Burmese women engaged in. For example, crying and quarrelling was believed to cause women to have a severe headache. Additionally, women should avoid reading and watching television after birth to avoid eye strain. Sein (2013) also reported women obtained abdominal massage to help blood flow and relieve gas after delivery and wore a brooch to ward off evil spirits to ensure the baby’s safety during pregnancy (Liampuntong et al., 2005). Similarly, others report that pregnant women should avoid
attending funerals and weddings, as the rituals could harm their pregnancy (Wulandari & Whelan, 2011).

In Pakistan, the head of the newborn is shaved to maintain health and wellbeing (Raman et al., 2016b). Many of these practices would not surprise Thai health staff, as many Thai women, particularly those in rural areas, participate in a range of traditional practices during pregnancy (Liamputtong, 2007). Like many migrant women, Burmese women also engage in traditional postpartum practices while seeking safety and empathy from family, social and health care supports when needed (Atuyambe et al., 2009; Dennis et al., 2007; Hoban & Liamputtong, 2013). Many symbolic rituals are common throughout the childbearing period. For example, Burmese women believe that turmeric is beneficial for mothers’ and babies’ health. Thus, women smear turmeric on their body or drink it so the substance passes through their breastmilk to the baby (Sein, 2013).

8.3.3 Accessing antenatal care.

The 10 participating women attended antenatal care and believed that this was important for their health and that of their baby. In contrast to some other studies of migrant women (Almeida et al., 2013), they appeared to prioritise antenatal care despite their precarious employment status and poverty. The interpreters believed this was most likely because of their legal status in Thailand and access to a healthcare card. Pearson and Kusakabe (2012) reported that because Burmese women are often in Thailand illegally, they cannot access services. They described that in one location, Mae Sot, pregnant Burmese women accessed diaspora-run clinics, which are private and supported by external donors. Informants in their study, similar to this study, reported that the cost of childbirth and the convenience and quality of services were better than those available on the Burmese side of the border.
It may be that other Burmese women living in Ranong who did not attend antenatal services in the study site viewed pregnancy as a normal life event that did not require the input of health professionals (Finlayson & Downe, 2013). Numerous studies report that in LMICs, across a range of cultures, women perceive pregnancy as a normal event, something that does not require regular medical care (Finlayson & Downe, 2013; Raman et al., 2016b). However, it may also be that they had not recognised or acknowledged the pregnancy (Finlayson & Downe, 2013). Avoiding antenatal care has health consequences for migrant mothers and babies. A systematic review by Almeida et al. (2013) revealed that lack of maternal health care contributed to higher health risks and increased incidences of co-morbidity leading to adverse effects on pregnancy, such as miscarriages, neonatal death and postpartum depression symptoms. These problems are related to the sociodemographic status of migrant women and are affected by personal knowledge and behaviours of health and pregnancy-related complications. However, this current study of Burmese women in Ranong demonstrates that if migrant women have access to free health care, that is promoted in the community, they are more likely to attend.

However, the interpreters in this study indicated that some Burmese women did not access the antenatal services because interpreters were not always available to assist them with communication. The interpreters believed that because of their availability, women felt comfortable to access antenatal clinics (Phanwichatkul et al., 2017). Many studies indicated that some migrant women were unable to communicate with health staff when accessing maternity care and needed help to overcome language barriers. This was attributed to migrant women’s lack of knowledge to navigate unfamiliar health systems and language barriers (Fisher & Hinchliff, 2013; Higginbottom et al., 2014; Murray et al., 2010; Niner et al., 2013).
8.3.4 Balancing work and pregnancy.

Paid work was essential for day-to-day survival and to maintain remittances to families in Burma. All the women prioritised their health as much as possible; some ceased work, others attempted to work less or reduce the strenuous work they did, as they wanted to avoid miscarriage and ensure their babies were born safe and well. Similar concerns and actions were taken by Thai women in northern Thailand (Liamputtong et al., 2005), Burmese women living in Rangoon (Sein, 2013) and Indian women in Bangalore (Raman et al., 2016b).

Therefore, women had to make a difficult decision of whether to continue working during pregnancy or to cease due to the demanding and dangerous conditions. Some women were able to negotiate, or were supported by their employers, to reduce their working hours, but others made the decision to leave their job knowing that it may be difficult for them to secure work again. This balancing or juggling of work was also reported by Kusakabe and Pearson (2010).

Some had no choice in how or when they worked and, as reported in other studies, women reported concerns about their health and managing their conflicting responsibilities (Grice, McGovern, Alexander, Ukestad & Hellerstedt, 2011). Similarly, factory employers in other parts of Thailand do not allow female Burmese labourers to have antenatal visits. If they do, the time taken is deducted from their daily wage (Kusakabe & Pearson, 2014).

In this study, most women had their families around them and were supported by women in the community to make decisions about continuing to work when they became a new mother. Pearson and Kusakabe (2012) discovered that many Burmese female workers relied on other families to care for their children while they balanced work responsibilities and continued to remit money to the families in Burma.
8.4 Poor Health Literacy, Service Access and Health-Promoting Behaviours

Many migrant women have preconceptions of motherhood that include the importance of health care, but they may lack the knowledge or resources to access information about where to seek safe and supportive health care (O’Mahony et al., 2013). However, the level of literacy, specifically health literacy, can impede the use of services. Many women in the study had not completed primary school; thus, they had a low level of literacy. Some women did not know how to register with the health system, registered under a different name or were unsure of when antenatal care was provided. Thus, they had a long wait at the clinic. There were also aspects of care that the Burmese women did not agree to or comply with. For example, some women did not take folic acid and almost all the women consumed very sweet carbonated drinks, despite advice that these were not healthy. Carrara et al. (2011) also studied pregnant Burmese women living along the Thailand–Burma border and reported that only half of the Burmese women were literate in their own language. They discovered that low literacy levels were associated with premature birth, low birth weight and neonatal death (Carrara et al., 2011). In Carrara’s work, and other studies (Greenaway, Leon & Baker, 2012), the level of formal education significantly raised the use of health services. Thus, interpreters can be crucial.

In this study, the interpreters played a key role in working with the community. As the participant interpreters indicated, without the support of interpreters, migrant women would experience numerous challenges accessing health information and navigating the healthcare system (Fatahi, Nordholm, Mattsson & Hellström, 2010; Yelland et al., 2016).
8.4.1 Poor maternal nutrition.

Women living in poverty have higher levels of morbidity and malnutrition, both mother and infant, than in other contexts (Raman, Nicholls, Ritchie, Razee & Shafiee, 2016a). The findings of this study suggest that the nutritional status of the participating Burmese women was not optimal for two reasons. First, the women were living in poor socio-economic circumstances. While their daily diet included vegetables and some fish, it was difficult for them to obtain protein-rich foods like meat due to the expense. To compensate for limited access to food, women ate a diet high in fat and gained energy from consuming sweet carbonated drinks. The Burmese mothers in this study believed they needed the energy from the carbonated drinks to continue working and that these drinks, and other sugary foods, were beneficial. This is a significant concern, as GDM is more common among South-East and South Asian populations (Carolan et al., 2012; Guariguata, Linnenkamp, Beagley, Whiting & Cho, 2014). The prevalence of GDM among Burmese women living in the study site has not been officially reported but is around 10 per cent (Health manager, personal communication, October 10\textsuperscript{th} 2015). Gilder and colleagues (2014) studied GDM in Burmese women living in camps on the Thailand–Burma border and reported a 10.1 per cent prevalence of GDM.

Second, cultural practices such as avoiding certain types of foods and drinking an alcohol-based herbal tonic, as reported in this thesis, may also affect the nutritional status of women and their babies. As is commonly reported (Raman et al., 2016b; Rodrigues, Patel, Jaswal & De Souza, 2003), migrant women comply with traditional food restrictions; for example, limiting certain vegetables such as eggplant. It is particularly concerning that many women continued to drink the alcohol-based herbal tonic advised by elderly family members, although the quantities of alcohol or
frequency of use was not disclosed. Similar mixtures have been described in other cultures. One US study by Lee et al. (2008) reported that women from South-East Asia used home-brewed rice wine as a herbal tonic in pregnancy and after giving birth. These women believed that the tonic was not addictive, as it was combined with traditional herbs. D’Amico et al. (2007) also reported that this is a customary practice among South-East Asian women.

8.4.2 Anaemia and medication ‘non-compliance’.

Due to poor nutrition, the risk of anaemia is high among this population of pregnant women. A study of Burmese and Thai women, on the Thailand–Burma northern border, demonstrated prevalence of anaemia of 49 per cent (Thai 36 per cent, Burmese 60 per cent) (Siriwong, 2012). Additionally, Zhao’s study of women in Burma discovered that the prevalence of anaemia was 60.3 per cent in lactating women, with 20.3 per cent of lactating women having severe anaemia (Zhao et al., 2014). In this study, some women avoided taking certain medications advised by health professionals, such folic acid and iron, whereas others were quite happy to follow the advice; some even doubled the dose. These conflicting practices are reported by others. Research with a Karen community in Minnesota indicated that pregnant women perceived that folic acid would not work as the tablet was too small and some reported constipation and did not take it (Oleson, Chute, O’Fallon & Sherwood, 2012). In contrast, a study of women from Burma living in Melbourne found that medication is obtained and taken with a sense of pride (Nailer, 2015). Having medication (which sometimes is reportedly not needed) provides peace of mind and the pleasant thought of restored health. There seems to be a strong psychological element and sociocultural symbolism that medication represents among many Burmese communities (Nailer, 2015).
8.5 The Central Role of Social Support

Across all cultures, social support is a key factor that modifies the transition to motherhood (Morrow, Smith, Lai & Jaswal, 2008; Raman et al., 2014; Schmied et al., 2017). In an ethnographic study of Indian women, Raman et al. (2014) identified multiple sources of support, including their mothers, husbands and diverse female networks to help them with child care and infant feeding. In my study, while the Burmese women drew on their own personal resources to navigate the difficulties of their mothering journey, the support of their partners, families and social network was essential for their emotional and physical wellbeing. The findings in Chapter 5 demonstrated the positive practical and emotional support these women received from their husbands, family, friends and even employers. Their ability to undertake traditional practices were key factors in their feelings of positivity about motherhood.

These findings contrast with those of many other studies of migrant mothers. Upon migration, many migrant mothers reported being unhappy if they were not coping with the demands of motherhood (Schmied et al., 2017). Most migrant women required the support of their own mothers, families and husbands during the perinatal and postpartum rest period, which became most important for them (Morrow et al., 2008). Without family and social support, migrant women often reported difficulty coping and adhering to the traditional role of a ‘good mother’. These feelings may contribute to the higher rates of depression (Schmied et al., 2017) among migrant mothers.

8.5.1 The father’s role.

In many cultures, particularly in LMICs, fathers’ are viewed as responsible for financial security and protection of children by routine caretaking such as maintaining and improving children’s health (Liamputtong et al., 2004; Riggs et al., 2016; Williams
et al., 2012). The findings in this study support previous literature that migrant mothers, for instance, Indian mothers, rely strongly on their partners as sources of support in nuclear households. Specifically, after-birth support requires the husband to manage household work and care for both the woman and baby (Riggs et al., 2016). Similarly, qualitative perspectives of Mexican immigrant mothers in North Carolina are provided by Ornelas et al. (2009). They reported that a major source of support for the women is their husbands, who helped women to cope with economic and social stressors, and emotional health by staying by their wives’ side as companions. In this study, it was notable that the baby’s father is not only a vital financial support, he is also central to helping women raise their children and take care of the family household chores and household income. The baby’s father also plays a significant role in parenting.

Studies conducted in LMICs also report men adopting a positive role as fathers (Raman et al., 2014). Liamputtong et al. (2004) described Thai women’s belief that their husbands became more mature and responsible as fathers and assisted them in raising their children. On becoming parents, some women asserted that their relationship with their husbands had improved and created family harmony. Women relied on their partners to take them to hospital for birth and assist with childcare (Raman et al., 2014). Raman et al. (2014) also reported that the husbands were perceived as a source of support, love and care, and a financial resource for health care.

There does not appear to have been any studies of fathers living in Burma or migrant fathers. However, in Burmese culture, Burmese women have absolute responsibility for household labour and care for children and family members (Nwe, 2003). In a study of refugee women from Burma living along the northern Thailand–Burma border, women reported that husbands did not take responsibility for helping
women with household chores (Fellmeth et al., 2015). Similarly, in the past in Thai culture, fathers did not contribute to or interfere with rearing children, although they felt responsible for providing for their families and reported feelings of love for their children (Liampittong et al., 2004). Contemporary Thai fathers however, appear to be more likely to participate in childrearing as they recognise the importance of preventing health problems in both their child(ren) and their wife (Sriyasak, Almqvist, Sridawruang, & Häggström-Nordin, 2015). In a recent study of Thai men becoming first-time fathers, the researchers reported that men still saw their primary role as providing financially for their children (Sansiriphun, Kantaruksa, Klunklin, Baosuang, & Jordan, 2010). They also wanted to be seen as a “good father” and 92.8 percent agreed that being a good father is a self-fulfilling and rewarding and 80 percent stated that they helped their wife with childrearing and child care. For example, taking care of the child when the child is sick, and taking their child to get a vaccination (Sriyasak et al., 2015).

In the context of migration, many men are expected to take an active ‘hands-on’ role. For example, Sudanese and Russian migrant fathers in Canada described interacting with their children and fostering their children’s wellbeing (e.g., playing sport, reading and working on the computer with their children) (Este & Tachble, 2009). Similarly, Afghani fathers in Australia play a vital role in supporting their wives and babies during the pregnancy and postnatal period, such as asking health staff to care for and focus on their wives’ and infants’ safety (Riggs et al., 2016). However, despite spousal support, many migrant women argue that their husbands are often absent during pregnancy and after the birth of their child (Liampittong & Naksook, 2003; Watts et al., 2015). Moreover, if women’s husbands appeared to support them
during the postnatal rest period, some husbands were helpful, while others lacked a clear understanding of the mothers’ emotions (Buultjens & Liamputtong, 2007).

8.5.2 The crucial role of the families in supporting women.

Many migrant women discuss seeking safety and empathy from the family (Atuyambe et al., 2009; Dennis et al., 2007; Hoban & Liamputtong, 2013; Schmied et al., 2017). However, in many cases, they do not have access or proximity to family. A meta-ethnographic study among migrant women in both developed and developing countries by Schmied et al. (2017), indicated that to fulfil the mother’s overwhelming traditional role of a ‘good mother’, migrant women needed to receive social support and cultural traditions. A study of Benza and Liamputtong (2017) among Zimbabwean women living in Australia indicated that motherhood has both community and familial benefits, as it brings people together. Moreover, a study of young African mothers living in Melbourne (Australia) revealed that they received solid support from their families, relatives and close friends, but rarely from their partner (Watts et al., 2015). These findings concur with Cambodian migrant mothers in Australia, who were home alone without extended support from the family, which led to emotional pressures and tension in child-bearing (Hoban & Liamputtong, 2013). Traditionally, on motherhood, most mothers wished families to support and prepare confinement practices that are essential for child-bearing, especially for migrant women in a different living environment (Atuyambe et al., 2009; Dennis et al., 2007). Family support is central to transition for women, and lack of support is a constant factor associated with perinatal depression (O’Mahony et al., 2013).

8.6 Thai Maternity Services and the Role of Interpreters

This study has provided a unique opportunity to explore the role of healthcare interpreters in a MIC. The role of the interpreter (lam) in the PHC clinic and hospital
in Ranong province appears to be fairly unique in the context of Thai maternity services, and more broadly, in the context of VHW or community health workers (CHW) in LMICs. In this study, two key components of the role were identified: interpreting and healthcare-related tasks. This was reflected in the role titles of VHW at the PHC clinic or Foreign Health Workers in the hospital, despite being referred to as lam (interpreter).

Participants emphasised the benefits of the lam for Burmese women, the Burmese community and the Thai midwifery team, as well as for the lam themselves. All four lam expressed a high level of satisfaction with their role. They particularly valued their relationships with the midwives and the women. They also believed that the ‘on-the-job’ training they received could open other employment opportunities. However, this study also identified some challenges in the role, such as poor remuneration. There was a lack of clarity about the scope of the role in terms of healthcare work, with some Thai midwives showing concern at the extended healthcare role assumed by the lam, particularly given the low literacy of the Burmese workers.

**8.6.1 The interpreting role of the lam.**

Both the midwives and the Burmese women relied on lam to interpret for them. The lam believed that their presence encouraged many Burmese women to attend antenatal care regularly, increasing opportunities for health education. Studies about healthcare interpreting from HICs report mainly positive perceptions of interpreters, reducing disparity and facilitating efficient patient–caregiver communication (Hadziabdic, Heikkilä, Albin & Hjelm, 2009; Rosenberg, Leanza & Seller, 2007). A meta-ethnography by Brisset et al. (2013) revealed that access to interpreters can improve clinical outcomes and quality of care. Skilled interpreters can build language
skills and empower patients with healthcare knowledge (Hsieh, Ju & Kong, 2010). For example, in a Swedish study of Arabic-speaking migrants, the use of interpreters was experienced as a benefit, as it offered the opportunity to express concerns, feelings and pain in the patient’s mother tongue (Hadziabdic et al., 2009). However, interpreting is a complex role, requiring interpreters to negotiate the diverse understandings and experiences of individual patients, health professionals and the healthcare system to achieve a shared understanding. Within the health encounter, the presence of an interpreter transforms the dyadic health professional–patient encounter into a triadic communication process (Brisset et al., 2013; Greenhalgh, Robb & Scambler, 2006; Laidsaar-Powell et al., 2013). Greenhalgh and colleagues (2006) reported that, in the general practice context, lack of trust, time pressures and a mismatch of needs or agendas and power imbalances can make this triadic communication precarious. In a study by Hadziabdic et al. (2009), the use of interpreters was also problematic because of concern that the interpreters were not translating correctly, and the shame associated with openly discussing sexual relationships and bodily concerns in the presence of the interpreter. Trust on the part of both patients and health staff is critical (Brisset et al., 2013; Hsieh et al., 2010). When used appropriately, an interpreter can provide the opportunity for a woman to express her needs and to be more proactive, rather than a passive receiver of information from both the health provider and the interpreter (Greenhalgh et al., 2006).

Swartz et al. (2014) noted that the quality of interpretation by interpreters varies widely. While studies reporting the role of healthcare interpreters emphasise the importance of faithfully translating the patients’ and the health professionals’ statements, interpreters are required to clarify meaning, and mediate or negotiate effective communication outcomes (Brämberg & Sandman, 2013; Sleptsova, Hofer,
Morina & Langewitz, 2014). Thus, interpretation must accurately reflect shared information and intended meaning. However, studies report that miscommunication may occur. For example, one interpreter did not speak the same dialect as the woman. This resulted in a lack of understanding and inadequate communication (Hadziabdic et al., 2009). Factors such as the broad linguistic knowledge, cultural understanding and ethical background of the interpreters also influence the accuracy of the interpretation (Hsieh, Pitaloka & Johnson, 2013; Lianpuppong, 2010; Rosenberg et al., 2007). For example, in this study, one interpreter provided incorrect information to the woman, as she was not prepared or able to wait for guidance from the health professional.

Establishing interpreting services and maintaining ongoing training is costly. While these services are quite sophisticated in high-income host countries, it is difficult to establish this type of service in LMICs. Thus, there are few, if any, studies on the use of healthcare interpreters in LMICs (Lewin et al., 2010). Finding alternatives to trained interpreters is important for the many millions of people who migrate from LMICs, such as those migrating from Burma to Thailand.

8.6.2 Role in performing healthcare tasks.

The participating lam were observed undertaking a range of healthcare-related tasks, including taking blood pressure and performing perineal care. The difference between the lam’s role and a VHM or CHW in Thailand and other LMIC is that the lam are located in health facilities. In many respects, the lam’s role is similar to that of a trained nurse aide or practical nurse in Thailand (Kok et al., 2015). As discussed in Chapter 2, in some services in Thailand, these health workers are known as MHW or if unpaid, MHV and they play a crucial role in the community in assisting health staff to provide health education and participate in surveillance of contagious disease in the
migrant communities (Archavanikul, 2013; Sirilak et al., 2013). Studies of CHWs indicate that these roles primarily provide a range of health-promotion activities addressing issues such as the prevention of infectious or communicable diseases (e.g., HIV, malaria and education about immunisation) (Oliver, Geniets, Winters Rega & Mbae, 2015; Pallas et al., 2013).

Studies of CHWs in LMICs (Oliver et al., 2015; Pallas et al., 2013) describe the positive impact of CHWs on disease prevention, healthy behaviour adoption, and access to care. Pallas et al. (2013) identified several important characteristics of CHWs that facilitate the success of programs: strong connections to the community; having a clearly defined role and relationship with the formal health system; being supported by the government and other health service providers; and the investment in training, coordination and motivation for CHWs. Many of these can be applied to the role of the lam in health facilities in Ranong province. However, what is different in this study is that the lam were employed to work in health facilities such as the Ranong Hospital as Foreign Health Workers or in the Pak Klong Clinic as interpreters.

8.6.3 Lack of clarity of role.

Defining the role of lay health workers or CHW is important (Oliver et al., 2015; Pallas et al., 2013). In this study, there was little role clarity or demarcation of role boundaries for the lam. Interpreting appeared to be the primary role. However, there were no specified job criteria, other than speaking some Thai, or guidance on what healthcare tasks the lam should or should not do in the antenatal clinics or postnatal ward. This lack of clarity has been reported by others (Hsieh et al., 2010; McDowell, Messias & Estrada, 2011; Sleptsova et al., 2014). Some Thai nurse-midwives expressed concern that the lam sometimes undertook health assessments for pregnant women without the nurse-midwife or another health professional present.
Other nurse-midwives appeared more relaxed about this, believing that the lam were confident in their role. They trusted them to continue their work without interference. However, issues of power between patients, interpreters and health professionals are also important to consider (Karliner, Pérez-Stable & Gildengorin, 2004). It is unlikely that Thai health professionals have the training in cultural safety and opportunity to reflect on their own cultural identity and the impact that their position of power may have on their interaction and communication with Burmese women (Phiri, Dietsch & Bonner, 2010).

8.6.4 Community fit or being accepted in the community.

Pallas et al. (2013) identified one of the most important enabling factors of the CHW role as the degree of community fit or acceptance. Each of the lam came from the Burmese community in Ranong province and had worked as a migrant labourer in that community. They were familiar with and known by many of the Burmese people living there. Indeed, holding a position as a lam may have enhanced their credibility and accountability among the community (Lewin et al., 2010). The lam stated that many Burmese women would attend the antenatal clinic or hospital because they knew the lam and trusted them. Community trust in the lam meant that Burmese women and their families would seek their advice outside the clinic context.

In the observed interactions, the Burmese women frequently turned to the lam for guidance in responding to a question from the midwives. Others reported similar interactions between patients and interpreters during consultations (Fatahi, Mattsson, Hasanpoor & Skott, 2005). This comfort with interpreters is not always evident. Yelland and colleagues (2016) found that Afghani women receiving maternity services in Victoria, Australia, were dissatisfied with access to interpreter services. Some women believed that the interpreter had not correctly interpreted their message, others
only had access to male interpreters and other times, interpreters were not available. In recent Swedish research, Hadziabdic et al. (2009) reported that in situations when interpreters are sparingly used or the consultation relates to highly sensitive issues, migrants often feel insecure and uncertain. It is possible that this may be the case for the Burmese women who do not seek antenatal care in Ranong province.

8.6.5 Teamwork, trust and friendship.

In this study, the lam saw themselves as important members of the healthcare team. A study about interpreters’ experiences of general practitioner–patient encounters revealed that the interpreters thought that they were one of the health staff and attempted to send information as accurately as possible to patients (Fatahi et al., 2005). Findings from this study on Burmese interpreters revealed a high level of mutual trust between midwives and the lam. This is important because trust between a midwife and an interpreter is crucial for valid interpreting (Edwards, Temple & Alexander, 2005). Eklöf et al. (2015) discovered that the most positive outcomes from interpreting came when interpreters coordinated closely with health providers in a workplace. The importance of trust between the midwife and the interpreter is crucial to enable shared goals to be achieved (Hsieh et al., 2010). Hsieh et al. (2010) identified that learning each other’s communicative needs and anticipating each other’s approach led to greater efficiency and better communication. Our findings also showed that this trust extended to social and emotional concerns that midwives held for the lam as people, outside their professional role.

8.6.6 Qualifications and training.

The Burmese lam had received limited school education in Burma and some could not read or write in Thai or their own language. However, it was essential that the lam spoke some basic Thai. They did not have a professional interpreter licence,
nor did they have any specific professional training. Eklöf et al. (2015) indicated that using a professional interpreter does not mean that the interpreter has an advanced level of interpretation skills. The lam also learnt a range of healthcare-related tasks when working in the antenatal clinics or postnatal ward. Reviews by Pallas et al. (2013) and Lewin et al. (2010) reported a variety of approaches to training CHWs. For example, in some locations, a CHW will be trained in health education and promotion, and basic care of specific conditions such as diarrhoea (Lewin et al., 2010). Training may comprise a 15-day training course, which may be supplemented by opportunities to attend seminars, discussion groups, meetings, workshops with role play, practical training and fieldwork (Lewin et al., 2010). This does not necessarily provide CHWs with formal professional certification and there is no agreement on beginning skill level (Lewin et al., 2010). In some countries, local health services oversee the training and supervision of CHWs. However, in many cases, CHWs are not trained and management and supervisory practices are insufficient (Pallas et al., 2013).

In this study, the lam received no training before commencing their role. They learnt on the job by listening and copying the nurse-midwives. Pallas et al. (2013) identified the importance of ongoing supervision and support. Given how busy the clinics and the postnatal ward were, no specific supervision sessions with staff were observed. However, the nurse-midwives indicated that they supervised the work of the lam by ‘keeping an eye’ on them. It is also likely in this setting in Ranong province that the nurse-midwives, obstetricians and public health officials did not have sufficient training to manage and support this lay workforce.

8.6.7 A trade off: Inadequate remuneration versus job satisfaction.

The participants in this study all mentioned the low pay that the lam received. Pallas et al. (2013) and Lewin et al. (2010) identified that insufficient pay or incentives
for CHWs relative to other employment opportunities was one of the biggest barriers to increasing the use of lay health workers. Some studies reported that CHWs are effectively volunteers in the community with no formal salary (Kauffman & Myers, 1997). In this study, while the lam received payment, there were aspects of their work that remained unpaid. For example, if a pregnant Burmese woman came to maternity services at the PHC clinic or hospital when the lam was not working, they would be called in to assist. This additional work was not paid.

The lam’s hourly rate of pay was less than a labourer’s rate at the markets or harbour (Fujita et al., 2010). This raises the question of exploitation, as lam are not provided with training and support, yet they willingly take on work that is beyond their scope without monetary reward. The nurse-midwives were aware of this but had no control over the salary. Although the lam felt discouraged about their low income, they preferred to continue to work in this role because they had better working conditions than the dirty, dangerous and manual labour available in the fish markets (Fujita et al., 2010). The poor remuneration led to attrition of some lam because they were able to gain better employment (e.g., at the private health clinic).

However, job satisfaction was high among the four lam. They believed that they were effective in helping their community access maternity services and in this process, they gained new skills. Other researchers have reported that serving as a CHW contributes to personal, family and community involvement in health-promoting activities (Ayón, 2013; Glenton et al., 2013).

8.7 Engaging with Thai Health Professionals and Health Services

The organisation of antenatal care represented a production line, in which women were processed and, despite the presence of interpreters, their communication and cultural needs were, at times, disregarded. Although the health providers offered
positive views about their experiences of interacting with Burmese women, the feeling of ‘being processed’, with women having to wait for many hours to be consulted, was a negative aspect of antenatal care. A lack of recognition of cultural values in the antenatal services was evident; this may have been a major barrier to some women accessing antenatal care. In contrast, the care provided in the postnatal ward appeared more caring. The women appeared more relaxed, they were able to have female family or friends with them 24 hours a day and the health providers appeared more supportive of their needs.

8.7.1 Being processed.

Despite the commitment by the Ranong health services to provide a specific antenatal clinic for Burmese women with interpreters, antenatal care was bureaucratic and represented a ‘production line’. Women did not receive care individualised to their needs but instead were offered the same care, that resembled a list of tasks. Dykes (2006) used the term ‘the production line’ to describe in-hospital postnatal care in the UK. This analogy to factory work implies that women are processed like mechanical objects, with busy staff giving little time to women’s individual needs, offering a one-size-fits-all approach to care, with no opportunity for relational care (Burns, Fenwick, Sheehan & Schmied, 2013; Dykes, 2006).

The ‘production line’ approach to postnatal care has been identified by other researchers in Australia (Burns et al., 2013; Schmied, Cooke, Gutwein, Steinlein & Homer, 2008), the UK (Beake, Rose, Bick, Weavers & Wray, 2010) and in Switzerland (Kurth et al., 2014). As a result of routine and procedure-oriented antenatal services, women report feeling disrespected and objectified (Tandon, Parillo & Keefer, 2005), and are less likely to engage in services (Finlayson & Downe, 2013). At times, health staff were strict and seemed unpleasant in their interactions with the
women. Studies in both HICs and LMICs indicate that disrespectful care disempowers women (Finlayson & Downe, 2013). The growing recognition of the degree to which women are subject to disrespect and abuse by caregivers, in formal maternity care systems, also explains why women may not attend antenatal care or why they may attend once and not again (Bohren et al., 2015; Bowser & Hill, 2010). A study by Hussein Dahlen, Duff and Schmied (2016) in Jordan demonstrated how midwives providing labour and birth care disregarded women’s needs, labelling women as uncooperative and uneducated. An ethnographic study of women who lived in a rural Hmong village in northern Thailand reported that women who experienced previous negative encounters with antenatal care were less likely to attend again; some preferred to birth at home for subsequent children (Culhane-Pera et al., 2015).

However, the behaviour of nurse-midwives is often the result of working in pressured environments with high workloads with procedures and guidelines that must be followed and reported. In their systematic review, Mannava, Durrant, Fisher, Chersich and Luchters (2015) reported that most health providers wished to provide quality care focused on women’s wellbeing and satisfaction. However, as Murray and colleagues (2010) discovered, while most midwives are kind, reassuring and helpful, they do not have enough time to meet women’s needs. Interestingly, in this study, the production line dominated the antenatal clinic services, but not the postnatal ward.

8.7.2 Stigma: Discrimination and disregards of cultural needs.

It was also evident that some midwives in the antenatal clinics at times disregarded the cultural needs of the Burmese women. For example, they restricted the use of body powder and preferences to not be offered sterilisation, while other staff (including those in the postnatal ward) supported these traditional practices. The capacity to participate in, or adhere to, certain cultural practices is important to many
migrant women. These practices can ensure women’s emotional and physical safety during pregnancy and childbirth, and when supported, builds trust with health providers (Finlayson & Downe, 2013; Downe et al., 2009). Lack of cultural sensitivity by health providers or services (Hrycak & Jakubec, 2006) can discourage women from attending health care services (Culhane-Per et al., 2015). However, there is variability reported in the support women receive to engage in traditional practices during pregnancy or postnatal services (Culhane-Pera et al., 2015; Kaewsarn, Moyle & Creedy, 2003). For example, Thai nurse-midwives supported Burmese women’s use of herbal tonics and other food practices both before and after birth. Kaewsarn and colleagues (2003) also reported that Thai women in north-eastern Thai hospitals were supported to follow traditional practices, such as lying close to the fire and placing heated lamps close to the perineum to aid recovery (Kaewsarn et al., 2003). This coexisted with Western medicine (Liamputpong et al., 2005). In contrast, Culhane-Pera and colleagues (2015) found that when Hmong women living in Thailand were not supported in their traditional practices, they did not use antenatal care and often decided to give birth at home for subsequent children.

Some Thai health providers in this study advised Burmese women to be sterilised after delivery. They implied this would be safer for women and better for their health. However, the Burmese women were against sterilisation, as having a big family was important to them and they believed that sterilisation might affect their health. Other studies of Burmese women in northern Thailand (Belton & Whittaker, 2007; Whittaker, 2013) reported that Burmese women lacked knowledge about fertility, menstruation and birth control, and did not know how to plan for having a baby (Whittaker, 2013). Some Burmese women in the US had received a tubal ligation and some considered sterilisation, but these women did not fully understand the birth
control options (McGinnis, 2012). Fear of sterilisation may have impeded some women from seeking antenatal care.

This experience has been reported in other studies of migrant and refugee women. Many cultures value the practice of having many children (Higginbottom et al., 2014; Carolan et al; 2012; Briscoe & Lavender, 2009) and were sensitive to the cultural differences in family planning in their host country. Some migrant/refugee women report feeling judged when they visited hospital multiple times for birth (Briscoe & Lavender, 2009) leading to women avoiding antenatal care and hospital visits.

8.7.3 Being alone in labour.

One aspect of maternity care that was particularly distressing for Burmese women was their experience of birth in the Thai public hospital. This is because the health staff would separate women from their relatives to be alone in the delivery room for labour and birth (Chunuan et al., 2004). However, women needed support from their family/relatives/husband during labour and childbirth (Chunuan et al., 2004; Culhane-Pera et al., 2015). Displaced Karen women resettling in Australia also described being frightened and discomforted when they were left alone in an unfamiliar environment while giving birth in Australia (Niner et al., 2013). Similarly, African women living in Brisbane in Australia who had given birth in hospitals expressed feelings of fear, loneliness and suspicion of the health system (Murray et al., 2010). These findings align with the results of this thesis (see Chapter 5), which illustrated that some Burmese migrant women described being afraid and scared when they were alone in the birth room.
8.7.4 Being cared for.

The health providers offered positive views about their experiences of interacting with Burmese women. The more positive context of person-centred care evident in the postnatal ward can inform service delivery globally. In general, studies of postnatal care demonstrate that postnatal wards are extremely busy places where midwives and nurses are not able to provide individualised care and communicate information effectively to women because their time is so limited (Beake et al., 2010; Schmied et al., 2008). Conversely, this study discovered that while staff in this Thai postnatal ward were very busy, they were also caring towards the Burmese women and appeared to take the time to guide and explain infant care in the postnatal care environment.

This may have been facilitated by the fact that women were able to have support people with them much of the time, including their partners and female relatives, who were permitted to stay overnight. Social support provided by partners, family, female relatives and friends is necessary for both the physical and psychological health of women after birth (Forster et al., 2008; Yuenyong, Jirapaet & O’Brien, 2008). However, many migrant are separated from their families when giving birth in a new country. Hence, their needs must be met in some way by caregivers and services (Schmied et al., 2017). Schmied and colleagues (2017) found that many migrant women were distressed that they were alone in the postnatal ward after birth, particularly if they could not speak the language of the care providers. Having family members enables women to celebrate the birth of their baby and access additional support in terms of infant care and someone who may speak the language of the care providers, as was the case in this study.
The use of informal Thai language was interesting in the postnatal ward, as many of the Burmese women had some understanding of this dialect. This contrasted with the more formal Thai language (Central Thai) which is used in the antenatal clinic setting. The official language of Thailand is Central Thai or Formal Thai, and this is the language used by government, education and in formal communications with strangers (Sisamouth & Lah, 2015). In contrast, the southern Thai dialect is more informal and is used generally when speaking with family, friends or familiar people (Sisamouth & Lah, 2015). Some Burmese women or their relatives spoke or understood this more informal Thai language. Thus, there was a more comfortable conversation flow, even if the interpreter was not available.

The care provided appeared to reflect what was described in a meta-synthesis of studies examining the breastfeeding support needed by women in HICs. Care was characterised by kindness, positive appraisal, reassurance, shared experiences and realistic and credible advice and information, which resulted in positive breastfeeding outcomes (Schmied et al., 2012). Further, a study by Smythe, Payne, Wilson & Wynyard, 2013) in New Zealand described positive outcomes from postnatal environments in which women felt relaxed, replenished and nourished. While this postnatal ward environment was a shared space, having one’s family members present may have helped create a relaxing environment.

8.8 Conclusion

This chapter has discussed the key findings of this study in relation to the SEM and extant literature. Being a mother was a central part of Burmese women’s role, and the participants and their families desired many children. Figure 8.1 captures not only the risk factors that affect women’s experiences and lives, but also the protective factors or strengths illustrated through the interviews and observations. In Chapter 9,
I comment on the value of the SEM for understanding both the risk and protective factors for these migrant women and discuss implications for practice and further research.
Chapter 9: Conclusion

9.1 Introduction

This chapter presents the conclusion to this study of the experiences of Burmese migrant women as they become mothers in Thailand. I provide a brief overview of the key study findings and interpret these findings in the context of the SEM with a focus on the key factors influencing Burmese migrant women’s experiences as mothers and their engagement in maternity services. I then discuss the implications for Thai maternity services and healthcare professionals’ practice. The strengths of the study, limitations, recommendations for further research, and my journey as a researcher are provided in the final sections of the chapter.

9.2 Overview of Study Findings and the SEM

The study explored Burmese women’s perceptions of becoming a mother in Thailand, their health-promoting practices and their experiences with Thai maternity services. To enhance the understanding of the women’s experience, I also explored the perceptions and experiences of Thai health professionals and Burmese interpreters (lam). SEM was used as a framework in this study to understand the multiplicity of factors that affect and shape Burmese migrant women’s experiences.

Drawing on the micro level of the SEM, the study findings offer a relatively unique perspective of the strengths or protective factors, and the difficulties or risk factors evident in the lives of individual Burmese migrant women. Motherhood was a central part of Burmese women’s role, and the participants and their families desired many children. Despite the many difficulties they faced, the women in this study held a very positive attitude towards becoming a mother and were aspirational in terms of what they wanted for their children and families. The women demonstrated a powerful
desire to take care of themselves and their baby to the best of their ability. Further, with the knowledge that their children would go to Burma when they were of school age, these women spoke of the love or strong attachment they desired with their child/ren before they reached this age and were separated. The women also appeared to successfully combine traditional childbirth and parenting practices with the more Western style of antenatal care offered through Thai health services. Accessing antenatal care was a positive health-seeking behaviour noted in this community. However, it was not available to all.

Arguably, these participants demonstrated a level of positive psychological resource or resilience. In contrast with many studies of migrant women, the women in this study spoke of their strong social support. This social support offered by partners, family, neighbours, employers and the community was potentially the most important factor in ensuring their wellbeing in pregnancy and after birth. Further, it is likely that they were comfortable in the knowledge that they were still close to Burma and could visit family with relative ease if their financial situation and employment allowed this.

However, at the meso level, participants experienced numerous challenges. They were living in poor conditions, often in a single room with little lighting or ventilation and with multiple family members. Some had accommodation in their workplaces, which had benefits for flexibility in child care but at times was disadvantageous to their health because of long working hours. The women were employed in low-paying and difficult jobs, which meant they experienced continual financial hardships, and at times were exposed to unequal treatment or discrimination in the workplace. For example, when pregnant, they knew there was a risk they would lose their job.
Negotiating the demands of earning an income led to unhealthy practices such as consuming energy drinks and herbal, alcohol-based tonics to improve wellbeing or provide energy. Women’s access to iron-rich food was limited, which could contribute to anaemia. Iron and folate supplements were recommended to compensate for possible iron deficiency; however, some women did not take the supplements, despite access to antenatal care.

At this meso-system level, this study also demonstrated that Burmese women’s access to Thai maternity services was influenced by several factors. The most important of these was access to interpreters on specified days, as well as the availability of information and resources in Burmese. This made a crucial difference to these women. They were also more likely to access services that fitted well with their work responsibilities; they preferred the hospital ANC because they did not have to wait for extended periods. If they were made to wait for half a day, this had a significant impact on their work and their employer, and sometimes women left the clinic without consulting a midwife. It was also important that staff were kind, and demonstrated empathy and care. As reported in many studies of maternity care worldwide, when staff are unkind, rough or abusive towards women, women are disinclined to return to the service (Downe et al., 2009; Hussein et al., 2018). When the Thai health staff treated women with respect and recognised their cultural practices, women were keen to engage in services.

At the macro level, Thai immigration and health policies may also have influenced the women’s experiences. Not all women accessed antenatal care, as many migrant Burmese women faced difficulties gaining work permits and accessing health insurance. Despite changes to Thai immigration policies that allowed increased
mobility of Burmese migrants, many were constrained, as they retained the status of an illegal migrant.

9.3 Implications for Practice and Service Design and Delivery

The findings from this study contribute to a conceptual understanding of Burmese migrant mothers and other migrant mothers in their motherhood journey. They offer insights for practice and service improvements. Sections 9.3.1–9.3.6 outline several areas in which improvements could be made.

9.3.1 The provision of effective social support.

The crucial role of social support in the lives of migrant mothers has been clearly demonstrated in the study. The findings provide a robust case for ensuring that all Burmese pregnant women have social support. While the key informants in this study had solid family and neighbourhood support, not all Burmese women do. Therefore, it is crucial to consider models of care and support in the community that build social support and community connections. Models of peer and community support are commonly used both in LMICs and HICs to build community connections and disseminate health information and change health practices in relation to significant health issues. For example, in the UK, peer-support models are very common to support women with breastfeeding (Thomson, Balaam & Hymers, 2015).

In Ranong province, organisations such as World Vision were very active in the late 1990s and 2000s with programs to prevent and treat malaria, HIV and TB. These programs included initiatives to support community connection as a strategy to disseminate information about health issues (Fujita et al., 2010). While this strengthened community connections during this period, reduction in funding reduced these services significantly; thus, there is less opportunity to bring the community together around health issues. It appears with the large Burmese communities living
in Ranong that it would be timely to support the interpreters or CHWs to revitalise community groups and offer pregnancy and birth education, particularly for healthy diets and the value of iron supplementation. Extending the role of the *lam* as CHW is proposed in Section 9.3.3. However, there is the potential to consider the role that other community members, including grandmothers, may play as peer supporters for women in this community.

### 9.3.2 Fathers as supporters of healthy behaviours.

The women in this study reported positive engagement of their partners in both the pregnancy and postnatal periods. This commitment by Burmese men may be a useful strategy to help change health behaviours, such as drinking sweet fizzy drinks and not taking iron supplements. Aguair and Jennings (2015) conducted a systematic review of the impact of male partner attendance at antenatal care. They discovered that male partners accompanying women to antenatal care is an important strategy in improving maternal knowledge, skilled attendance at birth and early postnatal care use. However, men’s accompaniment to ANC may not significantly affect behaviours, such as subsequent ANC use and birth preparedness. Begum et al. (2016) found that women living in Niger who received their husbands’ advice about attending ANC were more likely to attend ANC and adhere to iron and folic acid recommendations compared to those who did not receive any advice.

### 9.3.3 Potential to broaden the role of *lam* as CHWs.

Currently, most health-promotion activities with pregnant women appear limited to interactions with nurse-midwives and interpreters in the clinics. With strong connections to the community, the *lam* could potentially play a critical role in supporting Burmese women to change health behaviours. However, in this southern Thailand community, CHW or MHW are only employed to work with the community.
to improve health literacy around HIV and malaria. There is perhaps a missed opportunity to provide additional training for the lam to formally take on the role as a MHW in the community, as well as in the hospital and PHC clinic. This would require a level of formal training and support and a move away from on-the-job learning. In their review, Pallas et al. (2013) suggested that there are characteristics of CHW that facilitate the success of programs: clearly defined roles and relationships with the formal health system; supported from government and other health service providers; and investment in training, coordination and motivation for CHWs. This would require a commitment from the Ranong health services to establish these new or extended positions. Thailand has actively promoted and become known internationally for its support of Migrant Health Worker or Migrant Health Volunteer schemes.

9.3.4 Reorganisation of antenatal care processes.

In this study, Burmese migrant women often waited many hours for their antenatal appointments, particularly in the PHC clinic. This was very stressful, as women had to take time away from paid employment or their children. Figures 6.2 and 6.3 illustrate that staff and space in the clinic were not used in the most effective way. There is an opportunity to rethink how antenatal care is provided. One option may be to introduce a group-based antenatal care model, such as the model developed by Sharon Schindler Rising in the US: Centering Pregnancy (Schnidler-Rising, 2012). Group-based antenatal care involves exchanging the individual examination room for a group setting, which includes self-monitoring and extended time with the provider. Centering Pregnancy incorporates the three components of ANC—education, risk assessment and supportive care—into one entity, and encourages women to take responsibility for their own health.
Interestingly, there has been one Thai study (Wisanskoonwong, 2012) that developed a model of group-based antenatal care facilitated by nurse-midwives. Wisanskoonwong (2012) reported that group-based care could improve safety of women and their babies, and their satisfaction with care. If initiated in Ranong, this model could provide Burmese migrant women with additional social support from nurse-midwives, interpreters and other women in the group.

This study also highlighted the need for family support during labour and birth. As noted in Chapter 8, some women do not engage in antenatal care because they are aware that they will not be able to have a family member with them during birth (Culhane-Pera et al., 2015). Therefore, they remain outside the system, birthing in their communities without trained health professionals. Over a decade ago, Chunuan et al. (2004) and Siriwan et al. (2008) stated that Thai health policy is in urgent need of change to allow women’s close relatives to support them during labour and birth. This will require a major system change but is a practice that is increasingly supported in Thai private hospitals (Siriwan et al., 2008).

9.3.5 Training and support for the lam (Burmese interpreters).

It was evident from the interviews with midwives and Burmese women using the maternity services that the lam were crucial to effective maternity care. However, the employment of Burmese people as interpreters in health facilities in Thailand appears to be relatively new and lacks formal recognition in terms of qualifications and training. Further, there is no training of Thai midwives to work with interpreters. The on-the-job learning resulted in a lack of clarity about the role with some midwives expecting the lam to act as healthcare workers and others expecting the lam to primarily be interpreters.
Therefore, it is important that maternity services in Ranong province consider options for formal training of lam that will also provide them with basic qualifications allowing increased job opportunities. Training for midwives and other health professionals in working effectively with lam is also needed. Consideration may also be given to offering a fair salary commensurate with work expectations. Moreover, there is the opportunity to increase the use of lam in other maternity services in Thailand.

9.3.6 Training of health staff in cultural competency.

In general, the Thai health staff were positive about working with Burmese women and valued working with the Burmese interpreters. However, there were many examples in which Thai staff were uncaring or judgemental towards the Burmese women. Training in cultural competency would give staff a greater awareness of the needs of these women and enable them to provide compassionate care. Further, working with interpreters is complex and Thai health staff would benefit from training in how to effectively engage women using interpreters.

9.4 Strengths and Limitations

The use of an ethnographic approach was a strength of this study. This approach guided the observations of practice and interactions in the antenatal clinics, postnatal ward and in the community. These data triangulated with in-depth interviews from three groups: Burmese women, Burmese interpreters (lam) and health professional. This provided a rich dataset to understand the experiences of migrant Burmese women who became mothers while living in Thailand.

However, there are several limitations to this study. This study was conducted in only one province on the Thailand–Burma border in the south of Thailand; services and needs may be different in other border provinces or in cities. Only 10 Burmese
pregnant women were asked to participate; this small group of women is in no way representation of most women living in this community. All Burmese women who agreed to participate in the study were legally living in Thailand and had a work permit. Therefore, they may have felt more confident to take part in the study. Conversely, illegal migrant women who did not participate may have felt less confident to take part. It is likely that they were also concerned about impacts on their family members who held uncertain work status. Further, although all nurse-midwives in the antenatal and postnatal service agreed to participate in the observations, only nine participated in the interviews. This may have influenced the findings.

Finally, but perhaps most importantly, the study depended on the use of interpreters. As the researcher, I relied on them to accurately translate the questions I asked of the women and to translate their responses to me in Thai. This complex three-way interaction meant there may have been misinterpretation of questions and responses. Following this, the recorded interviews had to be translated to English, potentially introducing another stage in which misinterpretation may have occurred. Therefore, it is possible that the Burmese women’s views may not have been accurately interpreted.

These communication challenges were addressed in several ways. First, the interpreters received training in the role, including a thorough explanation of the study. I also engaged the interpreters to reflect with me on their perceptions of the interviews with the Burmese women and staff. Further, there were opportunities to reconfirm women’s experiences in the follow-up interviews and telephone calls.

9.5 Recommendations for Further Research

The observation data and interviews with staff suggested that rates of GDM and anaemia are high in this community. However, women appeared unaware of the
risks and symptoms of GDM. Given the serious nature of this condition for both the baby and ongoing health of the woman, it would be beneficial to conduct an epidemiological study to determine the prevalence of GDM and gather information on postnatal follow-up and longer-term outcomes.

It would also be important to evaluate the current role of the interpreters and to compare this model of care with an expanded role for the lam working in the community.

Most importantly, if the opportunity arose, it would be interesting to redesign the model of antenatal care along the lines of a Centering Pregnancy model and to evaluate the outcomes of this for women and health staff.

**9.6 The Researcher’s Journey**

As the researcher, this study was important for me in many ways. Through this journey I have learnt a lot about the lives of migrant Burmese women becoming mothers and how they negotiate this in my country, Thailand. I have learnt about Thai migration policy, something I knew little about, and how well the health services meet migrant women’s and their families’ needs.

The original motivation for this study was concern on my part and that of my colleagues as nurse-midwives for the health and wellbeing of migrant mothers, and particularly, concern for the health of their children. Immersing myself in this community and engaging with Burmese people and the interpreters has provided me with new insights about how Burmese migrant women care for their children and families despite adversity. As a nurse-midwife and educator, I have learnt the importance of family and community support for women and the value of fostering this in migrant communities. I have also observed the impact, both positive and negative, of how Thai health professionals interact with migrant women and
interpreters; I will take these lessons to my teaching and practice with student nurse-midwives at Surattani University.

I have gained skills and confidence as a researcher, particularly undertaking an ethnographic study. There were times when I found being in the field challenging. To collect these data, I had to travel for four hours from my home town of Surattani, across a difficult mountain route, often with heavy rain. I did not know Ranong and the Burmese villages well and at times I felt a little uneasy being a Thai woman, on my own, observing in the community. Over time, and with the support of an interpreter, I became comfortable in the environment. Undertaking this research, in three languages and across three cultures—Burmese, Thai and the social context in which I undertook most of my study, Australia—was very challenging.

Mostly, this was a personal struggle as, in parallel with the Burmese mothers, I too was separated from my two beautiful daughters during the time of study in Australia. I have come to understand the many sacrifices that women make as mothers. However, the journey has been well worth it. I hope that this work can initiate change in Thai health services.

9.7 Conclusion

This study has examined the experiences and perceptions of Burmese migrant women as they negotiate motherhood in a new country, Thailand. Knowledge about this experience was supplemented by interviews with interpreters and Thai health staff. Drawing on the SEM, the findings contribute to a conceptual understanding of Burmese migrants’ journey as mothers. Burmese women, like many other migrants, experience poor living and working conditions and this is likely to affect their health and that of their children. Thai health services in Ranong province have responded by offering specific clinics with interpreters for Burmese women. However, the way these
services are organised limits access by women. All participants valued the interpreters; however, the employment of Burmese people as interpreters in health facilities in Thailand appears to be relatively new and lacks formal recognition in terms of qualifications and training. The study offers important insights into women’s experiences and identifies potential improvements in service delivery.
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Appendices

Appendix A: Authorisation letter

Appendix B: Ethics Approval

Appendix C: Approval letter from study sites

Appendix D: Information sheet for participating Burmese women and Consent Form (in English)

Appendix E: Information sheet for participating Burmese women and Consent Form (in Burmese)

Appendix F: Information sheet for participating Burmese women and Consent Form (in Thai)

Appendix G: Information sheet for Nurse-midwives and the other health staff (in English)

Appendix H: Information sheet for Nurse-midwives and the other health staff (in Thai)

Appendix I: Recruitment flyer for women

Appendix J: Observation tools
Appendix A: Authorisation Letter

Letters of access study sites (in English)

PERMISSION LETTER TO ORGANISATIONS

February 16, 2015

Dear The Managing Director of Ranong province,

PERMISSION TO CONDUCT A RESEARCH AT RANONG HOSPITAL AND PAK-KLONG PRIMARY HEALTH CARE FOR A PHD

I am Titaree Phanwichatkul, a lecturer in nursing and midwifery, Faculty of Nursing, Suratthani Rajabhat University, Suratthani, Thailand. Currently, I am a PhD student at the School of Nursing and Midwifery, at the University of Western Sydney, Australia. My study is entitled: ‘Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study’.

I write to seek your permission to use Thai health cares in Ranong province including Ranong Hospital; prenatal care and postnatal ward, as well as prenatal care at Pak-Klong Primary Health Care as a site for my research. Your organisations have been chosen for the study because there have been increasing numbers of Burmese women who access maternity care. I specifically request your permission for me to interview 10 Burmese women and health staff, conduct participant observations, and other observations within your organisations with those who are involved in the study (see more detail that have been attached). I will make clear to the participants that their individual responses to questions will not be made available to others so as to establish trust with interviewees. In the process of the research, the Burmese women and health staff may decide to withdraw without any explanation even if they have initially agreed to participate.

In the event that this situation arises any previous data collected from the participant will not be used in the data analysis unless (s)he has given permission for its inclusion. This study will generate new knowledge about the experience of Burmese women seeking maternity care in Thailand.
It is vital information for health professionals and services to improve services to these vulnerable women. The benefits of such a study would not only be for this vulnerable group of women, but also for all current relevant Burmese and maternity care for Thai women.

You are assured of the confidential keeping of information obtained from your organisations. This is an important requirement of the UWS’s Human Ethics Protocol governing research of this nature. Data obtained would be primarily for the purposes of the thesis. Confidential will be assured throughout the process of the research. I have attached the following documents in this email including a research proposal, table of data collection methods, and a response permission form. For the successful completion of this study, I highly appreciate your kind assistance. If you need more information about my study, please do not hesitate to contact me.

I look forward to your positive response and kind cooperation.

Yours faithfully,

Titaree Phanwichatkul (PhD candidate) 17867678@student.uws.edu.au
Nae.p@hotmail.com Mobile phone +66 089 7271099 (Thailand), +61 0416 147 045 (Australia)
เรื่อง ขอความร่วมมือ และประสานแหล่งข้อมูลเพื่อใช้ในการวิจัย

เรียน ผู้อำนวยการโรงพยาบาลระนอง

ที่ดีที่สุด

พณทูนบมจ. พันธุ์วรรณนา สาขาวิชาการพยาบาลและการสุขภาพของมนุษย์ มหาวิทยาลัยราชภัฏสุราษฎร์ธานี กำลังศึกษาปวิชาเอก สาขาการพยาบาลและการสุขภาพของมนุษย์ที่ประเทศออสเตรเลีย มหาวิทยาลัย The University of Western Sydney โดยมีหัวข้อเรื่อง การวิจัยแบบชาติพันธุ์วรรณนาด้านการดูแล สุขภาพมารดาและทารกตามการรับรู้จากประสบการณ์ของหญิงพม่าในภาคใต้ของประเทศไทย (Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study) โดยมีวัตถุประสงค์ เพื่อศึกษาระะสุขภาพของมารดาพม่าที่ตั้งครรภ์จนกระทั่งคลอดบุตรในโรงพยาบาลไทยมีการให้บริการด้านสุขภาพที่ดีแก่ทั้งมารดาและทารก ที่มีชายแดนไทยติดกับประเทศพม่า ซึ่งเป็นจุดที่มีการเคลื่อนย้ายผู้อาศัยจากประเทศพม่าไปแรมช่วยในการให้บริการสุขภาพ ตามแผนการจัดการสุขภาพที่มีการกำหนดไว้ในระดับนโยบาย รวมถึงการให้บริการที่มีประสิทธิภาพ ให้แก่ผู้มารดาและทารกที่ตั้งครรภ์และคลอดในโรงพยาบาล ทั้งในสถานที่มารดาที่มีการอยู่ในสถานที่ที่ตั้งและทารกที่เกิดในสถานที่ที่มีการดูแลที่ดี ทั้งในรูปแบบที่มีการให้บริการที่มีประสิทธิภาพ และการให้บริการที่มีการผ่านการฝึกอบรมที่มีความรู้ที่ดี ในการให้บริการที่มีการดูแลที่ดี ทั้งในรูปแบบที่มีการให้บริการที่มีประสิทธิภาพ และการให้บริการที่มีการผ่านการฝึกอบรมที่มีความรู้ที่ดี ในการให้บริการที่มีการดูแลที่ดี ทั้งในรูปแบบที่มีการให้บริการที่มีประสิทธิภาพ และการให้บริการที่มีการผ่านการฝึกอบรมที่มีความรู้ที่ดี ในการให้บริการที่มีการดูแลที่ดี ทั้งในรูปแบบที่มีการให้บริการที่มีประสิทธิภาพ และการให้บริการที่มีการผ่านการฝึกอบรมที่มีความรู้ที่ดี
หลังคลอด โรงพยาบาลระนอง และ 2. สถานีอนามัยปากคลอง ด้วยมูลนิธิ จังหวัดระนอง โดยได้
แนวรายละเอียด ดังนี้ 1. โครงการวิจัย 2. ตารางสรุปการเก็บข้อมูล 3. แบบฟอร์มตอบรับในการให้
ความร่วมมือจากที่ประชุมและสถานีอนามัยปากคลอง ทั้งนี้ภายใต้การดูแล จริยธรรมของ
มหาวิทยาลัยและหน่วยงานจริยธรรมของประเทศออสเตรเลีย เป็นไปโดยชอบและถูกต้องตาม
หลักจริยธรรมทุกประการ

ทั้งนี้ขอให้ท่านยินยอมให้ใช้ข้อมูลที่ได้เก็บข้อมูลใน
ประเทศออสเตรเลีย ในการดำเนินการวิจัย จนถึงที่จะส่งมอบข้อมูลจริยธรรมโรงพยาบาลระนองอีก
ครั้งที่ผู้ดูแลก่อน การเก็บข้อมูล
จึงเรียนมาเพื่อโปรดพิจารณาอนุญาต
ขอแสดงความนับถือ

(นางฐิตารีย์ พันธุ์วิชาติกุล)
อาจารย์ประจำคณะพยาบาลศาสตร์
Dear Professor Virginia Schmied,

I write to inform you that I support the PhD study of Mrs Titaree Phanwichatkul, entitled “Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study”. Subject to her gaining ethics approval from the Human Research Ethics Committee (HREC) of University of Western Sydney, this permission allows Mrs Titaree to conduct her research project at Ranong hospital.

ขออนุญาตให้การสนับสนุนการวิจัยของคุณ ทีทารี ผันวิชัยทัศ ให้กับการเข้าใช้บริการและการดูแลสุขภาพมารดาและการรับรู้จากประสบการณ์ของหญิงตั้งครรภ์ผู้พำในภาคใต้ของประเทศไทย โดยทั้งนี้การวิจัยนี้จะต้องผ่านการรับรองโดยคณะกรรมการจัดการในมูลนิธิของมหาวิทยาลัย Western Sydney ที่มีการเก็บข้อมูล

(..................................)

นายแพทย์อวิศักดิ์ ตันศุภเดช
ผู้อำนวยการโรงพยาบาลระนอง

The Director of Ranong hospital
Permission letter from Ranong Public Health Province

Dear Professor Virginia Schmied,

I write to inform you that I support the PhD study of Mrs Titaree Phanwichatkul, entitled “Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study”. Subject to her gaining an ethics approval from the Human Research Ethics Committee (HREC) of University of Western Sydney, this permission allows Mrs Titaree to conduct her research project at Ranong hospital.

(Thai text)

(Thai signature)

The Head of Ranong’s Public Health Province

February 2015
Appendix B: Ethics Approval

Ethics Approval

Locked Bag 1797
Penrith NSW 2751 Australia
Office of Research Services
ORS Reference: H11099

HUMAN RESEARCH ETHICS COMMITTEE

4 May 2015
Professor Virginia Schmied
School of Nursing and Midwifery

Dear Virginia,

I wish to formally advise you that the Human Research Ethics Committee has approved your research proposal H11099 ‘Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study’, until 17 June 2017 with the provision of a progress report annually if over 12 months and a final report on completion.

Conditions of Approval
1. A progress report will be due annually on the anniversary of the approval date.
2. A final report will be due at the expiration of the approval period.
3. Any amendments to the project must be approved by the Human Research Ethics Committee prior to being implemented. Amendments must be requested using the HREC Amendment Request Form: http://www.uws.edu.au/__data/assets/pdf_file/0018/491130/HREC_Amendment_Request_Form.pdf
4. Any serious or unexpected adverse events on participants must be reported to the Human Ethics Committee via the Human Ethics Officer as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the Committee as a matter of priority.
6. Consent forms are to be retained within the archives of the School or Research Institute and made available to the Committee upon request.

Please quote the registration number and title as indicated above in the subject line on all future correspondence related to this project. All correspondence should be sent to the email address humanethics@uws.edu.au.

This protocol covers the following researchers:
Virginia Schmied, Pranee Liamputtong, Elaine Burns, Titaree Phanwichatkul

Yours sincerely

Professor Elizabeth Deane
Presiding Member,
Human Researcher Ethics Committee
Appendix C: Approval Letter from Study Sites

Approval Letter from Ranong Hospital Committee (in Thai)
5. แบ่งพื้นที่พักผ่อนสำหรับผู้เข้าร่วมการวิจัย และแบ่งตอบรับเข้าร่วมการวิจัย สำหรับเจ้าหน้าที่
(ฉบับภาษาอังกฤษ ไทย)

6. แบ่งพื้นที่สำหรับผู้เข้าร่วมการวิจัย และแบ่งตอบรับเข้าร่วมการวิจัย สำหรับผู้เป็น
ตัวครวมเพศ (ฉบับภาษาอังกฤษ ไทย และภาษา)

จึงเรียนมาเพื่อโปรดพิจารณาอนุมัติต่อ

ขอแสดงความนับถือ

(นางสาวศิริยา พันธุ์ชีวชีวจิต)
อาจารย์คณะแพทยศาสตร์

(นายสมชาย มะลิรักษ์)
หัวหน้าเจ้าหน้าที่
พยาบาลวิชาชีพประจำสถานพยาบาลพิเศษ

(นายสมชาย มะลิรักษ์)
หัวหน้าเจ้าหน้าที่
พยาบาลวิชาชีพประจำสถานพยาบาลพิเศษ

(นายสมชาย มะลิรักษ์)
ผู้อานวยการวิชาชีพประจำสถานพยาบาลพิเศษ
บันทึกข้อความ

ส่วนราชการ กรมพยาบาลศาสตร์ โทร. 3308
ที่ รัฐบาล 6 พฤศจิกายน 2558
เรื่อง ขอความร่วมมือ เกี่ยวกับการวิจัย
เรียน ผู้อำนวยการ สำนักงานสาธารณสุขจังหวัดระยอง

ด้วยช่างภาพ นางสาวสุรรชีร undeniable อาจารย์คณะพยาบาลศาสตร์ มหาวิทยาลัยราชภัฏสวนสุนันท์ ได้ทำการจัดทำเอกสารประกอบการส่งต่อให้กับ The University of Western Sydney ประเทศออสเตรเลีย โดยมีที่มาเพื่อทำการประชุมคู่มือในครั้งนี้ การวิจัย

บนซีสชิพผู้ป่วยน่าน สำนักงานปลัดกระทรวงสุขภาพและสุขภาพจิต ตามการบริการ จำกัดแบบการรักษา หญิงมุสลิม ในภาคใต้ของประเทศไทย (Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study) โดยมีวัตถุประสงค์ เพื่อศึกษา ภาวะสุขภาพของ

สำหรับในการตั้งครรภ์ จนกระทั่งคลอดบุตร ไม่ปรากฏรายละเอียด.

การวิจัยได้ทำการตั้งต่อไปนี้ ได้รับการอนุมัติจาก

มหาวิทยาลัยศาสตร์ จิตวิทยา และคณะการวิจัยการวิจัยในนั้น หากเกิดข้อขัดข้องในกรณีที่มีการไม่สามารถส่งต่อไปได้

กรณีที่ มีการบันทึก 3600 (ต่อเอกสารแนบ) ข้าราชการที่ทำงานจะมีเพื่อการตั้งค่าการศึกษาที่เกี่ยว

ขั้นตอนพื้นที่ที่เกี่ยวข้องในผลการวิจัยการวิจัยในครั้งนี้ ให้สามารถใช้ประโยชน์ในการวิจัยการศึกษาที่เกี่ยวข้อง

ขั้นตอนพื้นที่ที่เกี่ยวข้องในผลการวิจัยการศึกษาที่เกี่ยวข้อง

ขั้นตอนพื้นที่ที่เกี่ยวข้องในการวิจัยการศึกษาที่เกี่ยวข้อง

ขั้นตอนพื้นที่ที่เกี่ยวข้องในการวิจัยการศึกษาที่เกี่ยวข้อง

ขั้นตอนพื้นที่ที่เกี่ยวข้องในการวิจัยการศึกษาที่เกี่ยวข้อง
5. แบบที่กิจสิทธิ์ผู้เข้าร่วมการร่ำริง และแบบตอบรับเข้าร่วมการร่ำริง สำหรับเจ้าหน้าที่ (ฉบับภาษาอังกฤษ ไทย)

6. แบบที่กิจสิทธิ์ผู้เข้าร่วมการร่ำริง และแบบตอบรับเข้าร่วมการร่ำริง สำหรับผู้ป่วยตั้งครรภ์ (ฉบับภาษาอังกฤษ ไทย และพระมหากษัตริย์)

จึงเรียนมาเพื่อโปรดพิจารณาอนุมัติ

[ลายเซ็น]

ขอแสดงความนับถือ
(นางจิตติภูมิ พันธุ์ฤทธิ์กุล)
อาจารย์คณะแพทยศาสตร์

[ลายเซ็น]

(นางประภาพร ธรรมแพทย์)

นักวิชาการประจำการดูแลผู้ป่วยที่มีการร่ำริง ปฏิบัติหน้าที่ในวันนี้

นักวิชาการประจำการดูแลผู้ป่วยที่มีการร่ำริง (นางสุทธิภัณฑ์ นาค) ปฏิบัติงานอย่างมีประสิทธิภาพ

นำเสนอนายทะเบียนศูนย์บริการรวม

8 พ.ย. 2566

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Appendix D: Information Sheet for Participating Burmese Women and Consent Form (in English)

Information sheet for participating Burmese women (in English)

Human Research Ethics Committee
Office of Research Services

Participant Information Sheet (Medical)

Project Title: Burmese women’s experience of maternity care in the South of Thailand: An ethnographic study.

Who is carrying out the study?

You are invited to participate in a study conducted by Mrs Titaree Phanwichatkul, a doctoral student from the School of Nursing and Midwifery, at the University of Western Sydney. Mrs Phanwichatkul is being supervised by Professor Virginia Schmied, University of Western Sydney, Dr Elaine Burns, University of Western Sydney and Professor Pranee Liamputtong, La trobe University

What is the study about?

The purpose of the study is to examine Burmese women’s experience of maternity care in southern Thailand. The study objectives are to:

• To describe Burmese women's perception of becoming a mother and their health care and support needs in pregnancy, birth, and postpartum.
• To explore factors that facilitate or hinder Burmese women’s access to maternity care in Thailand.
• To describe Burmese women’s perception of the quality of the care received and their experience of interactions with health workers.
• To describe health providers’ and community workers’ perception of the needs of Burmese women and their experience of providing maternity care to this group of women.

This study will generate new knowledge about the experience of Burmese women seeking maternity care in Thailand and provide information for health professionals and services about improving services for this vulnerable group of women.

What does the study involve?
You are being invited to participate in this study because you are a Burmese woman who is pregnant and will give birth to your baby and receive postnatal care at Ranong Hospital in Thailand. If you agree to participate in this research, you will be asked to sign the Participant Consent Form. Your participation will involve the following:

• Answering a few brief questions about your age, if you are married, where you are living and whether this is your first or subsequent baby.

• You will be asked to participate in a face-to-face interview with a researcher in pregnancy and a second interview after your baby is born. The focus of the interviews will be on how you feel about becoming a mother. What were your first thoughts when you found out you were pregnant with this baby, your experience of antenatal care at Ranong Hospital or Pak-Klong Clinic. The second interview will focus on your experience of postnatal care. The interviews will occur in a private space with a translator working alongside the researcher. Each interview will be between 30 and 60 minutes long and will depend on your availability. With your permission the interview will be audio-recorded using a digital voice recorder.

• You will also be asked permission for the researcher, Mrs Titaree Phanwichatkul to observe the interaction that you have with a midwife, public health officer or translator when they are providing you with care in the antenatal clinic. The researcher will be present during the clinic appointments or when you are on the postnatal ward. The focus of these observations will be on the actions of the midwife and other health staff and the interactions that you have with them. Aspects of these interactions will be recorded in field notes, but they will not be digitally recorded.
How much time will the study take?

The observations of your interactions with health staff will be the same length of time that you would normally spend with them in your antenatal appointment or in the postnatal ward, that is between 15 to 30 minutes. The one-to-one interviews will be approximately 30 to 60 minutes.

Will the study benefit me?

We cannot guarantee or promise that you will receive any benefits from this research; however, possible benefits may include you having an opportunity to talk about your experience of antenatal and postnatal care with a researcher. Longer-term benefits will include improvements to the way in which prenatal care and postnatal care are delivered.

Will the study have any risks?

The risks of participating in this research may include:

- You may feel uncomfortable having a researcher observe your interactions with a health professional or observing the work of a midwife or health worker who is providing care for you. At any time, you can request that the researcher ceases observations while you or your baby are receiving care.
- Participating in interviews with the researcher may also be time-consuming. You can request that these be rescheduled to suit your needs.
- There is also the risk that you may become distressed when talking about your experience of prenatal care during the interviews with the researcher.

If you do become distressed during the research, the researchers will be able to arrange for counselling or other appropriate support. Any counselling or support will be provided by qualified staff who are not members of the research project team. This counselling will be provided free of charge.
How is this study being paid for?

The research student, Mrs Titaree Phanwichatkul will receive some funding from the School of Nursing and Midwifery at the University of Western Sydney.

Will anyone else know the results? How will the results be disseminated?

All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants.

Can I withdraw from the study?

Participation is entirely voluntary: you are not obliged to participate and – if you do participate – you can withdraw at any time without giving any reason. Whatever your decision, it will not affect your medical treatment or your relationship with the medical and midwifery staff at Ranong Hospital or Pak-Klong Clinic.

Can I tell other people about the study?

Yes, you can tell other people about the study by providing them with the chief investigators contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.

What if I require further information?

When you have read this information, the research student, Mrs Titaree Phanwichatkul will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Mrs Titaree Phanwichatkul at 17867678@student.uws.edu.au, or on (+61) 0416147045 (Sydney) or (+66) 0897271099 (Thailand) or contact Titaree’s supervisor, Professor Virginia Schmied at v. schmied@uws.edu.au, or (+61) 0296859505 or 0430242140 (Sydney).
What if I have a complaint?

This study has been approved by the University of Western Sydney Human Research Ethics Committee and NSW Department of Health Area Health Service. The approval number is [H11099]

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethics@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome. If you agree to participate in this study, you may be asked to sign the Participant Consent Form.

The information sheet is for the participant to keep and the consent form is retained by the researcher.
Consent form for study participants (in English)

Human Research Ethics Committee

Project Title: Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study

I, .........................................................., consent to participate in the research project titled Burmese women’s experience of maternity care in the south of Thailand.

I acknowledge that:

I have read the participant information sheet [or where appropriate, ‘have had read to me’] and have been given the opportunity to discuss the information and my involvement in the project with the researcher/s.

The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

I consent to the interview and observational components of the study including audio recording of interactions with health staff.

I understand that my involvement is confidential, and that the information gained during the study may be published but no information about me will be used in any way that reveals my identity.

I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher/s now or in the future.

Signed: ____________________________________________

Name: ____________________________________________

Date: ____________________________________________

Return Address: Suratthani Rajabhat University, School of Nursing
272, Surat-Na San Road, T. Khun Thale Muang, Surat Thani 84100, Thailand

This study has been approved by the University of Western Sydney Human Research Ethics Committee.
The Approval number is: H11099

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email human.ethics@uws.edu.au. Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome.
Appendix E: Information sheet for participating Burmese women and Consent Form (in Burmese)

Information sheet for participating Burmese women (in Burmese)
မိုးအနီးသူကြက်ကလေးများသည်ကျွန်းစုလေးများဖြစ်သည်။ ထို့အတွက် ဗိုလ်ချုံးအချက်သိရှိရန်အတွက် အခြေခံနေရာများကိုကြည့်ရှုလိုပါသည်။

မိုးအနီးသူကြက်ကလေးများကို အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။ ထို့အတွက် အခြေခံနေရာများကိုကြည့်ရှုလိုပါသည်။

- သူမြင်ပြချက်များအရ အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။
- သူမြင်ပြချက်များအရ အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။

အခြေခံနေရာများကိုကြည့်ရှုလိုပါသည်။

- သူမြင်ပြချက်များအရ အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။
- သူမြင်ပြချက်များအရ အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။

အခြေခံနေရာများကိုကြည့်ရှုလိုပါသည်။

- သူမြင်ပြချက်များအရ အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။
- သူမြင်ပြချက်များအရ အခြေခံနေရာများကိုကြည့်ရှုမှုများဖြစ်သည်။

အခြေခံနေရာများကိုကြည့်ရှုလိုပါသည်။
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Consent form for study participants (in Burmese)
Appendix F: Information sheet for participating Burmese women and Consent Form (in Thai)

Information sheet for participating Burmese women (in Thai)

คณะกรรมจริยธรรมการวิจัยในมนุษย์
สำนักงาน ด้านบริการงานวิจัย

แบบฟอร์มพิทักษ์สิทธิผู้เข้าร่วมวิจัย

ชื่อวิจัย: การวิจัยแบบชาติพันธุ์วรรณนา การเข้าใช้บริการและการดูแลสุขภาพมารดาและทารก ตามการรับรู้จากประสบการณ์ของหญิงตั้งครรภ์พม่า ในภาคใต้ของประเทศไทย

ใครคือผู้ดำเนินการวิจัย
ท่านได้รับเชิญให้เข้าร่วมการวิจัย โดย นางฐิตารีย์ พันธุ์วิชาติกุล นักศึกษาระดับปริญญาเอก สาขาการพยาบาลและพฤติกรรม คณะพยาบาลศาสตร์และการผดุงครรภ์ จากมหาวิทยาลัยเวสเทรินน์ ซิดนีย์ ประเทศออสเตรเลีย ทั้งนี้ นาง ฐิตารีย์ ดำเนินการวิจัยโดยมีอาจารย์ที่ปรึกษา ศาสตราจารย์ Dr. เวอจิเนียร์ สมิทด์, ดร. อีเลน เบรนส์ จากมหาวิทยาลัยเวสเทรินน์ ซิดนีย์ และ ศาสตราจารย์ ดร. ปราณี เหลี่ยมพุฒทอง จากมหาวิทยาลัย ลาโธบ ประเทศออสเตรเลีย

ศึกษาเกี่ยวกับอะไร
จุดมุ่งหมายของการศึกษานี้คือ การสำรวจประสบการณ์ของหญิงตั้งครรภ์พม่าในการใช้บริการเกี่ยวกับการพยาบาล, การดูแลและการรักษาในสถานบริการสุขภาพภาคใต้ของประเทศไทย โดยมีวัตถุประสงค์ดังนี้

1. เพื่อทราบความเข้าใจ ความรู้สึกของหญิงตั้งครรภ์พม่าเกี่ยวกับการมารดา และเพื่อทราบประสบการณ์ของหญิงตั้งครรภ์พม่าที่ได้รับการให้บริการทางสุขภาพการ
สนับสนุน และการตอบสนองต่อความต้องการ จากเจ้าหน้าที่ในระหว่างการตั้งครรภ์ การคลอด การขยายหลังการคลอด

2. เพื่อสำรวจปัจจัยเกี่ยวกับและอุปสรรคของหญิงตั้งครรภ์ที่มีการใช้บริการสุขภาพทางการพยาบาลและการรักษาที่ที่ที่มีการตอบสนองต่อความต้องการจากเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด

3. เพื่อศึกษาประสบการณ์ของหญิงตั้งครรภ์ที่มีการใช้บริการสุขภาพทางการพยาบาลและการรักษาที่ที่มีการตอบสนองต่อความต้องการจากเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด

4. เพื่อทราบความข้างต้นของบุคคลการตั้งครรภ์ที่มีการใช้บริการสุขภาพทางการพยาบาลและการรักษาที่ที่มีการตอบสนองต่อความต้องการจากเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด

การศึกษาครั้งนี้เกี่ยวกับ

ท่านเป็นบุคคลที่มีความสำคัญในการให้ข้อมูลการศึกษาครั้งนี้ เนื่องจากท่านจะเป็นหญิงชาวพม่าที่มีการตั้งครรภ์และมีการตอบสนองต่อความต้องการจากเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด ที่มีการตอบสนองต่อความต้องการจากเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด ยังมีการสอบถามความรู้สึกและความต้องการจากประสบการณ์การตั้งครรภ์ การคลอด การขยายหลังการคลอด ยังมีการสอบถามความรู้สึกและความต้องการจากประสบการณ์การตั้งครรภ์ การคลอด การขยายหลังการคลอด

การศึกษาครั้งนี้มีข้อกำหนดการศึกษา

ท่านจะถูกขอให้ลงนามในการร่วมการศึกษา และมีข้อกำหนดการร่วมการศึกษา

- การขอทราบข้อมูลของท่านเพื่อส่งให้กับเจ้าหน้าที่ที่มีการตอบสนองต่อความต้องการจากเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด

- ท่านจะถูกขอให้สัมภาษณ์กับนักวิจัย และเจ้าหน้าที่ในการตั้งครรภ์ การคลอด การขยายหลังการคลอด

การร่วมการวิจัย

ท่านจะมีการร่วมการวิจัย และมีส่วนร่วมในการพัฒนาและปรับปรุงการให้บริการทางด้านสุขภาพของหญิงชาวพม่าที่ได้รับการรักษาตามการร่วมการศึกษาครั้งนี้
โรงพยาบาลระนอง โดยการสัมภาษณ์ทุกครั้งจะมีการบันทึกเสียง และการจดบันทึกบางส่วน หรือทั้งหมดโดยผู้วิจัย ทั้งนี้เพื่อให้ได้ข้อมูลถูกต้องครบถ้วนชัดเจน ระยะเวลาในการสัมภาษณ์แต่ละครั้งใช้เวลาประมาณ 30 นาที ถึง 60 นาที ทั้งนี้ระยะเวลาขึ้นอยู่กับความเหมาะสมและความสะดวกของท่าน

ท่านจะถูกขออนุญาตจากนักวิจัย คือ นางฐิตารีย์ พันธุ์วิชาติกุล เพื่อขอสังเกต การมีปฏิสัมพันธ์ ระหว่างท่านกับเจ้าหน้าที่ เมื่อท่านมีการพบเห็นกับเจ้าหน้าที่ สาธารณะหรือในส่วนที่ท่านมาใช้บริการทั้งหมดที่โรงพยาบาลระนอง ซึ่งผู้วิจัยจะเน้นสังเกต กิจกรรมทั้งหมด เช่น การพูดคุย ตอบข้อซักถาม ท่าทาง กริยาอาการของผู้สังเกตการณ์ ซึ่งกันและกัน นักวิจัยจะมีการจดบันทึกข้อมูลบางส่วน ในส่วนนี้จะไม่มีการบันทึกเสียง ด้วยเครื่องบันทึกเสียงแต่อย่างใด

เป็นระยะเวลานานเท่าใดในการศึกษาข้อมูล
การติดตามสังเกต ปฏิสัมพันธ์ระหว่างท่านกับเจ้าหน้าที่ จะใช้เวลาเหมือนเช่นท่านมาใช้บริการ ในแต่ละครั้งตามการนัดหมายในการฝากครรภ์ หรือการใช้บริการในแผนกหลังคลอด 15 – 30 นาที ส่วนการสัมภาษณ์รายบุคคล จะใช้เวลาประมาณ 30 – 60 นาที

ท่านจะได้รับประโยชน์ใดบ้างในการศึกษา
ที่ผู้วิจัยไม่สามารถให้สัญญาหรือยืนยันได้ว่า ท่านจะได้รับประโยชน์อย่างใดบ้างในการศึกษาครั้งนี้ อย่างไรก็ตาม ประโยชน์มีอยู่ เช่น ท่านจะได้รับการให้ข้อมูลทางสุขภาพ ตนเองและผู้สังเกตการณ์ การให้บริการในแผนกหลังคลอดในสถานบริการอนามัยแม่และเด็กในประเทศไทย ที่ท่านได้รับบริการทางสุขภาพที่ท่านจะเป็นประโยชน์ในอนาคต เป็นแนวทางเพื่อใช้พัฒนา ปรับปรุง ระบบการให้บริการทางสุขภาพมารดาและทารกต่อไป

จะมีความเสี่ยงใดบ้างที่จะเกิดขึ้นในการศึกษา
ในการศึกษาครั้งนี้ ผู้เข้าร่วมวิจัยอาจมีความเสี่ยง: 315
ท่านอาจจะรู้สึกอัดอึด ไม่สบายใจ เมื่อมีนักวิจัยสังเกตปฏิสัมพันธ์ระหว่างท่านกับเจ้าหน้าที่ ในช่วงที่เจ้าหน้าที่ท่านทำงานหรือให้บริการทางสุขภาพแก่ท่าน ท่านสามารถยุติการเก็บข้อมูลของนักวิจัยได้ตลอดเวลา เมื่อท่านต้องเจรจาบริการทางสุขภาพหรือเมื่อต้องการดูแลสุขภาพ。

ในการให้สัมภาษณ์กับนักวิจัยอาจจะใช้เวลานาน ท่านสามารถขอให้ปรับเวลาการสัมภาษณ์ให้เหมาะสมกับความต้องการของท่านได้.

ระหว่างการให้สัมภาษณ์ ท่านอาจจะเกิดความเครียดในกรณีที่ท่านได้บอกเล่าประสบการณ์ การให้บริการทางด้านกลุ่มวิจัย อย่างไรก็ตาม หากท่านเกิดความเครียดระหว่างให้ข้อมูล นักวิจัยสามารถช่วยท่านได้ ด้วยการเตรียมแหล่งช่วยเหลือให้คำปรึกษา และให้การสนับสนุนท่านอย่างเหมาะสม ซึ่งเจ้าหน้าที่ที่ผู้ให้คำปรึกษาจะไม่ใช่บุคคลที่มาจากทีมวิจัยในการศึกษานี้ และการให้บริการให้คำปรึกษาช่วยเหลือท่าน จะไม่มีค่าใช้จ่ายแต่อย่างใด.

ค่าใช้จ่ายในการศึกษานั้นอย่างไร

นางฐิตารีย์ พันธุ์วิชาติกุล นักศึกษาปริญญาเอก จะได้รับเงินสนับสนุนจากคณะพยาบาลศาสตร์มหาวิทยาลัยเวิสเทริน ซิดนีย์ ประเทศออสเตรเลีย

ใครบ้างที่จะทราบผลการศึกษานี้ และผลการศึกษานั้นจะถูกเผยแพร่อย่างไร

ข้อมูลที่ได้ทุกประการของการศึกษานี้ รวมทั้งผลลัพธ์ จะเป็นความลับและมิให้นักวิจัยที่จะสามารถเข้าถึงข้อมูลเกี่ยวกับผู้เข้าร่วมวิจัย การนำเสนอจะใช้เพียงนามสมมุติ ไม่ใช้ชื่อแท้จริง.

ข้อจำกัดของข้อมูลในการเข้าร่วมการวิจัยได้หรือไม่

ท่านสามารถแจ้งข้อจำกัดในการขอข้อมูลและการมีส่วนร่วมให้ข้อมูล และสามารถถอนตัวจากการเข้าร่วมวิจัยได้ทุกเมื่อตลอดเวลา โดยประกาศจากการให้เหตุผลใดๆ และการถอนตัวจากการเป็นผู้เข้าร่วมวิจัย ไม่ว่าจะมีผลหรือไม่ต่อการเข้าร่วมบริการทางแพทย์ และไม่ส่งผลกระทบต่อความมั่นคงระหว่างท่าน และเจ้าหน้าที่ทางการแพทย์ สถานที่ และบุคคลอื่นๆ ของสถานีอนามัยปากคลอง และโรงพยาบาลระนอง.
ข้าพเจ้าสามารถบอกคนอื่นเกี่ยวกับการศึกษาได้หรือไม่
ท่านสามารถบอกคนอื่นเกี่ยวกับการศึกษานี้ได้ โดยการติดต่อกับท่านนักวิจัย หากคุณต้องการแสดงความคิดเห็นหรือแลกเปลี่ยน หรือต้องการข้อมูลเพิ่มเติม จากโครงการวิจัยนี้

กรณีที่ข้าพเจ้าต้องการทราบข้อมูลเพิ่มเติม ต้องทำอย่างไร
เมื่อท่านได้อ่านข้อมูลเอกสารนี้ นักศึกษาปริญญาเอก นางฐิตารีย์ พันธุ์วิชาติกุล จะชี้แจงข้อมูลที่เกี่ยวกับข้อซักถามและตอบคำถามท่านทุกประการ หากท่านต้องการทราบข้อมูลเพิ่มเติมใดๆ กรุณาติดต่อด้วยประการใดๆฐานะการศึกษา ท่านนักวิจัย ได้ติดต่อผ่านอีเมล์ 17867678@student.uws.edu.au หรือเบอร์โทรศัพท์ (+61) 0416147045 (ชิไน) หรือ (+66) 0897271099 (ในประเทศไทย) หรือ หากท่านต้องการติดต่อกับอาจารย์ที่ปรึกษาของนางฐิตารีย์ คือ สาสรทางวิทยา ดร. เวอร์จิเนียร์สมิดร์ อีเมล์ v.schmied@uws.edu.au หรือเบอร์ (+61) 0296859505 หรือ 0430242140 (ชิไน)

กรณีที่ข้าพเจ้าต้องการร้องเรียน ต้องทำอย่างไร
การศึกษานี้ ภายใต้การสนับสนุนจากมหาวิทยาลัยไวสเทรินิ้น ประเทศออสเตรเลีย และคณะกรรมการจริยธรรมการวิจัยในมนุษย์ และสำนักงาน การบริการด้านสุขภาพของรัฐนิวเซาท์เวิลส์ สามารถติดต่อได้ที่เบอร์ (+61) 24736 0229 หรืออีเมล์ humanethics@uws.edu.au

หากท่านมีข้อสงสัย ข้อถกเถียงการวิจัยนี้ ท่านสามารถติดต่อได้ที่สำนักงาน ด้านบริการงานวิจัย เบอร์ (+61) 24736 0229 หรืออีเมล์ humanethics@uws.edu.au

ทุกประเด็น ที่ท่านต้องการทราบ การให้ความชัดเจนและความเข้าใจและการตรวจสอบ การขอทราบผลลัพธ์ทั้งหมดนี้ หากท่านเห็นว่าต้องการมีส่วนร่วมในการศึกษานี้ ท่านจะถูกขอให้ลงนามตอบรับข้อตกลงการวิจัย โดยแบบฟอร์มตอบรับการเข้าร่วมการวิจัยสามารถขอได้จากนักวิจัย และจะมีการเก็บแบบตอบรับการเข้าร่วมวิจัยโดยนักวิจัยที่ให้ข้อมูลท่าน
แบบฟอร์มตอบรับเข้าร่วมวิจัย

ชื่อวิจัย: การวิจัยแบบชาติพันธุ์ธุรกรรมการเข้าใช้บริการและการดูแลสุขภาพมาตราและทารก ตามการรับรู้จากประสบการณ์ของหญิงตั้งครรภ์พม่า ในภาคใต้ของประเทศไทย

ข้าพเจ้า .......................... อินเดียร่วมให้ข้อมูลในการวิจัยในนี้ ขอวิจัย
“การวิจัยแบบชาติพันธุ์ธุรกรรมการ เข้าใช้บริการและการดูแลสุขภาพมาตราและทารก ตามการรับรู้จากประสบการณ์ของหญิงตั้งครรภ์พม่า ในภาคใต้ของประเทศไทย”

ลายมือชื่อ ..........................

ชื่อ - นามสกุล ..........................

วันที่ ................................

กรุณาส่งคืน ตามที่อยู่นี้: คณะพยาบาลศาสตร์ มหาวิทยาลัยราชภัฏสุราษฎร์ธานี 272 ถ. สุราษ-นาสาร ต. ขุนทะเล อ. เมือง จ. สุราษฎร์ธานี 84100

การศึกษาครั้งนี้รับการอนุมัติโดย มหาวิทยาลัยเวสเทรินซิดนีย์ และคณะกรรมการจริยธรรมการวิจัยในมนุษย์ ได้รับการอนุมัติเลขที่ H11099
Appendix G: Information Sheet for Nurse-midwives and the Other Health Staff (in English)

Information sheet for Nurse-midwives and the other health staff (in English)

Human Research Ethics Committee
Office of Research Services

Participant Information Sheet (Medical)

Project Title: Burmese women’s experience of maternity care in the south of Thailand: an ethnographic study.

Who is carrying out the study?

You are invited to participate in a study conducted by Mrs Titaree Phanwichatkul, a doctoral student from the School of Nursing and Midwifery, at the University of Western Sydney. Mrs Phanwichatkul is being supervised by Professor Virginia Schmied, University of Western Sydney, Dr Elaine Burns, University of Western Sydney and Professor Pranee Liamputtong, La trobe University.

What is the study about?

The purpose of the study is to examine Burmese women’s experience of maternity care in southern Thailand. The study objectives are to:

1. describe Burmese women’s perception of becoming a mother and their health care and support needs in pregnancy, birth, and postpartum.
2. describe Burmese women’s perception of the quality of the care received and experience of interactions with health workers.
3. describe health providers’ and community workers’ perception of the needs of Burmese women and their experience of providing maternity care to Burmese women.

**What does the study involve?**

We are inviting you to participate in this study because you are a midwife, nurse, village health worker or other staff member providing care to women in pregnancy or after birth in Ranong Hospital or at Pak-Klong Clinic. If you agree to participate you will be asked permission for the researcher, Mrs Titaree Phanwichatkul to observe you while you are providing care for, or interacting with Burmese women either in the antenatal clinic or the postnatal ward. The researcher will be present during the clinic appointments that you conduct with pregnant women or the interactions you have with women on the postnatal ward. These women will also have agreed to be a study participant. The researcher will also be present in the waiting room area of the clinic or in the postnatal ward observing general activities and interactions. The researcher will also invite you to participate in a one-to-one interview. In this interview you will be asked to talk about your experience of providing care to Burmese women.

**How much time will the study take?**

The observations of your interactions with Burmese women will be the same length of time that you would normally spend with women, that is between 15 to 30 minutes. The one-to-one interviews will be approximately 30 to 60 minutes. The general observations of the antenatal clinic and postnatal ward will be conducted over a few days in each setting.

**Will the study benefit me?**

There may not be any specific benefits for you as a health worker. However often research participants indicate that telling their story and experience to a kind and sensitive researcher has benefits for them. The study will give you the opportunity to talk about things that are important to you in the work you do. This study will also
give Burmese women the opportunity to talk with the researcher and translator about issues that are important to them or are concerning them. This may have some psychological benefits.

**Will the study have any risks?**

It is anticipated that the risk to participants is minimal. The main risk is that you may feel uncomfortable being observed by the researcher and you may also feel discomfort talking about your personal work experiences. If you do become distressed during any of the data collection activities, you will be provided with immediate support and offered the temporary suspension of the interview or complete cessation of their participation and offered referral to counselling services at Ranong Hospital.

**How is this study being paid for?**

The research student, Mrs Titaree Phanwichatkul will receive some funding from the School of Nursing and Midwifery at the University of Western Sydney.

Will anyone else know the results? How will the results be disseminated?

All aspects of the study, including results, will be confidential and only the researchers will have access to information on participants.

Can I withdraw from the study?

Participation is entirely voluntary: you are not obliged to participate and – if you do participate – you can withdraw at any time without giving any reason. Whatever your decision, it will not affect your employment or relationship with the Ranong health service or Pak-Klong Clinic.

Can I tell other people about the study?

Yes, you can tell other people about the study by providing them with the chief investigator’s contact details. They can contact the chief investigator to discuss their participation in the research project and obtain an information sheet.
What if I require further information?

When you have read this information, Mrs Titaree Phanwichatkul will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Mrs Titaree Phanwichatkul at 17867678@student.uws.edu.au, or on (+61) 0416147045 (Sydney) or (+66) 0897271099 (Thailand) or contact Titaree's supervisor, Professor Virginia Schmied at v.schmied@uws.edu.au, or (+61) 0296859505 or 0430242140 (Sydney).

What if I have a complaint?

This study has been approved by the University of Western Sydney Human Research Ethics Committee.

The Approval number is [H11099]

If you have any complaints or reservations about the ethical conduct of this research, you may contact the Ethics Committee through the Office of Research Services on Tel +61 2 4736 0229 Fax +61 2 4736 0013 or email humanethigs@uws.edu.au.

Any issues you raise will be treated in confidence and investigated fully, and you will be informed of the outcome. If you agree to participate in this study, you may be asked to sign the Participant Consent Form.

The information sheet is for the participant to keep and the consent form is retained by the researcher.
ชื่อวิจัย: การวิจัยแบบชาติพันธุ์วิจารณ์ การเข้าใช้บริการและการดูแลสุขภาพมารดาและทารกตามการรับรู้จากประสบการณ์ของหญิงตั้งครรภ์พม่าในภาคใต้ของประเทศไทย

ใครคือผู้ดำเนินการวิจัย

ท่านได้รับเชิญให้เข้าร่วมการวิจัย โดย นางฐิตารีย์ พันธุ์วิชาติกุล นักศึกษาระดับปริญญาเอก สาขาวิชาพยาบาลและคุณค้รภ์ คณะพยาบาลศาสตร์และคุณค้รภ์ มหาวิทยาลัยออสเตรเลีย ซิดนีย์ และนาง ฐิตารีย์ ดำเนินการวิจัยโดยมีอาจารย์ที่ปรึกษา ศาสตราจารย์ ดร. เวอจิเนียร์ สมิทด์, ดร. อีเลน เบรนส์ จากมหาวิทยาลัยซิดนีย์ และศาสตราจารย์ ดร. ปราณี เหลี่ยมพุฒทอง จากมหาวิทยาลัย ลาโธบ ประเทศออสเตรเลีย

ศึกษาเกี่ยวกับอะไร

จุดมุ่งหมายของการศึกษาคือ การสำรวจประสบการณ์ของหญิงตั้งครรภ์พม่าในการใช้บริการเกี่ยวกับการพยาบาลการคลอดและดูแลสุขภาพทารกในสถาบันบริการสุขภาพภาคใต้ของประเทศไทย โดยมีวัตถุประสงค์ดังนี้

5. เพื่อพรรณนาความเข้าใจ ความรู้สึกของหญิงตั้งครรภ์ที่กำลังคลอดภายในมารดา และเพื่อพรรณนาประสบการณ์ของหญิงตั้งครรภ์พม่าในการใช้บริการทางสุขภาพ การ...
สนับสนุนและการตอบ สนองต่อความต้องการจากเจ้าหน้าที่ในระหว่างการตั้งครรภ์ การ
คลอด การภายหลังการคลอด
6. เพือ่ อธิบายประสบการณ์ของหญิงตั้งครรภ์พม่าเกี่ยวกับคุณภาพการใช้บริ การที่ได้รับการ
บริ การจากเจ้าหน้าที่ดา้ นสุขภาพ
7. เพื่อ พรรณนาความเข้า ใจของบุ ค คลากรผู ้ใ ห้บ ริ ก ารทางสุ ข ภาพ รวมถึ ง เจ้า หน้า ที่ ที่
เกี่ยวข้องในชุมชน ตามการรับรู ้จากประสบการณ์ที่ได้ให้บริ การ ช่วยเหลือ และตอบสนอง
ความต้องการ ด้านสุขภาพมารดาและทารกแก่หญิงตั้งครรภ์พม่า
การศึกษาครั้งนี้เกี่ยวข้ องกับ
ท่ า นเป็ นบุ ค คลที่ มี ค วามส าคัญ ในการให้ ข ้อ มู ล การศึ ก ษาครั้ งนี้ เนื่ อ งจากท่ า นเป็ น
บุ ค คลากรทางการ แพทย์ พยาบาล เจ้า หน้า ที่ ส าธารณสุ ข และเจ้า หน้า ที่ ท างสุ ข ภาพอื่ น ๆ ที่
ให้บริ การแก่หญิงชาวพม่า ที่ต้ งั ครรภ์และต้องการคลอดบุตรในสถานบริ การทางสุ ขภาพที่สถานี
อนามัยปากคลอง และโรงพยาบาล ระนองกรณี ที่ท่านให้ความร่ วมมือเข้าร่ วมการวิจยั ท่านจะถูก
ขอให้ลงนาม เพื่อ ตอบรับการเข้าร่ วมการวิจยั จากนางฐิ ตารี ย ์ พันธุ์วิชาติกุล ผูท้ ี่ขอเก็บข้อ มู ล
สังเกตการให้บริ การทางสุ ขภาพ การมีปฏิสัมพันธ์ระหว่าง หญิงพม่าและเจ้าหน้าที่ระหว่างที่ท่าน
ให้บริ การในแผนกฝากครรภ์ และการให้บริ การ ในแผนกหลังคลอด ที่โรงพยาบาลระนอง ซึ่ ง
นักวิจยั จะขอเก็บข้อมูลในระหว่างที่ท่านปฏิบตั ิหน้าที่ เช่น การให้ขอ้ มูลการ นัดหมายครั้งต่อไปแก่
หญิ ง พม่ า ผูว้ ิจ ัย จะเน้น สัง เกต กิ จ กรรม เช่ น การพูด คุ ย ตอบข้อ ซักถาม ท่ า ทาง กริ ย า ขณะมี
ปฏิสัมพันธ์ซ่ ึ งกันและกันนักวิจยั จะมีการจดบันทึกข้อมูลบางส่ วน ซึ่ งหญิงพม่าจะถูกขออนุ ญาต
ให้เข้าร่ วมการวิจยั ด้วยเช่นกัน นอกจากนี้ นักวิจยั จะขอใช้เวลาช่ วงที่หญิงพม่ารอรับบริ การทาง
สุ ขภาพ หรื อ ในแผนกหลังคลอด เพื่อ สังเกตข้อมูลทางกิ จกรรมและการมีปฏิสัมพันธ์อื่นๆ โดย
นักวิจยั อาจจะขอท่านเข้าร่ วมเป็ นผูใ้ ห้สัมภาษณ์รายบุคคล เกี่ ยวกับประสบการณ์ที่ท่านทางาน
ให้บริ การ การดูแลทางสุขภาพแก่หญิงพม่า
เป็ นระยะเวลานานเท่ าใดในการศึกษาข้ อมูล
การติดตามสังเกต ปฏิสัมพันธ์ระหว่างหญิงพม่ากับเจ้าหน้าที่ทางการแพทย์ จะใช้เวลา
เหมือน เช่นท่านให้บริ การในแต่ละครั้งตามการนัดหมายในการฝากครรภ์ หรื อการให้บริ การใน
แผนกหลังคลอด ประมาณ 15 – 30 นาที ส่วนการสัมภาษณ์รายบุคคล จะใช้เวลาประมาณ 30 – 60
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ท่านจะได้รับประโยชน์ใดบ้างในการศึกษานี้

ท่านอาจจะไม่ได้รับประโยชน์พิเศษใด ๆ โดยตรงค่อนท่าน เนื่องจากท่านเป็นเจ้าหน้าที่ทางการแพทย์อย่างไรก็ตาม การวิจัยอาจมีส่วนช่วยให้ท่านเห็นถึง การบอกเล่าประสบการณ์ด้วยความรู้สึกอย่างมีคุณค่า ซึ่งอาจจะช่วยให้ท่านได้มีโอกาสที่ดี นอกจากนี้ การศึกษานี้มีประโยชน์และสิ่งที่ท่านได้รับจะเป็นประโยชน์ที่มีคุณค่าต่อหญิงพม่าผู้รับบริการด้วย

การศึกษาครั้งนี้ ผู้วิจัยจะให้ข้อมูลแก่หญิงพม่าโดยใช้ล่ามแปลภาษาพม่า-ไทย เกี่ยวกับประเด็นต่างๆ ที่มีความสำคัญหรือเป็นความกังวลต่อหญิงพม่า ดังนั้นการศึกษานี้อาจเป็นประโยชน์ทางจิตวิทยา ในการบอกเล่าประสบการณ์ของตนเอง

จะมีความเสี่ยงใดบ้างที่จะได้รับในการศึกษา

ความเสี่ยงที่อาจเกิดขึ้นมีเพียงเล็กน้อยเท่านั้น ประกอบด้วยการบอกเล่าประสบการณ์ของตนเองท่านอาจรู้สึกอัดเสียไม่สบายใจ เมื่อมีนักวิจัยสังเกตปฏิสัมพันธ์ระหว่างท่านและหญิงพม่าท่านอาจรู้สึกอัดเสียเมื่อมีนักวิจัยสังเกตปฏิสัมพันธ์ระหว่างท่านและหญิงพม่า

ท่านสามารถแจ้งขอให้ยุติการเข้าร่วมการศึกษาได้ทันที

นางฐิตารีย์ พันธุ์วิชาติกุล นักศึกษาปริญญาเอก จะได้รับเงินสนับสนุนจากคณะพยาบาลศาสตร์ มหาวิทยาลัยเวิสเทริน ซิดนีย์ ประเทศออสเตรเลีย
ใครบ้างที่จะทราบผลการศึกษานี้ และผลการศึกษาจะถูกเผยแพร่ยังไง

ข้อมูลที่ได้ทุกประสบการของผลการศึกษานี้ รวมทั้งผลลัพธ์ จะเป็นความลับและมีเพียงนักวิจัยที่จะสามารถเข้าถึงข้อมูลก็ต่อเมื่อผู้เข้าร่วมวิจัยผลการศึกษาในครั้งนี้จะถูกนำเสนอและเผยแพร่ทางวิชาการ ประเทศไทย ออสเตรเลีย และอื่นๆ ตามความเหมาะสม ผู้วิจัยจะต้องมั่นใจว่าการศึกษาทางวิชาการ จะไม่มีการเปิดเผยข้อมูลของท่านรวมทั้งหน่วยงานของท่าน

ข้อจำกัดของอัตราการเข้าร่วมวิจัยได้หรือไม่

ท่านสามารถแจ้งถึงการเข้าร่วมการวิจัยได้ทุกเมื่อ การข้อมูลที่ได้ทุกประสบการของผลการศึกษาในครั้งนี้จะถูกนำเสนอและเผยแพร่ทางวิชาการ ประเทศไทย ออสเตรเลีย และอื่นๆ ตามความเหมาะสม ผู้วิจัยจะต้องมั่นใจว่าการศึกษาทางวิชาการ จะไม่มีการเปิดเผยข้อมูลของท่านรวมทั้งหน่วยงานของท่าน

ข้อจำกัดของเอกสารข้อมูลเกี่ยวกับการศึกษาได้หรือไม่

ท่านสามารถขอทราบข้อมูลเกี่ยวกับการศึกษาได้โดยการติดต่อเจ้าหน้าที่ ผู้วิจัย หากต้องการแสดงความคิดเห็นหรือแลกเปลี่ยน หรือต้องการข้อมูลเพิ่มเติม จากโครงการวิจัยนี้

กรณีที่ต้องการทราบข้อมูลเพิ่มเติม ต้องทำอย่างไร

เมื่อท่านได้อ่านข้อมูลเอกสารนี้ นักศึกษาปริญญาเอก นางฐิตารีย์ พันธุ์วิชานิกุล จะอธิบายเกี่ยวกับข้อขัดเกลาและตอบคำถามท่านทุกประสบการ หากท่านต้องการทราบข้อมูลเพิ่มเติมใดๆ กรุณาติดต่อ นางฐิตารีย์ พันธุ์วิชานิกุล ได้ตลอดเวลา อีเมล์ 17867678@student.uws.edu.au หรือเบอร์โทรศัพท์ (+61) 0416147045 (ซิดนีย์) หรือ (+66) 0897271099 (ในประเทศไทย) หรือ หากต้องการติดต่อกับอาจารย์ที่ปรึกษาของนางฐิตารีย์ คือ ศาสตราจารย์ ดร. เวอร์จิเนียร์ สมิตร์ อีเมล์ v.schmied@uws.edu.au หรือ (+61) 0296859505 หรือ 0430242140 (ซิดนีย์)
กรณีที่ข้าพเจ้าต้องการร้องเรียน ต้องทำอย่างไร

การศึกษาครั้งนี้ ภายใต้การสนับสนุนจากมหาวิทยาลัยเวิสเทริน ซิดนีย์ ประเทศออสเตรเลีย และคณะกรรมการจริยธรรมการวิจัยในมนุษย์ และสำนักงาน การบริการด้านสุขภาพของรัฐนิวเซาท์เวิล สามารถติดต่อได้ที่เบอร์ (+61) 24736 0229 หรือ อีเมล์ humanethics@uws.edu.au

หากท่านมีข้อสงสัย ขออภัยในความผิดพลาด ณ ฐานะจริยธรรมการวิจัยนี้ ท่านสามารถติดต่อได้ที่ สำนักงาน ด้านบริการงานวิจัย เบอร์ (+61) 24736 0229 หรือ อีเมล์ humanethics@uws.edu.au

ทุกประเด็น ที่ท่านต้องการทราบ การให้ความชัดเจนในความเข้าใจและการตรวจสอบ การขอทราบผลลัพธ์ ทั้งหมดนี้ หากท่านเห็นด้วยสามารถติดต่อกับนักวิจัยที่ให้ข้อมูลท่านได้ รวมถึงการเข้าร่วมวิจัยโดยนักวิจัยที่ให้ข้อมูลท่าน
Appendix I: Recruitment flyer for women

Recruitment flyer for women

Burmese women’s experiences of maternity care in Ranong Thailand

A study being conducted by TITAREE Phanwichatkul

Hi, I am Titaree

❖ I am a nurse and I am studying the experiences of Burmese women receiving maternity care in Ranong.

❖ I would be very interested to hear your story about the care you have received at the clinic or hospital?

❖ How do you feel about the interactions with health providers?

❖ Do you have any suggestions for how antenatal care can be improved?

If you would like to participate in this study, please ask the staff at the clinic to introduce you to Titaree.
Appendix J: Observations tools

Observations: Activities and communication during the interactions in the antenatal care and postnatal ward

<table>
<thead>
<tr>
<th>Interacting</th>
<th>Nurse/Midwife/Health staff</th>
<th>Yes/No</th>
<th>Client’s women</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to antenatal appointment</td>
<td>Not introduced</td>
<td></td>
<td>Easily engage with midwife</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Introduced self</td>
<td></td>
<td>Appears to feel comfortable in interaction (e.g., talks about feelings as well as health issues)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Rationale and purpose of visit explained</td>
<td></td>
<td>Open and talkative or withdrawn or unresponsive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Privacy discussed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Responds to woman’s questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care services</td>
<td>Answering the woman’s questions</td>
<td></td>
<td>Appears preoccupied</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Recommended health exercise, care, diet food, and other useful information in pregnancy</td>
<td></td>
<td>Appears interested or has attended education sessions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gives support for woman basic need</td>
<td></td>
<td>Not clear about questions or what is required- tangential responses</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identifies any health risks, discusses and refers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Style of interaction and non-verbal communication</td>
<td>Eye contact</td>
<td></td>
<td>Eye contact</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Use of jargon Posture, movements and gestures</td>
<td></td>
<td>Use of jargon Posture, movements and gestures</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facial expressions: smiling or frowning Voice pitch and tone, and intensity and fluency of speech</td>
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<td></td>
</tr>
<tr>
<td></td>
<td>Autonomic: breathing changes, blushing and tremor</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Debrief or summary at end of appointment</td>
<td>No debriefing offered</td>
<td></td>
<td>Woman responds to summary of needs or situation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Encouragement or counselling offered, or woman asked if she is okay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Timing of sensitive questions, affirmative answers and end points</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes
### Observational dimensions on Spradley guide

<table>
<thead>
<tr>
<th>Maternity unit</th>
<th>ANC PHC</th>
<th>ANC in hospital</th>
<th>Postnatal ward</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time commenced</strong></td>
<td>Health staff</td>
<td>Client’s women</td>
<td>Children</td>
</tr>
<tr>
<td>People present during the observation?</td>
<td>Their husbands</td>
<td>Visitors</td>
<td>Other</td>
</tr>
<tr>
<td><strong>The layout of the clinic</strong></td>
<td>T figure</td>
<td>L figure</td>
<td>Circle figure</td>
</tr>
<tr>
<td>Ward environments</td>
<td>Single unit</td>
<td>Mix-management</td>
<td>Other</td>
</tr>
<tr>
<td><strong>Contextual features</strong></td>
<td>Normal routine</td>
<td>Busy at certain times</td>
<td>Very busy all the times</td>
</tr>
<tr>
<td>Consult room</td>
<td></td>
<td>Nurse’ station</td>
<td>Separate room</td>
</tr>
<tr>
<td>Medical room</td>
<td></td>
<td>Other</td>
<td></td>
</tr>
<tr>
<td><strong>Seating arrangement</strong></td>
<td>Suitable</td>
<td></td>
<td>None</td>
</tr>
<tr>
<td>Limited</td>
<td></td>
<td>Unsuitable</td>
<td>Other</td>
</tr>
<tr>
<td>Appropriate for the setting</td>
<td></td>
<td>Relevant and current information</td>
<td>Not relevant or not current information</td>
</tr>
<tr>
<td>Giving information health guide</td>
<td></td>
<td>Staff profiles</td>
<td>None</td>
</tr>
<tr>
<td>Thai language information only</td>
<td></td>
<td>Both languages information</td>
<td>Other</td>
</tr>
<tr>
<td><strong>Signs on the wall</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Toilet</strong></td>
<td>Suitable</td>
<td>Good</td>
<td>Very good</td>
</tr>
<tr>
<td>Limited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appropriate for the setting</td>
<td>Very good</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Giving information health guide</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>The waiting area</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suitable</td>
<td>Good</td>
<td>Very good</td>
<td></td>
</tr>
<tr>
<td>Limited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Easily accessible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Some space children to play</strong></td>
<td>Limited</td>
<td>Suitable</td>
<td>Unsuitable</td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Who attends with Burmese women</strong></td>
<td>Husband</td>
<td>Mother</td>
<td>Mother - in - law</td>
</tr>
<tr>
<td>Friend</td>
<td>Sibling</td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

**Notes:**