Original Article

Barriers to Healthcare Access and Coping Mechanisms among Sub-Saharan African Migrants living in Bangkok, Thailand: A Qualitative Study

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INTRODUCTION

Access to health care services among migrant populations is a major public health concern. Migrants' health profiles, values and beliefs may differ from those of the host population and present a potential to increased vulnerability to ill health and barriers in accessing health services.[1] In addition, migrants may travel with or may acquire diseases or conditions while travelling or while staying in the host country, that present need for regular healthcare services.[2] Migrants often do not consider or prepare for potential health challenges in host countries.[1] According to the UN's *International Migration Report*, Asia received 4.4 million migrants from Africa in 2013 alone, most of which were from Sub-Saharan Africa (SSA) with Thailand alone receiving an estimated 100 000.[3] Data from Thailand's Immigration Bureau indicate that most SSA migrants in Thailand come from Nigeria, Kenya, South Africa, Ghana, Mali, Zimbabwe, and Tanzania.[4]

In April 2015, the Ministry of Public Health in Thailand introduced measures targeted at improving access to healthcare services among migrant workers.[5] These developments allow migrant workers from Myanmar, Laos, Cambodia and Vietnam to buy healthcare insurance which covers first health-checks, chronic diseases, surgeries, and even high cost anti-retroviral drugs, benefits which are similar to the Thai nationals. Migrants from other countries can only buy healthcare insurance which covers free medical treatments, vaccinations and first health-checks.

While language is a key determinant to healthcare access, especially for migrants, only premium private sector health services use English. Migrants from SSA often have different cultural values, health seeking behaviour and religious beliefs from the Thai who are a predominantly Buddhist society and this poses challenges.

Given the increasing trend of SSA migrants to new Asian destinations particularly Thailand, the study hypothesised that SSA migrants face challenges in accessing healthcare services in Bangkok, and that they rely on certain coping strategies in dealing deal with those barriers. No research on barriers associated with access to healthcare and strategies in coping with these barriers among SSA migrants exists in Thailand. This study explored barriers to access healthcare services and the common coping strategies by SSA migrants in Bangkok, Thailand.

METHODS

We employed a qualitative design to gain insights on barriers to healthcare access and coping mechanisms among SSA migrants in Bangkok. Seventy consenting documented migrants of SSA origin residing in Bangkok aged 18 years and above were included in seven focus group discussions (FGDs), each with ten participants. The number of FGDs conducted in this study was determined by research objectives, study population characteristics, and data saturation, that is, collecting data until no new insights are emerging.

Key words: *Access; healthcare utilization; barriers; sub-Saharan African; migrant; Thailand*

Sampling method and data collection

Before a study sample could be selected, the study population was stratified into different strata consisting of all characteristics of interest, *in terms of age, sex, country of origin, employment, educational level and duration of stay in Thailand. Sampling locations were identified from a wide range of sampling clusters, which are churches, universities, market places, common day and night bar centres and residential communities in Bangkok, from which study participants were purposively selected targeting to include both documented and undocumented migrants.* Data were collected by fluent English speakers trained in qualitative research methodologies. Seven FGDs, with ten participants in each, which lasted for forty-five minutes per session, were conducted using an FGD guide. Study participants in each focus group discussion were different in terms of such characteristics as country of origin and duration of stay in Bangkok. However, since they shared a common identity relevant to the discussion, such differences were not expected to impact negatively on group member disclosure. All the FGD responses were audio-recorded and transcribed verbatim into a word processing programme.

Data management and analyses

Data were stored in form of audio-recordings (transcripts), FGD notes, debriefing notes and session summaries. After each FGD session, audiotapes were transcribed verbatim into a word processing programme. Transcripts were marked and coded according to various areas of interest. Results from the FGD were combined onto a logbook consisting of a table that enabled data to be organised according to topics of interest before analysis.

Data were thematically analysed. This involved identifying, examining and recording themes (patterns) within the data. According to Braun & Clarke, thematic analysis allows established and meaningful patterns to be created, through coding the qualitative data in six phases which are; (1) familiarization with the data, (2) generating initial codes, (3) searching for themes among codes, (4) reviewing themes, (5) defining and naming themes, and (6) producing a final report.[6] Findings were presented according to emerging themes and excerpts were used to illustrate expressed thoughts, emotions and experiences by participants.

Ethical considerations

Approval to conduct the study was sought from the Thammasat University Research Ethics Committee (TU-REC). Participation in the study was on voluntary basis. Written informed consent was obtained from all participants. Confidentiality was ensured through removal of personal identifiers after entry in the electronic database, use of ID numbers, password protected storage of electronic participant logbook, transcripts and database. Study participants were informed that the information they gave was confidential and only used for academic purposes. Each FGD participant was given an incentive of 50 Thai baht for participating, and transport fares for those who lived far.

RESULTS

Demographic characteristics of respondents are summarized in Table 1.

Table1: Socio-demographic data for FGD participants n=70

DEMOGRAPHIC PROFILE	Frequency (n = 70)
Country of Origin:	
Zimbabwe	10
Nigeria	22
Tanzania	10
The Gambia	1
South Africa	2
Kenya	4
Ethiopia	5
Mali	7
Botswana	3
Ghana	6
Sex:	
Male	50
Female	20
Age:	
20 – 29 yrs.	38
30 – 39 yrs.	32
40 – 49 yrs.	-
50 – 59yrs.	-
60 and above	-
Religion:	
Christian	40
Muslim	30
Level of Education	
Tertiary	70
Employment status	
Formal	40
Unemployed	10
Self-employed	20
Marital status	
Single	40
Married	30
Duration of stay in Thailand	
<1year	38
1-5 years	28
>5 years	4
Reason for migrating to Thailand	
Study	32
Employment	8
Business	30

Table 2: Focus group Discussion composition by participant characteristics, n= 70

	Number	Sex	Religion	Marital Status	Age group, number per group	Country of Origin	Duration of stay in Bangkok	Level of education
FG1	10	Female	Christian	Married	30 - 39 (10)	Nigeria (3) Zimbabwe (3) Kenya (4)	< 1 year (10)	Tertiary
FG2	10	Male	Christian	Married	30 - 39 (10)	Nigeria (5) Tanzania (3) Ghana (2)	< 1 year (7) 1 – 5 years (3)	
FG3	10	Female	Christian	Single	20 - 29 (8) 30 - 39 (2)	The Gambia (1) Botswana (3) Zimbabwe (2) Ethiopia (2) South Africa (2)	1 – 5 years (8) >5 years (2)	
FG4	10	Male	Muslim	Single	20 - 29 (10)	Nigeria (4) Mali (3) Tanzania (3)	<1 year (5) 1 – 5 years (5)	

Following thematic data analysis, the following nine themes emerged from the discussion which included:

1. *Lack of/challenges with health insurance, and cost of services*

Health insurance restrictions appeared to be a barrier to access healthcare services among the participants. Most participants on health insurance schemes expressed disappointments on lack of information regarding the health services and type of facilities covered by the health insurance scheme. Participants were reportedly asked to pay cash for certain services as explained in the excerpt below;

'You're saying if you have [health] insurance it's easy to access healthcare services? They just put the card aside and ask for money! What about if I didn't have the money'? ***FZS-2***

There was also a general consensus that access to type of healthcare was overruled by financial costs and other considerations rather than by personal preferences.

'The issue here is, I can't go to these public hospitals even if they are cheap because it seems they are specifically for (locals), they won't understand me there. I know I won't face many challenges if I go to [premium-] private hospitals…but again they are too expensive…,' ***MZS-***

2. Language barriers or communication problems

Inability to communicate and describe symptoms among migrants and inadequacy of second language proficiency by providers emerged to be a key common barrier to access healthcare services. Migrants at times misunderstood, misinterpreted and failed to read the forms which were written in Thai language and the health care workers would at times fail to understand immigrants and to give render appropriate care.

'I went with my girlfriend to test for HIV and told them I wanted an HIV test. Then they misunderstood me and thought I was an HIV patient seeking ARVs and they referred me to some office for ART registration…,' ***MZE-8***

3. *Information and language challenges in getting to and from facilities*

While getting to and from healthcare facilities is a key factor determining access to healthcare services, many challenges concerning this issue resurfaced from the discussions with the FGD participants. Common challenges arising from the discussions included lack of information about available health facilities/not knowing where to go and challenges communicating destinations with taxi drivers.

'I don't even have information about healthcare facilities around my area... If you tell him (taxi driver) to take you to a hospital and he takes you to a church or hotel.' ***FSLE-7***

4. *Functional barriers (Health system and health providers)*

Participants encountered functional barriers which were centred on the functioning of the health system which included long waiting times. This challenge is exemplified in the following excerpt:

'…and with the long queues …the waiting time becomes too long for someone who is either seriously ill or requiring emergency attention.' ***MSAE-5***

5. *Racism/discrimination/stigma*

Most participants gave examples of their personal experiences of encountering racism and being discriminated against. Thai healthcare workers were reportedly giving less priority to Africans compared to other nationals.

'When you go to these [health] facilities here [in Bangkok], you know there is this way people look at you. U-umm…! …. They don't treat us [Africans] the same as whites at all…it's not only language which matters to access [healthcare] services, but also your origin.' ***MNB-10***

6. ***Climates of fear and mistrust***

The words "fear and mistrust" dominated a significant part of issues arising from the FGD sessions with the SSA migrant participants. Participants exhibited fear of being

misunderstood, being misdiagnosed, mistreated, being given wrong drugs and being overcharged.

*‘ Imagine, after a long time of struggling to understand what you will be telling them, they [healthcare workers] finally give you medication to take…they might have failed to understand me and therefore wrongly diagnosed me giving me a wrong treatment.' **FMS-9***

7. *Differences in perceptions on health, illness & healing*

Other than biomedical care, it emerged that participants shared a common belief that faith healing and traditional medicine play an important role in health care. These beliefs affected the health seeking behaviour of migrants. Thai health care providers had certain prejudices about African illnesses as shown by the following excerpt;

*The last time I went to the hospital, the two doctors that came were like “O-ooh! Do you come from Africa?” Their mind-set was thinking of Ebola…you end up feeling uncomfortable consulting such people who have wrong beliefs and perceptions about your health and culture.' **FKE-4***

***8.** Bad previous experiences as a result of other barriers*

Participants generally agreed that their own or colleagues unpleasant experiences in accessing Thai healthcare services were a discouragement and a facilitator for opting for alternative health care.

*'These bad experiences make you hesitant to access healthcare services in Bangkok again, and you tend to seek other options to avoid facing the encountered challenges.' **MZE-9***

***9.** Difficulties in accessing Sexual and Reproductive Health (SRH) products and services*

Most participants agreed that SRH issues were too private to share with everyone especially in the African context. The major complaint raised was infringement on privacy and confidentiality due to translation and interpretation of their SRH problems which normally attracted a large crowd of healthcare workers to assist during consultation at most public Thai healthcare facilities. Male participants narrated the difficulties they faced in trying to access condoms in healthcare facilities and other private outlets, a situation they said was very different to Africa. This is illustrated by the two excerpts below:

*'I don't feel comfortable going to these public hospitals and consult for sexually related health problems… to have everyone know about my sexual health issues.' **MZAU-6***

*‘In my country, you know condoms are widely available everywhere. Here I couldn't see any [condom]. These are private issues you do not feel comfortable to request. I finally used the expired one which had remained in my bag…,' **MNB-10***

Coping Mechanisms

Findings showed that participants depended on various coping mechanisms in dealing with the barriers to healthcare services they faced. *Common coping mechanisms mentioned by participants included; adoption of healthy behaviours, learning the Thai language, seeking assistance from Thai nationals, self-diagnosis and treatment, prayer and delaying health seeking till one returned to their country of origin.*

Adoption of healthy behaviours

There were indications that barriers to access healthcare services faced by participants could reinforce adoption of healthy behaviours so as to reduce chances of being sick. Given the various types of barriers participants had mentioned, there was a general consensus that avoidance of risky behaviours was key.

'I avoid getting ill while I am still here [in Bangkok], lest I face all these challenges that we have been talking about. I avoid risky sexual behaviours, maintain a good diet, seek internet information about common local diseases, take vaccinations and maintain good personal hygiene.' FME-7

Adaptation

Participants acknowledged the need to learn the basic Thai language to be able to effectively communicate with the healthcare workers.

'If you can't beat them join them”. At one point in time during your stay here [in Bangkok], you will need to

consult a Thai healthcare facility and hence the need to learn some basic Thai language.' MKB-5

Requesting the company of a Thai person

Some respondents mentioned that they would overcome language barriers by soliciting the company of a Thai colleague although this infringed on confidentiality issues.

'Being accompanied by a Thai friend to hospital is a good idea although this might be a challenge if your illness is confidential.' MSAE-6

Self-diagnosis, self-treatment and reliance on Internet

A common behaviour among respondents was self-diagnosis and self-treatment. According to explanations given, this was made possible due to several opportunities. Participants reported consulting medical professionals within their groups, using their existing knowledge or using the internet to diagnose and treat their illnesses. There were however communication barriers with pharmacists with the fear of getting wrong prescriptions. The other option was to import medication from their countries of origin.

'Among other options; internet is there, we have doctors and other healthcare professionals among us [Africans] and pharmacies are there as well.' MZE-9

Prayer/faith healing

Another alternative that emerged was relying on prayer/faith healing for their healthcare needs to avoid barriers in accessing Thai healthcare services among some participants.

'Since coming to Thailand, I have never been seriously ill, but for the few times I experienced some minor ailments, I relied on prayer.' MZE-8

Waiting to consult in home country

In some extreme cases, participants reported that they would also consider the type and severity of their illness and the time remaining before they return to their home country. If that time was short, they would wait till they returned home. Almost similar to this coping mechanism was ignoring the pain especially by male participants.

'Given all these challenges…sometimes you feel it's better to just endure illness until you return home…,' MZaU-4

DISCUSSION

Evidence from this study ostensibly suggests that SSA migrants living in Bangkok face a number of challenges in accessing healthcare services. Access to healthcare services includes: (i) "being able to get to and from services (ii) having the ability to pay for the services, and (iii) getting needs met once in the system".[7] The main factors hindering access to healthcare among our study respondents included inability to speak Thai language, mistrust of, and fear of discrimination from Thai healthcare workers. This finding supports the notion that migrant populations may have increased vulnerability to ill health and barriers in accessing health services.[1] Lin similarly argued that Chinese healthcare professionals identified language/communication as the major challenge in accessing healthcare.[8] Thus it is vital for migrant populations to consider potential barriers to accessing healthcare services before migrating. WHO[2] argues that most SSA migrants often migrate without paying a fair consideration to the potential barriers to access healthcare services they may face while living in host countries.

Choice of healthcare provider among migrants was seen to be influenced more by language, cost of services, health insurance and severity of illness among study participants. Language/communication challenges, from which most other barriers identified emanate, were the often-mentioned barriers to access healthcare services among the study participants. These barriers were confirmed by Boateng *et al*.[9] in their study on enablers and barriers to accessing the Dutch health care system among Ghanaians living in Amsterdam. in their review of African Immigrant health in the United States cited language difficulties and lack of insurance as some of the barriers.[10] Similarly reported language barriers which compromised appropriate health care provision.[8] In light of an increasing migrant population, in particular SSA migrant population to Thailand, the needs of this population to access healthcare services in the context of Thailand need to be timely assessed and considered before dire public health outcomes become a reality.

Among the participants, social support systems were seen to play an important role in accessing healthcare services as well as in coping mechanisms to deal with illnesses. The importance of social support in accessing healthcare services has already been established by previous research conducted among SSA migrants elsewhere.[11] Social support systems may have differing influence on migrants' health as suggested in our study. While making Thai connections may result in reduced barriers to access healthcare services, African and church connections may promote reliance on other treatment options which might be harmful to health (drug borrowing/lending and self-medication). Given the increasing trend of SSA migrant population to Thailand, the role of social support systems on barriers to access healthcare services as well as on coping mechanisms need further inquiry.

Self-medication for minor ailments was commonly mentioned among respondents. Migrants also reported to be accessing medications including antibiotics from pharmacies in Bangkok without the doctor's prescription. This could result in antibiotic-resistance which presents a public health problem.[12, 13]

Results of our study show the internet as the most common source of health information among the participants. Boateng *et al*.[9] found the internet as a widely used source of information to deal with difficulties with the Dutch language (inadequacy of language to describe symptoms) and mistrust in health care providers in accessing healthcare services. The global health significance of the internet remains debatable. Online information such as on promotion of healthy lifestyles, disease signs and symptoms and their treatment, common health risks prevalent in a particular area, location of healthcare facilities and drug outlets, types of healthcare services provided by the facility, costs of care, language translations, among others, can be helpful to both the public/patients and healthcare professionals.[14] However, there is no mechanism to monitor the credibility of online health information sources. With most Thai websites being mostly in Thai language, accessing Thai-specific online information could be a potential challenge faced by SSA migrants.

Racism/discrimination/stigma from Thai healthcare workers appeared to be a significant barrier to access healthcare services among the study participants, a similar finding by Lin.[8] Sub-Saharan migrants involved in his study cited race, different health beliefs, and negative perceptions towards health personnel, care providers' characteristics, health care costs and the lack of interpretation services and translated materials as main barriers hindering their access to health care services. *This is against the backdrop of the South to South cooperation which have seen an unprecedented increase in number of Africans migrating to Asia, and vice versa.*[1] *Transmigration may bring with it challenges related race, which make other races more vulnerable to discrimination/stigma in accessing healthcare services.*[12-15] *This calls for the revision of policies and reorientation of the health systems to build cross-cultural sensitivity among healthcare professionals to ensure equity in health.*

Various studies conducted elsewhere found lack of health insurance as one of the barriers to access healthcare services among SSA migrant populations, which was contrary to the findings from our study.[10, 16-18] Participants in our study reported paying cash despite having the health insurance card. Lovett-Scott & Prather recommend revision and reorientation of health systems in order to ensure equitable access to health care by the vulnerable populations like migrants.[7]

Findings from this study are not expected to resemble those from traditional immigrant countries like USA, and most other European countries, since Asia, Thailand in particular, is a unique case being only an emerging immigrant destination for SSA migrants. Thus it might not be easy to identify representative groups on all migrant characteristics, for example, there might be very few or no undocumented migrants, and not all age groups can be easily identified, at least at present. Various participant characteristics including sex, age, occupation, level of education, country of origin, duration of stay in Bangkok, migrant documentation status, among other background characteristics, can result in differences in the nature and type of barriers faced in accessing healthcare services uniquely defined based on each of these characteristics. Besides variations already discussed on sex and duration of stay in Bangkok, emerging themes on barriers experienced by participants were almost

common across other characteristics, and no significant differences could be identified from the data. The commonality of observed findings across heterogeneous FGDs can be explained in part due to almost similar characteristics with respect to age, level of education and migrant status. Most of the respondents were in the age category 20 – 35 years and lacking equal numbers of representative participants for other interesting age groups like teenagers and the elderly. Again, all study participants were documented migrants and thus we could not have information on the barriers faced by undocumented migrants. Though respondents from SSA countries where English is not the official language were part of the study, it was discovered that they also used English for their communication, thus making no distinction on language as a barrier to access healthcare between respondents from English speaking and French speaking countries.

Study Limitations

This study did not have a comparison group of local Thai population to ascertain whether the discussed challenges were unique to SSA migrants. The study also used registered migrants who might have been facing different challenges from the non-registered.

CONCLUSIONS

SSA migrant participants face many barriers to accessing Thai healthcare services in Bangkok. Characteristics influencing access to Thai healthcare services among SSA migrant participants were duration of stay in Thailand, Thai language speaking ability and self-rated health status. Environmental characteristics influencing access to Thai healthcare services among the SSA migrant participants mainly emanated from lack of cross-cultural competency of human resources in service delivery and unavailability of translation services at most Thai health facilities.

Mistrust of Thai healthcare workers, perceived discrimination by Thai healthcare workers and limited English proficiency of Thai healthcare workers were the main demotivating factors hindering SSA migrants from accessing Thai healthcare services. To overcome barriers, participants relied on multiple coping mechanisms more especially on internet information and self-medication. There is need for more studies on the challenges faced by the documented and undocumented migrants in Bangkok. Understanding the health worker perspectives could also be insightful.

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