



**QUALITY OF LIFE AND ITS ASSOCIATED FACTORS AMONG
MYANMAR MIGRANT WORKERS IN CHIANG RAI
PROVINCE, THAILAND**

TIN MI MI OHN

**MASTER OF PUBLIC HEALTH
IN
BORDER HEALTH MANAGEMENT**

**SCHOOL OF HEALTH SCIENCE
MAE FAH LUANG UNIVERSITY**

2025

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**THIS THESIS IS A PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
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Thesis Title: Quality of Life and Its Associated Factors among Myanmar Migrant
Workers in Chiang Rai Province, Thailand

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ABSTRACT

Quality of life among migrant workers is shaped by multilevel determinants across intrapersonal, interpersonal, institutional, and community levels. However, limited recent evidence exists on how these factors influence the quality of life of Myanmar migrant workers, particularly in border areas of Chiang Rai Province, Northern Thailand. This study aimed to assess the quality of life (QoL) and identify its associated factors among Myanmar migrant workers in Chiang Rai Province using the social-ecological model as the theoretical framework. A community-based cross-sectional study was conducted among 420 Myanmar migrant workers from eight randomly selected communities in Mueang and Mae Sai districts. Data were collected using validated structured questionnaires, including the WHOQOL-BREF, through self-administered and face-to-face interviews after obtaining informed consent. Chi-square tests and binary logistic regression were used to identify significant associations at a significance level of $p\text{-value} < 0.05$. A total of 420 Myanmar migrant workers participated in the study, with 53.1% being male and a mean age of 32.3 years ($SD = 9.9$). About 16.2% had chronic diseases and 21.2% were undocumented, while construction was the most common occupation (45.8%). Most participants reported moderate quality of life (68.6%), followed by poor (20.2%) and good quality of life (11.2%). Multivariable logistic regression identified chronic disease, type of residence, depressive symptoms, social support, job satisfaction, and discrimination as significant factors associated with poor quality of life. The odds of having poor quality of life were

2.96 times (95% CI = 1.29-6.81) higher for those who had chronic diseases like hypertension and diabetes mellitus compared to those who did not have any chronic diseases. Those who lived in house provided by employer, on-site work compound or shared housing with other families had a greater chance of poor quality of life than those who were staying in rented house with 3.59 times (95% CI = 1.75-7.38). Moreover, participants who had moderate to extremely severe depressive symptoms had 15.33 times (95% CI = 5.86-40.08) higher chance of poor quality of life compared to those who had no to mild depressive symptoms. Those who received low to moderate social support had a greater chance of having poor quality of life than those with high social support with 6.35 times (95% CI = 2.15-18.74). The odds of poor quality of life were 6.72 times (95% CI = 3.33-13.56) higher for the individuals who had very low to low job satisfaction compared to those who had average to very high job satisfaction. Lastly, participants who reported moderate to high discrimination had 3.50 times (95% CI = 1.44-8.53) higher odds of having poor quality of life compared to those who reported low discrimination. Targeted interventions addressing chronic disease management, mental health support, and workplace conditions are needed to improve the quality of life of Myanmar migrant workers. Strengthening social support systems and reducing discrimination through community and policy-level actions are also essential to promote their overall well-being.

Keywords: Quality of Life, Myanmar Migrant Workers, Factors Associated, Border Area, Thailand

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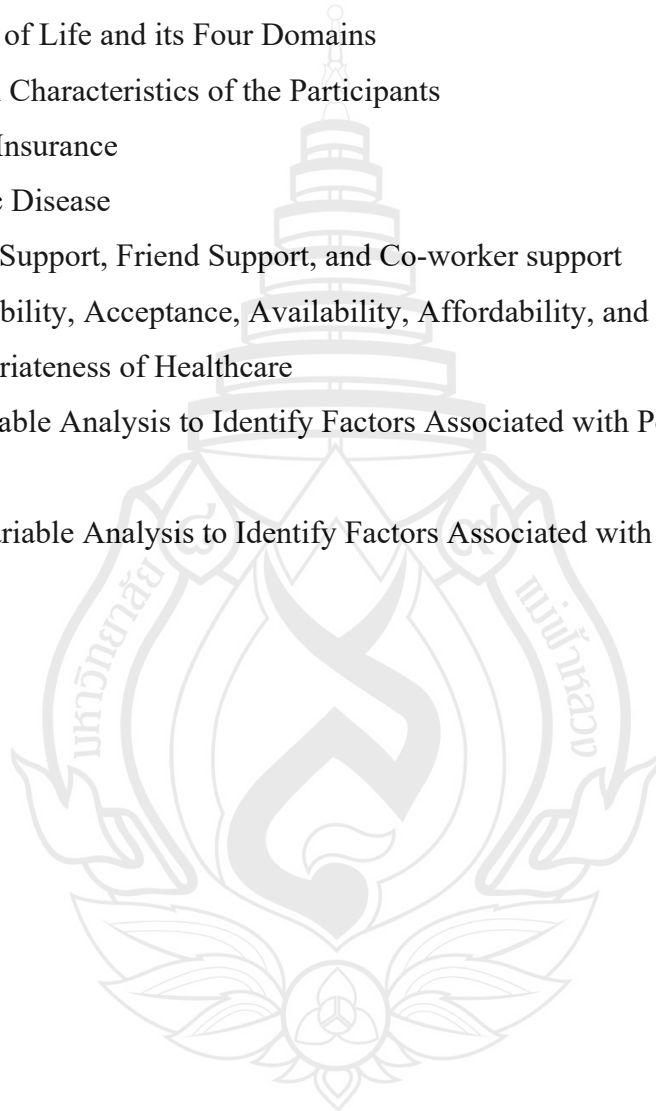
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ABBREVIATIONS AND SYMBOLS

aOR	Adjusted odds ratio
CI	Confidence interval
cOR	Crude odds ratio
DASS-21	Depression Anxiety Stress Scales-21
EDS	Everyday Discrimination Scale
HRQoL	Health-related quality of life
IOM	International Organization for Migration
MHIS	Migrant Health Insurance Scheme
MoU	Memorandum of Understanding
QoL	Quality of life
SDGs	Sustainable Development Goals
SEM	Social-Ecological Model
SSS	Social Security Scheme
WHO	World Health Organization
WHOQOL	World Health Organization Quality of Life
WHOQOL-BREF	World Health Organization Quality of Life – BREF version

CHAPTER 1

INTRODUCTION

1.1 Background

Migration has been a defining feature of human history, driven by various factors such as the pursuit of work, education, and economic opportunities, family union, and escape from conflict. Environmental factors, including climate change and natural disasters, have also played a significant role in shaping migration patterns. The current United Nations estimate is that there are approximately 281 million international migrants globally, accounting for 3.6% of the world's population, with 169 million of them being migrant workers (1).

Myanmar nationals, like other migrants worldwide, move internationally to find job opportunities and improve their lives, often driven by economic challenges, natural disasters, political conflicts, and ongoing warfare (2). According to the 2014 Myanmar Population and Housing Census, over 2 million Myanmar nationals had migrated globally even at that time. Migration destinations include developing countries like Thailand, Malaysia, Vietnam, China, and India, as well as developed nations such as the United States, United Kingdom, Singapore, the Republic of Korea, and Japan. Since then, Thailand has played as the main country of destination for most migrants from Myanmar, hosting over 70.0 % of all Myanmar nationals abroad (3).

Recent data from the International Organization for Migration (IOM) still highlights Thailand as the most significant destination for Myanmar nationals. The Thailand-Myanmar border, spanning over 2,400 kilometers, is recognized as the largest migration corridor in Southeast Asia and one of the top 20 in the world. Between January 2023 and February 2024, approximately 1.5 million Myanmar nationals crossed this border, mainly through Mae Sai border crossing (4, 5). Moreover, following the military takeover in 2021, there was a significant increase in irregular entries of Myanmar migrants, despite the steady number of entries from 2018 onwards. As of March 2024, the Department of Employment reported 2,308,166 registered

Myanmar migrant workers in Thailand which is the highest number in recent years, accounting for 70.0% of all registered migrants (4). The main driver for long-term migration to Thailand was employment, with a majority of Myanmar migrants moving in search of employment opportunities (5).

Based on the data by IOM as of June 2024, Myanmar people usually migrate to provinces like Tak, Chiang Rai, Kanchanaburi, Chumphon, Chiang Mai, Mae Hong Son, Phetchaburi, Prachuap Khiri Khan, Ranong, and Ratchaburi (6). Additionally, from 2022 onwards, Chiang Rai, a semi-urban province in Northern Thailand near the Thai-Myanmar border, has become a more popular destination for Myanmar migrants, hosting 50,900 of them as of June 2024 (4, 6). According to the Chiang Rai Provincial Employment Office, Myanmar nationals make up 94.9% of all migrant workers in the province, with the highest concentrations in Mueang Chiang Rai District and Mae Sai District (7). Furthermore, the IOM Thailand report, Multi-Sectoral Assessment of Needs: Chiang Rai Factsheet, highlighted that the top three regions of origin among surveyed migrants in Chiang Rai were Shan (East), Mandalay, and Yangon. Notably, 45.0% of respondents reported migrating to Thailand after the military takeover in Myanmar in February 2021(8).

Migrants from Myanmar mostly find employment in construction, agriculture, food production, services, vendor, fishing, domestic work, hospitality and manufacturing (4, 8). Among these, sectors such as agriculture and fisheries are vital to Thailand's economy but rely heavily on migrant labor. These industries often offer low wages and poor working conditions, attracting a lot of undocumented workers especially from Myanmar (3). Additionally, these migrant workers often take on "3D jobs" (difficult, dangerous, and dirty) that would not attract most native Thai employees, exposing them to higher risk of work-related accidents and health problems than that faced by nationals (9). Moreover, a World Bank Group report highlighted that migrant workers from Myanmar, Laos, and Cambodia in Thailand face poor living and working conditions. Unregistered migrants are especially vulnerable, lacking legal protection and facing low wages, long hours, and exploitation. Many employers deduct costs from wages, and some workers receive less than the minimum wage. Additionally, poor working environments, crowded housing conditions, inadequate ventilation, and unhygienic facilities expose migrants to physical, emotional and social health risks.

Fear of deportation and inadequate services also prevent many from accessing healthcare and social support (10, 11). Additionally, migrant workers worldwide face high risks of occupational injuries and illnesses because they often work in dangerous conditions without proper safety training. Studies show that many face discrimination at work, have trouble reporting unsafe conditions due to fear of punishment, and struggle to access healthcare and compensation. Language barriers and short-term jobs also make safety training less effective, putting them at even greater risk (12).

Furthermore, recent policy changes by the United States (U.S.) government to freeze foreign aid have had significant adverse effects on Myanmar migrant workers and refugees in Thailand, as highlighted by multiple reports. The suspension of funding has severely disrupted essential services, particularly healthcare, leaving many without access to critical medical care and increasing health vulnerabilities, especially along the Thai-Myanmar border (13, 14). All of these cumulative issues mentioned above can significantly affect their physical, mental, social and environmental well-being, making migrant workers' quality of life a critical area of concern.

The term quality of life (QoL) is as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a multidimensional construct involving physical health, psychological health, social relationships, and environmental domains, as defined by the World Health Organization (15). Living with a high quality of life can promote overall well-being, enabling individuals to maintain good physical health, mental stability, social engagement, and environment satisfaction. However, living with poor quality of life can have significant impacts at individual, family, and societal levels, leading to severe health burdens, financial strain, and reduced workforce productivity. At the individual level, poor quality of life is closely linked to increased mortality risk, as lower quality of life scores are strong predictors of adverse health outcomes (16). At the family level, poor quality of life can impose emotional and financial burdens, as caregivers often experience psychological distress, economic hardship, and disruptions in daily life due to the high demands of care (17). On a societal scale, poor quality of life can contribute to widespread economic challenges by reducing workforce productivity, increasing absenteeism, and decreasing work efficiency (18, 19).

Numerous factors are continuously interrelated at various levels, shaping quality of life. These levels involve hierarchical interactions of physical, social, and institutional components between individuals, workplaces, and the broader community. Therefore, to fully understand how various factors influence quality of life at different levels, a comprehensive approach is essential. The social-ecological model provides such a framework, considering intrapersonal, interpersonal, institutional, community, and public policy levels, each representing different factors that interact to varying degrees in shaping quality of life.

In many studies worldwide, the quality of life of migrant workers has been shown to be mostly low or moderate. Research from developed countries, such as Germany (20), Spain (21), the United States (21), and Canada (21), revealed that migrant workers generally experience a lower quality of life than native residents likely due to discrimination experiences, undocumented status, and lack of health insurance. Similarly, studies from developing countries, including China (22), Bangladesh (23), and India (24, 25) highlighted that migrant workers' quality of life is also lower when compared to local residents. In fact, more than half of the migrant worker participants in these studies reported a low quality of life. Interestingly, studies done among Myanmar migrant workers in different regions of Thailand, such as South of Thailand (26), Chiang Rai Province (27), Samut Sakhon Province (28), and Phang Nga Province (29), stated that most Myanmar migrant workers had moderate quality of life scores, followed by low or high quality of life scores.

Most previous studies on migrant workers have focused on personal or unmodified factors contributing to quality of life (24, 25, 30). However, some studies have also highlighted modifiable factors, such as mental health status including depression, anxiety and stress (26, 31–33), chronic disease (22, 34), social support (35–37), access to healthcare (22), and health insurance status (28), which all play a role in quality of life among migrant workers. Identifying these contributing factors is essential because some predictors can be modified to improve quality of life. Despite this, research on key factors like discrimination and health risk behaviors among Myanmar migrant workers remains limited. Furthermore, there is a lack of recent, updated information on Myanmar migrant workers in Chiang Rai Province, even though the area is becoming an increasingly important destination for migrant labor. Most studies

in Thailand focus on provinces with larger industrial bases, overlooking the unique social, economic, and healthcare challenges faced by migrant workers in the northern provinces.

To address these gaps, the present study incorporated a broader perspective by assessing the combined influence of intrapersonal, interpersonal, community and institutional factors on quality of life of Myanmar migrant workers particularly in Chiang Rai Province by using the social-ecological model. The model is proven to be useful in explaining quality of life because it depicts how contextual and individual factors influence quality of life (38).

Furthermore, this research supports Sustainable Development Goals 3 by improving access to healthcare, addressing mental health issues, and reducing health gaps among vulnerable groups like migrant workers. It contributes to the goal of ensuring healthy lives and well-being for all by addressing inequalities and improving healthcare quality for marginalized groups. Additionally, this study aligns with Sustainable Development Goals 10, which focuses on reducing inequalities within and between countries. By addressing these disparities, the research helps promote social and economic equality for migrant workers, ensuring they are included in sustainable development efforts.

Therefore, this study aimed to examine the quality of life and its associated factors among Myanmar migrant workers in Chiang Rai Province, Thailand. By focusing on this underexplored region, the research provides locally relevant insights into the determinants of quality of life. The findings contribute to a deeper understanding of the unique challenges faced by this vulnerable population. Moreover, this study provides evidence-based recommendations and public health information to enhance policies and interventions. Ultimately, this research offers actionable insights to improve the well-being of Myanmar migrant workers and contributes to a more inclusive and equitable society.

1.2 Research Questions

1.2.1 What is the quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand?

1.2.2 What factors are associated with the poor quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand?

1.3 Research Objectives

1.3.1 To assess the quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand.

1.3.2 To identify the factors associated with the poor quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand.

1.4 Research Hypotheses

1.4.1 Intrapersonal level factors are significantly associated with the poor quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand.

1.4.2 Interpersonal level factors are significantly associated with the poor quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand.

1.4.3 Institutional level factors are significantly associated with the poor quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand.

1.4.4 Community level factors are significantly associated with the poor quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand.

1.5 Study Scope

This study focused on assessing the quality of life and its associated factors among Myanmar migrant workers in Chiang Rai Province, Thailand by using a quantitative cross-sectional design. The research examined various factors at the

intrapersonal, interpersonal, institutional, and community levels, including socio-demographic characteristics, mental health status, social support, workplace conditions, discrimination, and access to healthcare by using social-ecological model. Data was collected using structured questionnaires and analyzed statistically to determine the relationship between these factors and quality of life. Moreover, by using validated tools to measure mental health status, social support, discrimination, job satisfaction and quality of life of Myanmar migrant workers, the study aimed to provide a comprehensive understanding of the challenges faced by this population. The results contribute to evidence-based recommendations for improving public health policies, workplace environments, and healthcare accessibility for migrant workers. The study scope was geographically limited to Chiang Rai Province and does not cover other provinces or non-migrant populations.

1.6 Operational Definitions

1.6.1 A migrant worker specifically refers to an individual who move to another country to engage in paid employment. For this study, Myanmar migrant workers refer to workers originating from Myanmar who have resided in Mueang Chiang Rai District and Mae Sai District of Chiang Rai Province, Thailand, for at least six months before the data collection.

1.6.2 Quality of life (QoL) refers to an individual's perception of their position in life in the context of their culture, value systems, personal goals, and expectations, as defined by the WHO. Quality of life was measured using the WHOQOL-BREF, focusing on four domains:

1.6.2.1 Physical Health refers to bodily health, pain, energy, and medical dependence.

1.6.2.2 Psychological Health refers to emotional well-being, self-esteem, and cognitive functioning.

1.6.2.3 Social Relationship refers to personal relationships, social support, and communication.

1.6.2.4 Environmental Health refers to safety, financial stability, living conditions, and resource accessibility.

1.6.2.5 Overall quality of life refers to the total score derived from the four domains measured by the WHOQOL-BREF: physical health, psychological health, social relationships, and environmental health. Each domain was scored separately, and an overall QoL score was calculated by combining these scores according to the WHOQOL-BREF guidelines. Higher scores indicate a better-perceived quality of life. The quality of life scores were categorized into poor, moderate or good. For the data analysis, participants with “good” and “moderate” QoL scores were grouped together and compared with those with “poor” QoL scores.

1.6.3 Age refers to the number of years a person has lived since birth, as self-reported by the participant.

1.6.4 Sex refers to the participant's self-identified biological sex, categorized as male or female.

1.6.5 Ethnicity refers to a participant's self-identified affiliation with a specific ethnic group based on shared cultural, linguistic, or ancestral characteristics, categorised as Burma, Karen, Shan, Mon or other.

1.6.6 Living arrangement in Thailand refers to the participant's current residential status, specifically whether they live with family members (such as parents, siblings, spouse, children, or extended relatives), alone, or with non-family members.

1.6.7 Family members in Myanmar refers to whether the participant has family members currently residing in Myanmar, with response options categorized as yes or no.

1.6.8 Health insurance refers to whether an individual possesses insurance that helps cover medical expenses in cases of illness, injury, or other health-related needs, with response options categorized as no or yes.

1.6.9 Educational attainment refers to the highest level of formal education completed by the participant, categorized as no formal education, primary school, secondary school, or university and above.

1.6.10 Marital status refers to the participant's self-reported current relationship status, categorized as married, single, separate, divorced, or widowed.

1.6.11 Chronic disease refers to the self-reported presence of chronic conditions such as diabetes, hypertension, or other long-term illnesses diagnosed by the physician, categorized as no or yes.

1.6.12 Health risk behavior refers to any activity or lifestyle choice that impacts an individual's physical or mental health, categorized into alcohol use, smoking, or exercise.

1.6.12.1 Alcohol consumption refers to the consumption of alcoholic beverages at any point in life, classified into three groups based on self-reported drinking history: none (never consumed alcohol), ex-drinker (previously consumed alcohol but no longer drinks), and current drinker (currently consumes alcohol).

1.6.12.2 Smoking refers to cigarette smoking and other forms of tobacco use, categorized as none (never smoked), ex-smoker (previously smoked but has quit), and current smoker (currently smokes tobacco).

1.6.12.3 Exercise refers to physical activities, including moving an arm, leg and body for 30 minutes at least three times per week, categorized into no (does not engage in exercise) and yes (engage in exercise).

1.6.13 Duration of stay in Thailand refers to the total time the participant has lived in Thailand, measured in years.

1.6.14 Area of residence refers to the geographical location where a participant lives, classified based on the type of area, categorized as urban which is Mueang Chiang Rai District and semi-urban which is Mae Sai District.

1.6.15 Type of residence refers to the participant's current living housing, categorized as rented house, employer-provided housing, on-site work compound, and shared housing with other families.

1.6.16 Thai language proficiency refers to the participant's self-reported ability to read, listen, write and speak the Thai language, categorized as none, basic, or fluent for all four Thai language skills.

1.6.17 Documentation status refers to whether the participant has valid legal documentation to reside and work in Thailand, categorized as documented or undocumented.

1.6.18 Monthly income refers to the total earnings received by the participant within a month, measured in Thai Baht. This is followed by an assessment of income sufficiency, where participants indicate whether their monthly income is “insufficient” or “sufficient.”

1.6.19 Mental health status refers to the participant's psychological well-being, specifically focusing on symptoms of depressive symptoms, anxiety, and stress. Mental health status is measured using the Depression, Anxiety, and Stress Scale (DASS-21). Each subscale is categorized as normal, mild, moderate, severe or extremely severe.

1.6.20 Social support refers to the perceived availability and actual receipt of support from family members, friends, and coworkers. Social support is measured using a self-reported questionnaire adapted from Thoits' framework, categorized as low, moderate or high social support.

1.6.21 Type of occupation refers to the participant's employment sector, including their previous occupation in Myanmar and their current occupation in Thailand, categorized into agriculture, construction, manufacturing, or other relevant sectors.

1.6.22 Work environment refers to the physical setting where participants perform their primary job duties, as reported by the participants, categorized into indoor, semi-indoor, or outdoor.

1.6.23 Primary mode of transportation to the workplace refers to the mode of transportation used by the participant to commute between their place of residence and their workplace on a daily basis, categorised as own motorbike or bicycle, on foot or employer-provided vehicle.

1.6.24 Job satisfaction refers to the participant's overall sense of fulfillment with their current job. It is assessed using the Generic Job Satisfaction Scale, categorized as very high, high, average, low, or very low.

1.6.25 Length of time in current job refers to the duration that the participant has been continuously employed in their current position, measured in years.

1.6.26 Access to healthcare refers to a participant's ability to reach, obtain, and afford healthcare services, measured through five components: accessibility, acceptance, availability, affordability and appropriateness. The overall total score for access to healthcare is categorized as low, moderate, or high.

1.6.27 Discrimination refers to the participant's self-reported experiences of unfair treatment in their daily lives, based on interpersonal interactions, as measured by the Everyday Discrimination Scale (EDS), categorized into low, moderate or high discrimination.

1.7 Conceptual Framework

The conceptual framework for this study was developed using the social-ecological model to explore the factors influencing quality of life among adult Myanmar migrant workers in Chiang Rai Province, Thailand. The social-ecological model, originally proposed by Mcleroy et al. (39), outlines the interplay between various levels of influence on behavior and health outcomes. The original model has five levels: intrapersonal, interpersonal, institutional, community, and public policy. However, the model was adapted for this study to include only four levels.

Key independent variables were divided into 4 levels, including intrapersonal level (age, sex, ethnicity, living arrangement in Thailand, family members in Myanmar, health insurance, educational attainment, marital status, chronic disease, health risk behavior, duration of stay in Thailand, area of residence, type of residence, Thai language proficiency, documentation status, monthly income, monthly income sufficiency, mental health status), interpersonal level (social support), institutional level (previous occupation in Myanmar, current occupation in Thailand, work environment, primary mode of transportation to the workplace, job satisfaction, length of time in current job) and community level (access to healthcare, discrimination). The dependent variable, quality of life, consists of physical, psychological, social, and environmental health domains.

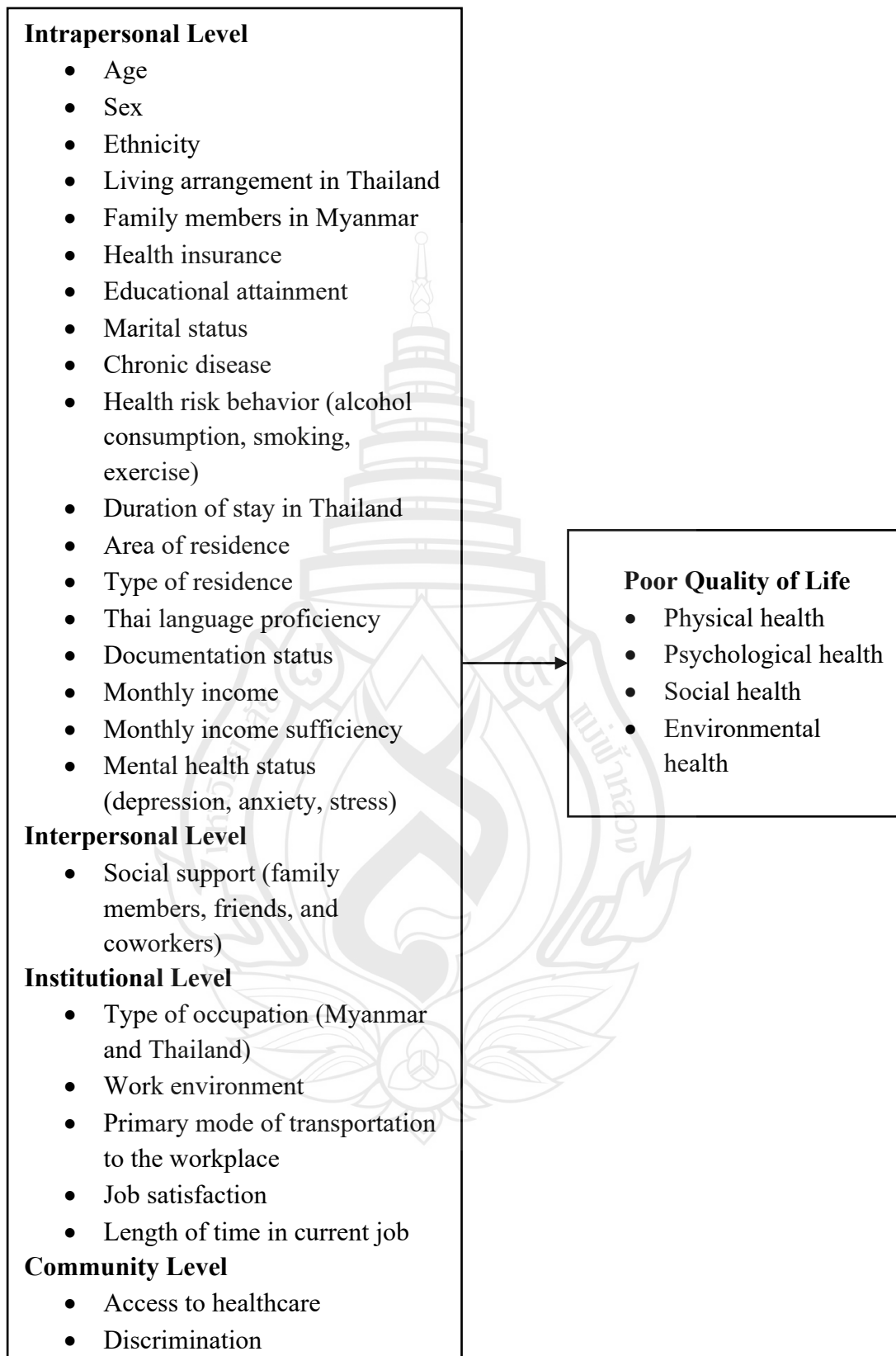


Figure 1.1 Conceptual Framework

CHAPTER 2

LITERATURE REVIEW

This chapter presents the literature on quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand. The literature includes the following topics:

- 2.1 Migration
- 2.2 Quality of Life
- 2.3 Quality of Life of Workers in Myanmar
- 2.4 Epidemiology of Quality of Life among Migrant workers
- 2.5 Impacts of Poor Quality of Life
- 2.6 Quality of life Instruments
- 2.7 Social-Ecological Model
- 2.8 Previous Related Studies

2.1 Migration

IOM defines “migration” as the movement of persons away from their place of usual residence, either across an international border or within a State. Additionally, the term "migrant" is used as an umbrella term, not defined under international law, reflecting the common lay understanding of a person who moves away from his or her place of usual residence, whether within a country or across an international border, temporarily or permanently, and for a variety of reasons. The term includes several well-defined legal categories of people, such as migrant workers, persons whose particular types of movements are legally defined, such as smuggled migrants, and those whose status or means of movement are not specifically defined under international law, such as international students. Furthermore, IOM defines a "migrant worker" as a person who is to be engaged is engaged, or has been engaged in a remunerated activity in a State in which he or she is not a national (40).

2.1.1 Types of Migration

According to IOM, migration patterns can be classified into several categories based on the circumstances and conditions under which people move. These categories are defined as follows (41):

2.1.1.1 Regular migration is the movement of individuals in accordance with the laws and regulations governing exit, entry, return, and stay in the States, as well as international law obligations. Regular migration ensures that the human dignity and well-being of migrants are upheld, their rights are respected, protected, and fulfilled, and the risks associated with migration are acknowledged and mitigated.

2.1.1.2 Irregular Migration is the movement of individuals that occurs outside the laws, regulations, or international agreements governing entry into or exit from the State of origin, transit, or destination.

2.1.1.3 Voluntary migration occurs when migrants knowingly and willingly decide to leave their country and are able to enter another with the approval of the authorities. These migrants generally meet the entry requirements established by the country of destination for admission.

2.1.1.4 Forced Migration is a migratory movement which, although the drivers can be diverse, involves force, compulsion, or coercion.

To sum up, the migration of Myanmar workers in Chiang Rai includes both regular and irregular types. While many migrants have regularized their status through in-country registration or the Memorandum of Understanding (MOU), there is a significant number of irregular migrants. IOM estimates suggest that the actual migrant population in Chiang Rai is 2.9 times larger than official records indicate, showing the extent of undocumented migration in the province (4).

According to Hayashi (42), the migration of Myanmar migrant workers in Chiang Rai falls under mixed migration, reflecting a combination of forced and voluntary migration. Many migrants fled due to the socio-political instability, seeking safety and survival, which fits the characteristics of forced migration. At the same time, some migrants chose to move in search of better economic opportunities and improved living conditions, reflecting voluntary migration. This situation is further complicated by the presence of undocumented migrants, making it challenging to categorize them strictly as either forced or voluntary migrants. Therefore,

the concept of mixed migration best captures the diverse motivations behind their movement (42).

2.1.2 Migration Worldwide

Migration is a significant global phenomenon, with an estimated 281 million international migrants in 2020, accounting for 3.6% of the global population. IOM stated that approximately one out of 30 people is a migrant. Most people migrate internationally for family, educational, or employment-related reasons. Europe and Asia hosted the largest shares, with approximately 87 million and 86 million migrants respectively, making up 61.0% of the total migrant stock. They were followed by North America, Africa, Latin America, the Caribbean, and Oceania (1).

2.1.3 Migration to Asia

Asia has become a major hub for international migration, hosting approximately 86 million migrants as of 2020. Notably, Asia experienced the highest growth in migration between 2000 and 2020, increasing by 74.0%, about 37 million people (1). This surge can be attributed to Asia's rapid economic and social transformations, which have made it an attractive destination for individuals seeking better opportunities. Countries in Asia have received migrants from diverse background. One of the countries that has experienced a particularly overwhelming number of migrants is Thailand.

2.1.4 Migration to Thailand

Thailand has emerged as a critical destination country in Asia, attracting millions of migrants from neighboring countries. Its strong ties to global investment, trade, and tourism have contributed to large migration flows, including refugees, displaced persons, skilled professionals, and labor migrants. Its prosperous and stable economy has made it a destination for individuals seeking employment and better living conditions. Most migrants in Thailand originate from Cambodia, Laos, and Myanmar, with Myanmar nationals forming the largest group (43).

For Myanmar migrants, the primary drivers of entry are economic factors such as seeking employment, trade, and better living costs (4). According to the data by IOM as of June 2024, Myanmar people usually migrate to provinces like Tak, Chiang Rai, Kanchanaburi, Chumphon, Chiang Mai, Mae Hong Son, Phetchaburi, Prachuap Khiri Khan, Ranong, and Ratchaburi (6). Moreover, Myanmar migrant workers tend to

follow specific regional migration patterns based on their states or regions of origin. According to IOM assessments, migrants from Kayin mostly settle in Tak, Pathum Thani, Kanchanaburi, and Nonthaburi. Workers from Tanintharyi typically migrate to Ranong, Chumphon, and Kanchanaburi, while those from Mon are primarily found in Samut Sakhon (4).

Additionally, Chiang Rai has increasingly become a prominent destination for Myanmar migrants since 2022 (4). The province offers employment opportunities and proximity to the Myanmar border, making it an accessible and strategic location and hosting 50,900 of Myanmar migrants as of June 2024 (6). According to the Chiang Rai Provincial Employment Office, Myanmar nationals account for 94.9% of the province's migrant workforce, with the majority residing in Mueang Chiang Rai and Mae Sai districts (7). This trend highlights Chiang Rai's growing importance in Thailand's migration landscape. Additionally, the IOM Thailand report, Multi-Sectoral Assessment of Needs: Chiang Rai Factsheet, identified Shan (East), Mandalay, and Yangon as the top three regions of origin among surveyed migrants in Chiang Rai. Notably, 45.0% of respondents stated that they migrated to Thailand following Myanmar's military takeover in February 2021 (8).

2.1.5 Challenges and Benefits Faced by Migrant Workers

Migrant workers often take on “3D jobs” (difficult, dangerous, and dirty) that many native residents avoid, making them more vulnerable to work-related accidents and health issues (9). Globally, migrant workers face high risks of occupational injuries and illnesses, as they are frequently exposed to unsafe working environments with insufficient safety training. Changes in the physical living and working conditions of migrant workers, such as poor work environments, mobility restrictions, and overcrowded housing, are closely linked to emotional and social problems (11). Many also experience discrimination, fear reporting unsafe conditions due to the risk of punishment, and struggle to access healthcare and compensation. Additionally, language barriers and the temporary nature of their jobs make safety training less effective, further increasing their risk (12). Nevertheless, it is also essential to acknowledge that migration can also bring endless advantages for migrant workers' quality of life, when managed under policies that prioritize human rights, safety, and dignity. Migration can create economic opportunities and contribute to improved

income levels and overall living conditions. For instance, according to IOM, individuals migrating from lower-income countries to the United States may earn up to four times more than they would in their home countries. Thai workers moving to Taiwan or Hong Kong also earn at least four times as much as they would in Thailand. And importantly, evidence suggests that migration is associated with improved health outcomes compared to individuals who remain in their country of origin (44). Similarly, Myanmar migrants in Thailand earn more than three times as much as their internal counterparts and exhibit better mental health, with nearly two-thirds of returning migrants reporting that working in Thailand has improved their financial situation (45, 46).

2.2 Quality of Life

WHO defines quality of life as individuals' perceptions of their position in life within the context of their culture and value systems, and with their goals, expectations, standards, and concerns (15). It is a multidimensional construct involving physical health, psychological health, social relationships, and environmental domains. This study will adopt the WHO concept of quality of life which includes physical health and the mental, social and environmental well-being of Myanmar migrant workers.

According to Teoli and Bhardwaj (47), quality of Life (QoL) is a broad concept that reflects an individual's or population's overall well-being, considering both positive and negative aspects of their lives at a given time. It encompasses various factors such as physical, mental, and spiritual health, relationships, education, work environment, social status, financial stability, security, personal freedom, decision-making autonomy, sense of belonging, and living conditions.

In summary, quality of life is a comprehensive measure of well-being that goes beyond physical health to include psychological, social, and environmental factors. Personal circumstances, cultural context, and societal values influence it. Understanding quality of life requires a comprehensive approach, considering material and health-related aspects, individual perceptions, social connections, and overall life satisfaction.

2.3 Quality of Life of Workers in Myanmar

The quality of life for workers in Myanmar has significantly declined due to economic instability, job losses, and poor access to essential services. Between 2017 and 2022, labor force participation and employment rates dropped, with female workers disproportionately affected. Women not only earn 13.0% less than men but also face workplace discrimination, fewer promotion opportunities, and pregnancy-related job losses, particularly in lower-level positions such as the garment industry (48).

The crisis has further strained healthcare access, with many public facilities no longer fully operational, forcing individuals to rely on costly private healthcare. As a result, many low-income households in Yangon struggle to afford medical services. More than one-third of employed migrants in Myanmar do not seek healthcare, a rate significantly higher than the national average of 19.8% (49). Similarly, a study among internal migrant workers in Myanmar reported that only one-fourth of participants had good quality of life (26.8%), and that mental health status, social capital, family living arrangements, and healthcare costs were significantly associated with quality of life (50).

Beyond financial struggles, mental health challenges are widespread, particularly among internal migrant workers and those affected by conflict. Many report symptoms of emotional distress, including low mood, sleep disturbances, and thoughts of self-harm. Those displaced by war and conflict experience the most severe mental health burdens due to financial hardship and the emotional strain of migration (46). With Myanmar's economy weakened by COVID-19, rising energy costs, and ongoing instability, people across the country continue to face increasing difficulties in securing employment, maintaining financial stability, and accessing basic healthcare (48).

2.4 Epidemiology of Quality of Life among Migrant Workers

2.4.1 Quality of Life Among Migrant Workers Worldwide

Studies from around the world have shown that the quality of life among migrant workers is generally low to moderate. In Germany, research indicates that migrants tend to have a lower quality of life than native residents, particularly in terms of mental health. Discrimination has been identified as a key factor contributing to this disparity (20). Similar findings have been reported in Spain, the United States, and Canada, where undocumented status, lack of health insurance, and experiences of discrimination have led to poor mental health outcomes, including depression, stress, and anxiety (21). These challenges, in turn, negatively impact the overall quality of life of migrant workers.

In Asia, studies also highlight significant disparities. Research from China has found that rural-to-urban migrant workers experience a lower quality of life in all aspects compared to local residents (22). A study conducted in Dhaka reported that 94.0% of adult migrant garment workers had a low quality of life, while only 3.2% had a moderate and 2.7% had a high quality of life (23). Similarly, in Chennai, 62.0% of migrant construction workers were found to have a poor quality of life, whereas 38.0% had a good quality of life (24). Research in Bangalore city also showed that more than half (54.0%) of migrant construction workers had poor quality of life (25). However, some studies suggest that not all migrant workers experience a low quality of life. For example, in Singapore, research found that a majority (73.6%) of migrant workers reported having a good or very good quality of life, while only 5.4% described it as poor or very poor (51). Similarly in Tamil Nadu, India, 84.0% of migrant workers in manufacturing industry had moderate to high quality of life, while only 16.0% were reported having low quality of life (52).

Overall, while some exceptions exist, most studies indicate that migrant workers face significant challenges that negatively affect their quality of life, especially in areas related to mental health, living conditions, and job security.

2.4.2 Quality of Life Among Migrant Workers in Thailand

Research on the quality of life of migrant workers in Thailand shows varying results, with most studies indicating that the majority of migrant workers experience a moderate quality of life, followed by either poor or high quality of life. Research conducted in 2020 among Cambodian migrant workers reported that about one-third (34.5%) had a poor quality of life, while the majority (55.3%) had a moderate quality of life, and only 10.1% had a high quality of life (32).

Findings from studies on Myanmar migrant workers in different provinces of Thailand also reveal similar patterns. A 2009 study in Mueang District, Chiang Rai Province, found that 56.0% of adult Myanmar migrant workers had a moderate quality of life, while 43.8% reported a high quality of life, and only 0.2% had a low quality of life (27). Another study from the same year, conducted in Samut Sakhon Province, showed that most respondents (94.0%) had a moderate quality of life, with only 3.2% reporting a low quality of life and 2.7% reporting a high quality of life (28). In southern Thailand, a 2020 study among Myanmar migrant workers found that 85.7% had a moderate quality of life, 11.4% had a good quality of life, and 2.7% had a poor quality of life (26).

Overall, while there are differences between regions, most migrant workers in Thailand tend to have a moderate quality of life, with smaller proportions experiencing either high or low quality of life.

2.5 Impacts of Poor Quality of Life

At the individual level, poor quality of life is often associated with increased mortality. A systematic review of quality of life and mortality in the general population by Phyto et al. (16) found that better QoL/HRQoL was associated with lower mortality risk. This means that lower QoL scores significantly predict higher mortality risk in the general population. This relationship underscores the importance of quality of life as a comprehensive measure of an individual's well-being, encompassing physical health, psychological state, and social and environmental relationships. At the family level, an individual's poor quality of life can lead to emotional and financial burdens for the

family members. Research by Golics et al. (17) highlighted that the impact of disease extends beyond patients' poor quality of life to affect family members' quality of life. A patient with chronic disease and poor quality of life has several impacts on family members, such as psychological distress of caring, financial burden of treatment costs, disruption of education or work, lack of leisure time, and drastic effects on their social lives. Family members often experience increased stress, anxiety, and economic strain due to caregiving responsibilities and associated healthcare costs. At the societal level, a population experiencing low quality of life often struggles with health challenges that directly impact workforce productivity and economic stability. Poor quality of life marked by chronic illness, mental health issues, and inadequate living conditions can lead to increased absenteeism and decreased work efficiency. A study by Brunner et al. (18) found that work stress significantly contributes to absenteeism and presenteeism which can lead to substantial economic costs. Similarly, research by Bialowolski et al. (19) demonstrated that health-related productivity losses can also lead to reduced economic performance, creating a cycle where poor quality of life diminishes individual well-being and, in turn, weakens overall economic growth.

2.6 Quality of life Instruments

Quality of life can be assessed using various tools, broadly categorized into generic tools, such as World Health Organization Quality of Life (WHOQOL), SF-36 Health Survey, and Nottingham Health Profile (NHP), and specific tools, which are designed to evaluate quality of life in particular populations, such as individuals with chronic conditions like rheumatoid arthritis. (53)

2.6.1 SF-36 Health Survey

The SF-36 Health Survey is a widely used tool for assessing health-related quality of life (HR-QOL), consisting of 36 items derived from the Medical Outcomes Study (MOS). It measures eight health domains: physical functioning, role limitations due to physical and emotional health, bodily pain, general health perceptions, vitality, social functioning, and mental health. The SF-36 provides two summary scores which are Physical Component Summary (PCS) and Mental Component Summary (MCS), which capture overall physical and mental well-being. It has demonstrated strong

reliability, with internal consistency estimates exceeding 0.78 in various populations and test-retest reliability ranging from 0.60 to 0.81. Validity studies confirm its ability to distinguish between individuals with different health conditions, making it a good tool for evaluating quality of life in diverse settings (53).

2.6.2 Nottingham Health Profile (NHP)

The Nottingham Health Profile is a widely used tool designed to assess perceived health status, developed in the UK by Hunt et al. (54). It consists of 38 items across six sections, with responses in a simple 'yes' or 'no' format, focusing on the layperson's perspective of health. The NHP was created to capture individuals' concerns about health and disease, making it particularly relevant and acceptable to patients. It has demonstrated good reliability, with test-retest correlations ranging from 0.71 to 0.88, and internal consistency reliability estimates between 0.62 and 0.82. The tool is also valid, as it effectively discriminates between different patient groups, such as those with rheumatoid arthritis and migraines. Although it provides insight into subjective health, the NHP is less sensitive to detecting minor health issues compared to the SF-36 (53).

2.6.3 WHOQOL-100

The WHOQOL-100 was developed by the World Health Organization (WHO) to assess individuals' perceptions of their position in life within the context of their culture, values, goals, and concerns. It includes 100 items, grouped into six domains: physical health, psychological health, level of independence, social relationships, environment, and spirituality/religion/personal beliefs. The tool has shown strong internal consistency, with Cronbach alpha values ranging from 0.71 to 0.86 across its six domain scores, indicating good reliability. However, the reliability for domains 1 and 4 should be interpreted with caution due to the limited number of items (three scores) used for these domains. The test-retest reliability of the WHOQOL-100 was assessed using data from a field trial across multiple centers, with correlations between items ranging from 0.68 to 0.95. These findings suggest that the WHOQOL-100 produces consistent scores over time, particularly when no significant life changes or interventions occur (55).

2.6.4 WHOQOL-BREF

The WHOQOL-BREF is a shortened version of the WHOQOL-100, developed by the World Health Organization to provide a more practical and concise tool for assessing quality of life (QoL), particularly in community settings where the length of the original WHOQOL-100 posed challenges. The WHOQOL-BREF consists of 26 items grouped into four domains: physical health, psychological health, social relationships, and environmental health. The tool has demonstrated good internal consistency, with Cronbach alpha values ranging from 0.66 to 0.84 across the domains, although the value for domain 3 (social relationships) should be interpreted with caution due to the use of only three items. The WHOQOL-BREF has shown strong correlations with the WHOQOL-100, ranging from 0.89 to 0.95, indicating that it is a reliable tool for assessing similar domain-level profiles. Furthermore, the WHOQOL-BREF has demonstrated strong discriminant validity, effectively distinguishing between ill and well groups across all domains, with significant differences observed in physical health, psychological well-being, social relationships, and environment (55).

Physical Health

The World Health Organization defines health as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.”

The physical health domain of the WHOQOL-BREF assesses well-being through seven key indicators: (1) limitations due to pain when performing essential activities, (2) need for medical treatment to carry out daily tasks, (3) energy levels sufficient for daily life, (4) mobility and ability to get around, (5) quality of sleep, (6) ability to perform daily activities, (7) capacity for work. Each item is scored on a five-point Likert scale, where higher scores indicate better physical health.

Psychological Health

Mental health is described by the WHO as “a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community.”

The psychological health domain of the WHOQOL-BREF evaluates mental well-being through six indicators: (1) enjoyment of life, (2) a sense of life's meaning and purpose, (3) ability to concentrate, (4) acceptance of physical appearance, (5)

satisfaction with oneself, (6) frequency of negative feelings. Each indicator is rated on a five-point scale, with higher scores representing better psychological well-being.

Social Relationships

Social relationships refer to the connections that exist between people who have recurring interactions that are perceived by the participants to have personal meaning. This definition includes relationships between family members, friends, neighbors, coworkers, and other associates (56).

The social relationships domain of the WHOQOL-BREF includes three indicators: (1) satisfaction with personal relationships, (2) satisfaction with sexual activity, perceived support from friends. Each item is rated on a five-point Likert scale, where higher scores signify greater satisfaction with social relationships.

Environmental Health

Environmental health refers to the influence of the physical, biological, chemical, social, and psychosocial environments on human health including quality of life (57).

The environmental health domain of the WHOQOL-BREF assesses eight aspects of an individual's surroundings: (1) feeling safe and secure in daily life, (2) quality of the physical environment (e.g., climate, housing), (3) financial resources to meet basic needs, (4) access to information and knowledge, (5) opportunities for leisure and recreational activities, (6) satisfaction with living conditions, (7) access to healthcare services, (8) satisfaction with transportation options. Each question is rated on a five-point scale, with higher scores indicating a more favorable environmental condition.

In summary, the WHOQOL-BREF is considered a gold-standard tool for assessing quality of life in every aspect. It has been successfully applied in previous studies conducted among Myanmar migrant workers in Thailand, demonstrating its reliability and cultural relevance. Therefore, the WHOQOL-BREF is a highly suitable instrument for evaluating quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand.

2.7 Social-Ecological Model (SEM)

Social-Ecological Model is a theoretical framework using a comprehensive approach to assess or explain human behavior. SEM has evolved over a number of decades in the fields of sociology, psychology, education, and health. It focuses on the nature of people's interactions with their environments (58).

The Social-Ecological Model was shaped by the contributions of three key researchers. Urie Bronfenbrenner first introduced the ecological systems theory in 1994, emphasizing the interaction between individuals and their environments. Later, Kenneth McLeroy and others expanded on this concept by developing the ecological model of health behaviors in 1988, which outlined five levels of influence on health behavior. Finally, Daniel Stokols built upon these foundations in 1992 by formulating the social ecology model of health promotion, establishing its core principles (59).

The core concept of SEM is that behavior is affected by multiple levels of influences, including intrapersonal level, interpersonal level, organizational level, community level, and policy level (39).

1. The intrapersonal level (Individual level) of the social ecological model includes characteristics of the individual such as knowledge, attitudes, behavior, self-concept, skills, and individual living conditions, etc. This includes the developmental history of the individual. Interventions at the intrapersonal level use a variety of intervention strategies or levels of intervention such as educational programs, mass media, support groups, organizational incentives, or peer counseling. However, the theory of change is one of changing individuals, and the targets of the intervention include characteristics of the individual, such as knowledge, attitudes, skills, or intentions to comply with behavioral norms (39).

2. The interpersonal level of the social ecological model consists of formal and informal social network and social support systems, including the family, work group, and friendship networks. Social relationships are essential aspects of social identity. They provide important social resources, including emotional support, information, access to new social contacts and social roles, and tangible aid and assistance in fulfilling social and personal obligations and responsibilities. Therefore,

intervention strategies at this level include enhancement of social supports and social networks, and increasing access (39).

3. The organizational level of the social ecological model takes into account of social institutions with organizational characteristics, and formal (and informal rules and regulations for operation. Organizations provide the opportunity to build social support for behavioral changes. Organizational characteristics, such as the use of incentives, management and supervisor support, changes in rules and regulations, changes in benefits, and changes in the structure of work may all be used as intervention strategies to support behavioral changes (39).

4. The community level of the social ecological model includes relationships among organizations, institutions, and informal networks within defined boundaries, including social experiences arising from the broader community environment. Interventions with a community focus for health promotion activities may include increasing coordination among community agencies, and coalition building to influence community awareness, local health policies, conflict resolution, mass media campaigns, and resource expenditures (39).

5. The public policy level of the social ecological model consists of local, state, and national laws and policies. Interventions at this level include policy development, public advocacy, policy analysis, and increasing public awareness which all have important implications for communities (39).

To clearly understand how quality of life is affected by various factors at different levels, it was necessary to use a comprehensive approach. The social-ecological model is one of the comprehensive approaches to explain health behaviors and how it is affected by multiple level of influence. Therefore, this study applied the social-ecological model to explain the quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand which was adapted into only four levels; including intrapersonal level (age, sex, ethnicity, living arrangement in Thailand, family members in Myanmar, health insurance, educational attainment, marital status, chronic disease, health risk behavior, duration of stay in Thailand, area of residence, type of residence, Thai language proficiency, documentation status, monthly income, monthly income sufficiency, mental health status), interpersonal level (social support), institutional level (previous occupation in Myanmar, current occupation in Thailand, work environment,

primary mode of transportation to the workplace, job satisfaction, length of time in current job) and community level (access to healthcare, discrimination).

2.8 Previous Related Studies

2.8.1 Age

Age is a critical determinant of quality of life, as mentioned in various previous studies. Research finding among migrant workers in Korea by Cho et al. (37) revealed that younger individuals, particularly those under 35, reported the highest QoL levels. Nevertheless, a study by Anjara et al. (51) among female migrant domestic workers in Singapore mentioned that their quality of life increases with age, with older age groups reporting significantly higher quality of life. The reason why younger individuals experience better quality of life might be due to higher energy levels, fewer chronic health conditions, career advancement and greater adaptability to new environments. However, in some contexts, older individuals might report higher quality of life due to increased emotional stability, life experience, and stronger social support networks.

In summary, age is an important variable which can contribute to quality of life among Myanmar migrant workers. Therefore, it needs to be examined in this context. Although this variable does not have modifiable characteristics, it is essential to map the target age group for the public health information and resource allocation.

2.8.2 Sex

Sex differences in health and quality of life outcomes are well-established in the literature. In a study conducted in Phang Nga Province among Myanmar migrant workers, Ti et al. (29) found a statistically significant association between sex and quality of life, reporting that migrant women often exhibit higher quality of life compared to their male counterparts. However, a study conducted among Turkish immigrants in Sweden by Bayram et al. (60) observed the opposite trend, where quality of life of male immigrants was found to be higher than that of females. Sex may influence quality of life through both biological and social mechanisms. Biologically, men and women may experience differences in physical health conditions that impact

their quality of life. For example, women might benefit from stronger social networks while men may experience advantages in certain contexts, such as employment stability.

To sum up, sex is a significant determinant of quality of life, with studies revealing conflicting trends based on context. Therefore, it should be investigated among Myanmar migrant workers. Even though this variable is not modifiable, understanding these gender-based differences is essential for developing targeted interventions that address the unique needs of both men and women to improve their overall well-being.

2.8.3 Ethnicity

Ethnicity is one of the important factors that can significantly influence quality of life, as they uniquely shape individuals' physical, emotional, and social experiences. Stein et al. (61) identified ethnicity as an independent factor influencing quality of life in heart failure patients, with race and ethnicity significantly affecting all four health-related quality of life measures. The reason could be that ethnicity can influence quality of life through cultural practices and social connections.

As reasoned above, ethnicity might contribute to quality of life. Moreover, there is little information on this variable and quality of life among Myanmar migrant workers. Hence, they need to be examined as a variable in the study.

2.8.4 Educational Attainment

Educational attainment plays a fundamental role in determining an individual's quality of life. A study conducted in Central and Northern Thailand by Linn et al. (35) found that Myanmar migrant women workers with a college or university education had higher quality of life than those with no education. Similarly, in a study conducted among migrant construction workers in Chennai, Manikandan et al. (24) further supported that education was significantly associated with quality of life and that having a good education is one of the key determinants of achieving a better quality of life. Education might influence quality of life by equipping individuals with the knowledge and skills necessary to access better job opportunities, earn higher incomes, adapt healthier life styles, and make informed decisions about their health and well-being.

Based on the above research literature review, educational status is a critical determinant of quality of life among migrant workers which is why it should be studied in this context.

2.8.5 Marital Status

Marital status plays a crucial role in shaping health outcomes and quality of life. In a study conducted in Samut Sakhon province, Thailand among adult Myanmar migrant workers, Thein et al. (28) found a significant association between marital status and health-related quality of life. Ti et al. (29) also highlighted that the married people had a higher quality of life among Myanmar migrants in Phang Nga Province, Thailand. Similarly, a study by Kittipichai et al. (62) revealed that marital status was associated with the overall quality of life among Thai workers in textile dyeing factories. The explanation might be that sharing life with a spouse gives a sense of security, allowing them to feel at ease and receive both physical and emotional support, which might enhance their ability to manage stress and maintain mental well-being. However, for unmarried individuals, the lack of a partner's support might result in increased feelings of loneliness and greater difficulty in coping with health challenges, potentially lowering their quality of life.

To sum up, marital status seems to be associated with quality of life. Then, it should be investigated among Myanmar migrant workers in Chiang Rai Province as well.

2.8.6 Chronic Disease

The presence of chronic diseases plays a significant role in influencing the quality of life. Research findings by Lu et al. (22) reported that Chinese Rural-to-Urban Migrant workers who had chronic illnesses had a lower quality of life compared to those without conditions. A study conducted by Bergmann et al. (63) mentioned that having chronic diseases like diabetes and ischemic heart disease were associated with lower overall physical quality of life and reduced mental quality of life. Similarly, Tsai (34) also revealed that the presence of chronic diseases such as hyperlipidemia ($\beta = -3.79$) and cardiovascular disease ($\beta = -13.6$) was associated with lower quality of life among of White-Collar Migrant Workers in China. The possibility might be that chronic illnesses often impose physical and emotional burdens, reducing an individual's ability to work or engage in daily activities. Additionally, it might be influencing the

cost of managing these conditions, which can create financial stress barriers to accessing regular medical care, which can increase the impact of chronic diseases on their quality of life.

In summary, chronic diseases are likely linked to reduced quality of life, especially in the migrant populations. Therefore, it is important to examine in this study and addressing the disparities through improved healthcare access, financial support, and targeted interventions could help mitigate the negative effects of chronic diseases on the well-being of migrant workers.

2.8.7 Health Risk Behaviors

Health risk behaviors, such as alcohol consumption and smoking, including exercise, play a significant role in influencing the quality of life in various studies. Pahn et al. (11) reported that higher level of physical activity such as exercise was positively associated with higher health-related quality of life. Anokye et al. (64) also highlighted that higher levels of physical activity such as exercise are associated with better health-related quality of life (HRQoL). A systemic review by Posadzki et al. (65) also stated that exercise decreases mortality rates and improves quality of life. This positive relationship was evident across different types of physical activity, as individuals engaging in activities such as exercise, sports, or walking reported better HRQoL compared to inactive individuals. Moderated drinking was one of the factors influencing quality of life according to the study conducted among Thai older people in a rural area of Thailand by Hongthong et al. (66). Interestingly, drinking has a positive association, indicating that alcohol consumption might be associated with better quality of life, though this could reflect cultural or social factors. It was possible that social drinking caused them to have better quality of life than those who were lonely. However, findings from Oo et al. (67) among older people in Myanmar highlighted contrasting results, where alcohol consumption was associated with poorer physical health. These opposite findings show that more research is needed to understand how cultural traditions, drinking behaviors, and personal health conditions affect the quality of life. In the same study, smoking habit was significantly associated with psychological status level of older people. Older people who were currently smoking trend to have better psychological status than the non-smoker. But in terms of social domain, older people who were smoking had higher level of social relationships

than non-smoking older people. These could be the case because smoking could serve as a way to relax, connect with others, reducing loneliness and fostering social interactions, which can improve their psychological and social well-being. On the contrary, a study conducted among migrant construction workers in Chennai by Manikandan et al. (24) revealed that avoiding tobacco is one of the determinants of having good quality of life.

According to the review of relevant research, many articles found that health risk behaviors tend to be associated with quality of life. However, these behaviors are modifiable, which means they can be managed to reduce the risk of having poor quality of life. Therefore, they are needed to examine this context among Myanmar migrant workers in Chiang Rai Province.

2.8.8 Duration of Stay in Thailand and Thai Language Proficiency

Duration of stay is one of the critical factors influencing the quality of life among migrant workers. In a systematic literature review by Cho et al. (37), three studies confirmed the length of residence as an influencing factor in the quality of life of migrant workers where longer stay in Korea indicated higher quality of life. Similarly, in a study conducted in Samut Sakhon Province, Thailand among Myanmar migrant workers by Thein et al. (28), duration of stay in Thailand showed significant association with health-related quality of life, indicating that the longer Myanmar migrant workers stay in Thailand, the higher their QoL score. The finding showed that an extended stay often leads to better adaptation and improved well-being. In the same study, the author also reported a significant association between Thai language proficiency and QoL, indicating that the better the Thai language skills, the higher the QoL score. Duration of stay may influence quality of life by helping migrants adapt to their environment, develop supportive social networks, leading to better access to jobs and essential services. Thai language proficiency can also enhance quality of life by reducing isolation, encouraging belonging, and enabling cultural engagement.

As reasoned above, both the duration of stay and Thai language skill play pivotal roles in enhancing quality of life among migrant workers which is why it is needed to investigate in this context as well.

2.8.9 Area of Residence and Type of Residence

Area of residence and type of residence are also important factors shaping quality of life. According to the systemic literature review for quality of life of migrant workers in Korea by Cho et al. (37), one study stated that area of residence was the one of the significant factors influencing quality of life where the higher the standard of living in the city, the higher the quality of life. Another study in the same review also mentioned that higher housing satisfaction also resulted in higher quality of life. In the study done in Samut Sakhon Province, Thailand, Thein et al. (28) stated that types of housing showed a significant association with health-related quality of life of Myanmar migrant workers. The author mentioned that those lodging in work compound reported the highest QoL scores. Similarly, a study among adult migrant garment workers in Dhaka City found that participants living in work compound housing reported higher mean quality of life scores than those renting accommodation (23). Moreover, in a study conducted among Cambodian migrant workers in Thailand, Laohasiriwong et al. (32) mentioned that those living in employer-provided housing were more likely to have poor quality of life 2.66 times than those in other housing (aOR = 2.66, 95% CI = 1.74-4.08). Living in areas with a higher standard of living, such as cities, often provides better access to healthcare, education, and social services, employment opportunities, all of which contribute to a higher quality of life when compared to rural areas. Moreover, type of housing might influence quality of life by affecting living conditions, privacy, and access to facilities.

Regarding the review of relevant research, articles found that of residence and type of housing tend to play important roles in enhancing quality of life. Then, a study of these variables is needed to test in this context among Myanmar migrant workers in Chiang Rai Province.

2.8.10 Documentation Status

Documentation status is a critical factor influencing the quality of life, particularly in terms of access to healthcare and social services. In a systemic literature review for health-related quality of life of migrant workers in Korea by Cho et al. (37), one study highlighted a strong correlation between migrants' legal or illegal residency status and their overall quality of life. The author stated that quality of life of illegal Mongolian migrant workers was significantly lower than that of legally resident ones,

emphasizing that legal protections play a vital role in improving the well-being of migrant workers. Moreover, in the study where the well-being of newly regularized migrant workers and the determinants of their satisfaction with life as compared to undocumented migrant workers and regular local residents were explored, Burton-Jeangros et al. (68) stated that satisfaction with life is significantly lower among undocumented migrant workers. Legal status might impact quality of life by providing migrants with the security and rights necessary to live in their host country without fear of discrimination or deportation. Documented migrants may have easier access to healthcare, education, and employment opportunities.

To sum up, previous studies stated that legal status significantly affects the quality of life for migrant workers. Therefore, it is needed to investigate in this study to recommend and implement targeted interventions for this specific group of migrant population.

2.8.11 Monthly Income and Monthly Income Sufficiency

Income is another key determinant of quality of life, with financial stability greatly affecting various dimensions of well-being. In a systemic literature review for quality of life among migrant workers in Korea by Cho et al. (37), two studies stated how higher monthly income results in higher quality of life of migrant workers. A report in Samut Sakhon Province, Thailand by Thein et al. (28) also mentioned that monthly income of Myanmar migrant workers showed significant associations with health-related quality of life where the higher the monthly income, the better the quality of life. Similarly, according to the study conducted in the South of Thailand by Hnuploy et al. (26), Myanmar migrant workers earning $\geq 9,300$ Baht per month had 1.62 times higher chances of having good quality of life than those earning less than 9,300 Baht (aOR = 1.62, 95% CI = 1.01-2.59). The possible reason might be that income influences quality of life by providing individuals with greater access to necessities such as nutritious food, housing, and healthcare services. Additionally, a stable income might reduce stress and anxiety contributing to an improved quality of life.

Based on the above research literature review, income serves as a foundational determinant of quality of life among migrant workers. Thus, it is also necessary to examine in this context among Myanmar migrant workers in Chiang Rai Province because it is important to address income disparities to improving quality of life.

2.8.12 Mental Health Status

Mental health is a significant concern among migrant workers, as various studies have highlighted its negative effects on their overall well-being. According to a mixed method study by Khai et al. (31) conducted among undocumented Myanmar migrant workers in Thailand, unemployed and undocumented persons tend to suffer from long and worsening mental health issues such as depression, anxiety disorder and stress, particularly during uncertain situations like the COVID-19 pandemic. Hnuploy et al. (26) also found that Myanmar migrant workers with no depressive symptoms were 3.83 times more likely to have a good quality of life compared to those with depressive symptoms (aOR = 3.83, 95% CI = 2.28-6.43) in the study conducted in South of Thailand. Moreover, Dineva R et al. (33) observed a significant negative relationship between depression and quality of life ($r = -0.47$) among Indonesian Migrant Workers in South Korea, suggesting that depressive symptoms exacerbate the impact of stress on an individual's health. Laohasiriwong et al. (32) also stated that among Cambodian migrant workers in Thailand, workers with high perceived stress levels were 4.36 times more likely to have poor quality of life compared to those with low or moderate stress levels. Similarly, a study conducted among female migrant domestic workers in Singapore found that stress contributed to poorer quality of life across most domains (51). According to a systematic review by Cho et al. (37), a study conducted among Indonesian migrant workers in Korea also reported a significant negative correlation between acculturative stress and quality of life (33). The reasons might be that poor mental health can negatively affect physical health, emotional stability, social relationships, and daily functioning, ultimately reducing quality of life.

Regarding the review of relevant research, many previous studies found that mental health status have been associated with quality of migrant workers. Therefore, it is an important variable to be examined in this study. Moreover, mental health status is considered as a modifiable factor, which can be managed and addressing these factors in research and interventions could provide a more comprehensive understanding of how to improve migrant workers' quality of life.

2.8.13 Living Arrangement and Social Support

Both living arrangement and social support play a crucial role in influencing both mental and physical health outcomes, as proven in several studies. In a study

conducted among Cambodian migrant workers in Thailand, Laohasiriwong et al. (32) stated that migrant workers who stay with family or relatives had 3.63 times higher odds of experiencing low quality of life compared to those who stay alone or with friends (aOR = 3.63, 95% CI = 2.42-5.45). This finding indicates that living with family may cause stress or financial burden for migrant workers.

In a study done among Myanmar Women Migrant Workers in Central and Northern Thailand, Linn et al. (35) stated that women who reported moderate social support had a 4.781 higher QoL score, and those with high social support had a 9.721 higher QoL score compared to those with low social support ($\beta = 4.781$ for moderate support and $\beta = 9.721$ for high support). Moreover, Kyaw (11) also mentioned that positive relationships with friends, relatives, and co-workers, together with different forms of social support such as emotional comfort, information sharing, advice, financial assistance, and job networking, can strengthen the resilience and coping capacity of migrant workers. Moreover, according to the study done among migrant workers in China by Yang et al. (36), the total scores of social support and quality of life showed an independent positive correlation in migrant workers ($\beta = 0.50$). A study done among new-generation migrant workers in Eastern China by Xing et al. (69) also reported that migrant workers' quality of life was positively influenced by social support in each domain and general health. Similarly, in a systemic literature review for quality of life of migrant workers in Korea by Cho et al. (37), three studies identified that social support was a significant factor associated with quality of life among migrant workers. Among these three studies, one study conducted by Dineva R and Choi (33) reported a significant positive association between social support and quality of life. Their results indicated that individuals with higher levels social support tended to have better overall quality of life scores ($\beta = 0.46$). The reasons for all of the above findings might be that social support can be a protective factor, mitigating stress and enhancing mental health leading to better quality of life.

In summary, living status and social support tend to be key determinants of quality of life and important variables to consider for improving Myanmar migrant workers' well-being which is why it is essential to investigate them in this context.

2.8.14 Type of Occupation and Work Environment

Type of occupation and work environment play a significant role in shaping the quality of life among migrant workers. Evidence from a study conducted among adult Myanmar migrant workers in Samut Sakhon Province, Thailand, by Thein et al. (28) demonstrated a significant relationship between type of occupation and quality of life. Similarly, Kutlu and Koruk (70) found that adverse working conditions have a negative impact on the quality of life of seasonal migrant farmworkers. Research conducted in China by Fitzgerald et al. (71) indicated that a large proportion of migrant workers are employed in hazardous work settings, which increases their exposure to injuries and trauma, particularly in high-risk industries such as manufacturing and construction. In addition, Sahlbok et al. (72) reported that migrant road construction workers in high-altitude regions of the Himalayas frequently experience symptoms related to high-altitude occupational conditions, including headaches and respiratory difficulties, as well as chronic illnesses such as bronchitis and lung cancer associated with prolonged exposure to environmental pollutants. Furthermore, a study among Nepalese migrant workers by Simkhada et al. (73) revealed that this population faces an elevated risk of occupational injuries, with common incidents including cuts, fractures, and sprains. The study also highlighted that a substantial proportion of workers in the agricultural and construction sectors reported experiencing workplace injuries within the past year. Based on those previous studies, all of the above factors might contribute to greater health risks, negatively affecting their well-being and quality of life.

According to the above research literature review, the type of occupation and work environment play important roles in determining the quality of life for migrant workers. Therefore, it is essential to be investigated in this context so that targeted intervention for specific groups of migrant workers can be recommended and implemented.

2.8.15 Primary Mode of Transportation to Workplace

Primary mode of transportation to workplace plays an important role in influencing quality of life of migrant workers. Laohasiriwong et al. (32) mentioned in their study conducted among Cambodia migrant workers in Thailand that workers who commute to work using their employer's vehicle or by foot are 1.64 times more likely to have poor quality of life compared to those who commute by motorbike or

bicycle (aOR = 1.64, 95% CI = 1.11-2.42). The reason could be that convenient transportation, such as owning a vehicle, can improve daily commuting and overall quality of living.

In summary, daily travel to workplace facilities is one of the important factors to consider because it tends to influence migrant workers' quality of life. Hence, it is needed to be studied in this context among Myanmar migrant workers as well.

2.8.16 Job Satisfaction and Length of Time in Current Job

For several reasons, job satisfaction and length of time in current job are linked to quality of life. In a systemic literature review of health-related quality of life of migrant workers in Korea by Cho et al. (37), one study mentioned that the higher the job satisfaction, the better the quality of life, with hope acting as a key mediator. The reason might be that when workers feel satisfied in their jobs, they are more likely to experience a sense of fulfillment, which can enhance their overall well-being. Moreover, in a study among Chinese rural-to-urban migrants, Liang et al. (74) reported that job satisfaction significantly influenced their physical and psychological health status. In a study conducted among adult Myanmar migrant workers in Samut Sakhon Province, Thailand, Thein et al. (28) also stated that length of time in current job, satisfaction on the work place (sound, light, ventilation, smell, work position and salary) showed significant associations with health-related quality of life. Furthermore, workers who have been in their current job for 4 years or more have a higher average QoL score compared to those with less than 4 years in the job. These factors can contribute to a healthier and more comfortable working environment, which in turn supports better physical and mental well-being.

To sum up, both job satisfaction and length of time in current job seem to contribute to migrant workers' quality of life according to the previous studies. They are also important factors that need to be investigated in this context among Myanmar migrant workers in Chiang Rai Province.

2.8.17 Access to Healthcare and Health Insurance

Access to healthcare services plays a fundamental role in determining health outcomes, especially for migrant populations. Health insurance is also crucial for ensuring access to essential healthcare services, which significantly impacts the quality of life for migrant workers. In a study conducted among Myanmar migrant workers in

Samut Sakhon Province, Thailand, Thein et al. (28) found that having and keeping a health insurance card is strongly associated with a higher quality of life among Myanmar migrant workers. The study also found that perceived difficulty in accessing health facilities and frequent crowding were associated with lower health-related quality of life scores. Moreover, a study conducted among migrant workers in Northern Thailand by Palita Charoensook et al. (75) reported that health insurance status is significantly associated with quality of life. In a systematic literature review on the health-related quality of life of migrant workers in Korea by Cho et al. (37), one included study found that the presence of medical benefits was significantly associated with higher HRQoL ($t = 2.75$). Migrant workers who had access to medical benefits reported better quality of life compared to those without coverage. Health insurance may improve quality of life by reducing the stress associated with healthcare costs and enhancing access to preventive and curative services. In a study done among Chinese Rural-to-Urban Migrant Workers, Lu (22) also suggested that migrant workers have a poor understanding of healthcare services and a limited awareness of medical insurance, further emphasizing the need for better education and support in this area. Migrant workers who can easily access healthcare are more likely to receive vaccinations, screenings, treatments, and early interventions, which can prevent the escalation of health issues.

As reasoned above, access to healthcare and health insurance status play a vital role in determining the quality of life for migrant workers. These variables are classified as modifiable, which means they can be managed by enhancing awareness and understanding of healthcare and insurance systems among migrant workers to maximize the benefits.

2.8.18 Discrimination

Discrimination is closely linked to quality of life because it can significantly affect the quality of life. In a study done among Latinx adults by Molina et al. (76) stated that higher perceived personal discrimination was directly associated with poorer quality of life which was mediated by depressive symptoms. The study by Jung et al. (77) also supports the association between racial discrimination and worse HRQoL among Asian Americans immigrants. Moreover, Urzúa et al. (78) reported that perceived discrimination was inversely associated with the quality of life of migrants

in Chile. A study among Brazilian female immigrants in Portugal also showed that higher perceived discrimination was associated with lower quality of life and had negative effects on both physical and mental health (79). Similarly, Wang et al. (80) found that discriminatory experiences had significant negative effects on both psychological distress and quality of life among rural-to-urban migrants in China.

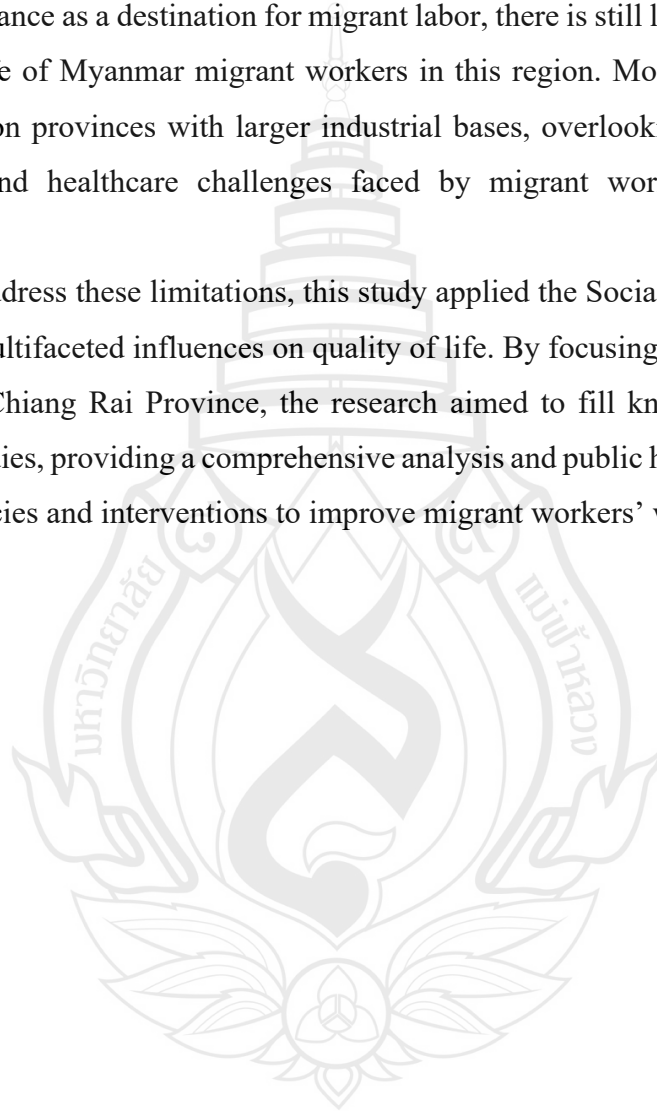
To sum up, perceived discrimination tends to affect quality of life significantly. Then, it is needed to be investigated among vulnerable populations such as Myanmar migrant workers in Chiang Rai Province in this study to help with appropriate public health intervention tactics in their contexts.

A review of relevant literature on quality of life among migrant workers has enhanced knowledge of the various factors contributing to their well-being, particularly among Myanmar migrant workers. Existing research highlights that studying quality of life among migrant workers is crucial for public health, social stability, economic development, and equitable healthcare access. Even though previous studies on the quality of life of Myanmar migrant workers in Thailand have provided valuable insights, they have limitations in terms of time and context. Earlier works explored various determinants of quality of life in specific regions like Phang Nga, Samut Sakhon, and Chiang Rai provinces (27–29). However, these studies are over a decade old, and their findings may no longer align with Thailand's current migration patterns, policies, and healthcare systems. Recent studies on the quality of life among Myanmar migrant workers in Thailand have primarily used qualitative methods, focusing on specific socio-cultural contexts, such as Samut Sakhon (81) and Mae Sot (82), as well as the mental health challenges of undocumented migrants during COVID-19 (31). While these studies provide valuable insights into lived experiences, there is a need for quantitative research to systematically assess quality of life of both documented and undocumented Myanmar migrant workers, thereby enhancing the generalizability and policy relevance.

More recent studies highlight the significant role of mental health, social relationships, and socioeconomic factors in shaping the quality of life among Myanmar migrant workers in Thailand. Studies have primarily focused on specific populations, such as women migrant workers and their access to social support and effects of violence on quality of life (35, 83), or have examined regional contexts like southern

and central Thailand (26). While these findings provide valuable insights, they do not fully address other important factors, such as discrimination, which can significantly impact migrant workers' well-being and opportunities. Moreover, they are either region-specific or gender-focused, leaving a gap in understanding the quality of life of both male and female migrant workers in northern Thailand. Despite Chiang Rai's rising importance as a destination for migrant labor, there is still limited research on the quality of life of Myanmar migrant workers in this region. Most studies in Thailand often focus on provinces with larger industrial bases, overlooking the unique social, economic, and healthcare challenges faced by migrant workers in the northern provinces.

To address these limitations, this study applied the Social-Ecological Model to assess the multifaceted influences on quality of life. By focusing on Myanmar migrant workers in Chiang Rai Province, the research aimed to fill knowledge gaps left by previous studies, providing a comprehensive analysis and public health information that informs policies and interventions to improve migrant workers' well-being.



CHAPTER 3

MATERIALS AND METHODS

This chapter presents the research design, study setting, study sample and sample size, sampling technique, research tools and its development, process of data collection, data analysis and ethical consideration.

3.1 Study Design

A community-based cross-sectional study design was employed to measure the quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand, while identifying the key associated factors that shape their quality of life.

3.2 Study Site

The research was conducted in Mueang and Mae Sai Districts of Chiang Rai Province located in the northern region of Thailand.

3.3 Study Population

The study population consisted of Myanmar migrant workers, both male and female, aged 18 and older who have resided in Mueang and Mae Sai Districts of Chiang Rai Province, Thailand, for at least six months prior to data collection.

3.4 Inclusion and Exclusion Criteria

3.4.1 Inclusion Criteria

This study included Myanmar migrant workers of both sexes and with any legal status who were aged 18 years or older. Participants were required to have resided in

Chiang Rai Province for at least six months prior to data collection. They also needed to be able to either read and write in the Myanmar language and complete the questionnaire independently, or, if unable to read and write but able to understand spoken Burmese, complete the same questionnaire through a face-to-face interview conducted by the researcher using the exact wording of the self-administered questionnaire. In addition, all participants were required to be willing and able to provide informed consent to participate in the study.

3.4.2 Exclusion Criteria

Individuals were excluded if they had acute medical conditions, such as severe infections, recent surgeries, or hospitalization, or if they had cognitive impairments such as diagnosed dementia, mental disability, or severe psychological disorders that could hinder their ability to complete the questionnaire or provide informed consent. Furthermore, individuals with physical disabilities were excluded if the condition directly limited their ability to communicate effectively or participate in the data collection process.

3.5 Sample Size Calculation

The following formula, referred to as Cochran's Formula (84), was utilized to determine the proper sample size where:

$$n = \frac{z^2 p(1 - p)}{d^2}$$

n = required sample size

z = standard value for 95% confidence interval = 1.96

p = prevalence of targeted population who have a moderate quality of life
= 56% (27) = 0.56

d = desired margin of error = 0.05

$$n = \frac{1.96^2 \cdot 0.56 \cdot (1-0.56)}{0.05^2} = 378.63$$

According to the calculation, about 380 individuals were required.

An additional 10% was added to the calculated sample size to account for partial responses and participant withdrawals.

$$\text{Sample size} = 380 + 380 (0.1) = 418$$

As a result, the final sample size was 418 participants, rounded to approximately 420.

3.6 Sampling Technique

A multistage sampling technique was employed to obtain a representative sample of Myanmar migrant workers from Mueang and Mae Sai districts of Chiang Rai Province, as these districts have the highest concentrations of Myanmar migrants (7). Firstly, simple random sampling was conducted to select four communities from each district, two large and two small, out of a total of 19 communities. Communities with a population of 200 or more were considered large, and those with fewer than 200 were classified as small. In the second stage, proportional allocation was applied to distribute the sample size among the selected communities based on their population size, ensuring that larger communities contribute more participants while maintaining representativeness. Finally, participants who meet the study's inclusion criteria were selected, ensuring a balanced and representative sample.

Table 3.1 Myanmar Communities with Estimated Population in Mueang Chiang Rai and Mae Sai Districts

Myanmar Communities with Estimated Population	
Mueang Chiang Rai District	Mae Sai District
MFU hospital Camp (200)	Ko Sai (250)
Ban Du (200)	Mai Lung Khon (250)
Bab Phlu Thong (100)	Mae Sai Mittraphap (250)
Doi Sa Ken (100)	Pa Muead (100)
Rai Boon Rod (200)	Chumchon Ban Chong (100)
Api Square (100)	Doi Ngam (300)
Hau Pla Kang (150)	

Table 3.1 (continued)

Myanmar Communities with Estimated Population	
Mueang Chiang Rai District	Mae Sai District
Den Ha (30)	
San Khong (30)	
Koh Loy (100)	
Ta Lard Mae Kron (50)	
Ta Lard Pa Ko (50)	
Thai Samut (100)	
Source Min (85)	

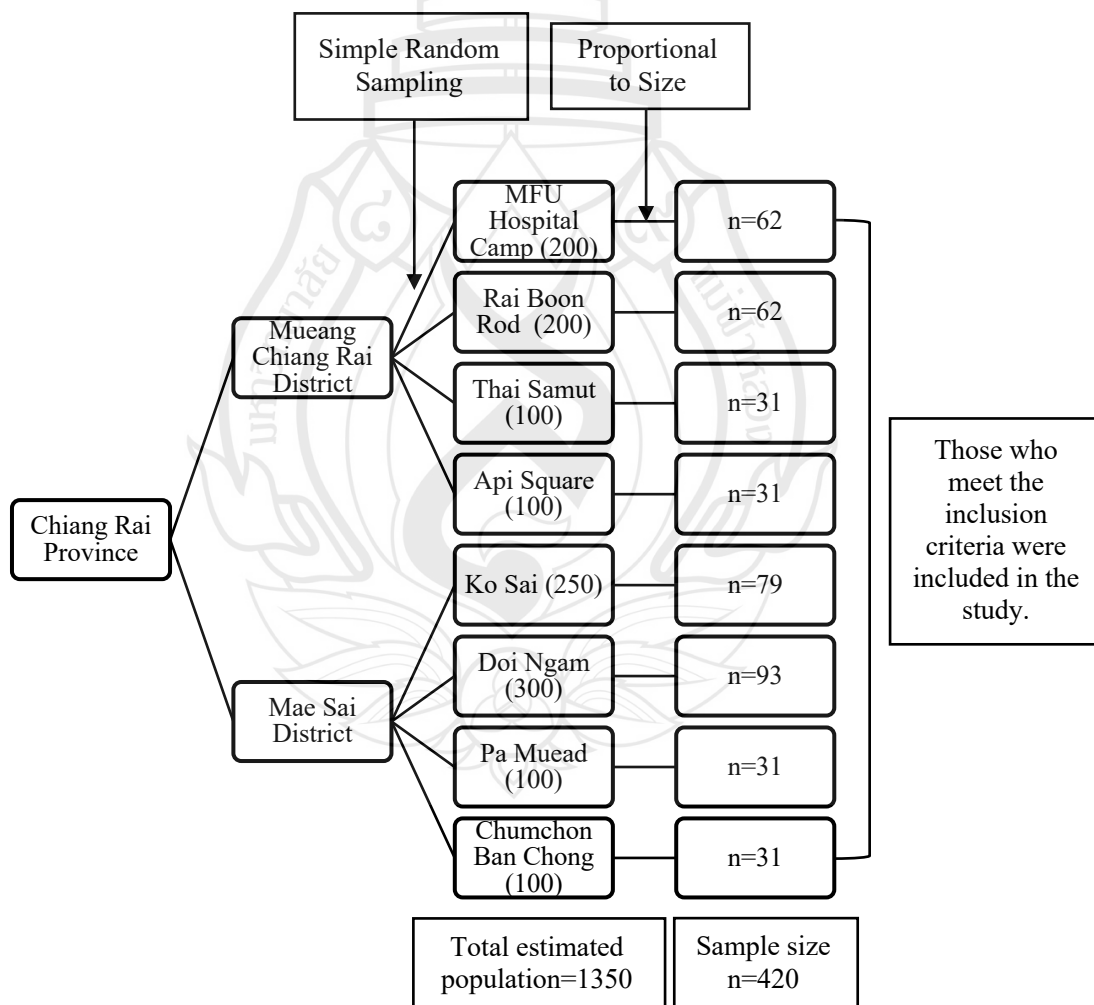


Figure 3.1 Diagram of Sampling Technique

3.7 Research Tools

The validated structured questionnaire was developed based on social-ecological model, integrating standardized tools. The questionnaire consisted of seven parts.

Part 1: General characteristics

This section comprised 19 questions that collected information about general characteristics such as age, sex, ethnicity, living arrangement in Thailand, family members in Myanmar, health insurance, educational attainment, marital status, chronic disease, health risk behavior (alcohol consumption, smoking, exercise), duration of stay in Thailand, area of residence, type of residence, Thai language proficiency, documentation status, monthly income and monthly income sufficiency, previous occupation in Myanmar, current occupation in Thailand, work environment, primary mode of transportation to the workplace, and length of time in current job.

Part 2: Quality of Life (WHOQOL-BREF)

Quality of life was assessed using the World Health Organization Quality of Life-Brief (WHOQOL-BREF), a widely validated instrument developed by the WHO (28, 55). The instrument consists of 26 items covering four domains: physical health (7 items), psychological health (6 items), social relationships (3 items), and environmental health (8 items). Responses are rated on a 5-point Likert scale ranging from 1 (not at all) to 5 (completely), reflecting participants' perceived quality of life during the previous two weeks.

Domain scores were interpreted as poor, moderate, or good according to established WHOQOL-BREF scoring criteria. Physical health scores ranged from 7-35 and were classified as poor (7-6), moderate (17-26), and good (27-35), while psychological health scores ranged from 6-30 and were categorized as poor (6-14), moderate (15-22), and good (23-30). Social relationships scores ranged from 3-15 and were grouped as poor (3-7), moderate (8-11), and good (12-15), while environmental health scores ranged from 8-40 and were classified as poor (8-18), moderate (19-29), and good (30-40). Overall quality of life scores ranged from 26-130 and were categorized as poor (26-60), moderate (61-95), and good (96-130). The Index of Item-

Objective Congruence (IOC) in the current study was 1.00, and Cronbach's alpha coefficient was 0.945.

Part 3: Access to Healthcare

Access to healthcare was assessed using a standard questionnaire based on literature review (38, 86, 87) to fit the context of the current study on healthcare access among Myanmar migrant workers. The questionnaire evaluated access to healthcare based on five dimensions: accessibility (3 items), acceptance (3 items), availability (3 items), affordability (3 items) and appropriateness (3 items) of healthcare services and included a total of 15 items.

For accessibility, the first question consisted of two response options: 0 (more than or equal 30 minutes) and 1 (less than 30 minutes). The second and third questions also had two response options which were 0 (no) and 1 (yes). The accessibility score ranged from 0-3 and was categorized as accessible (2-3) and not accessible (0-1).

Acceptance comprised of three questions with three response options: 0 (never), 1 (sometimes), and 2 (always). The acceptance score ranged from 0-6 and was divided into acceptable (4-6) and not acceptable (0-3).

In availability, the first question consisted of three response options: 0 (never), 1 (sometimes), and 2 (always). The second item had three response options which were 0 (more than 1 hour), 1 (30 minutes to 1 hour), and 2 (less than 30 minutes). The third item also included three response options: 0 (less than 10 minutes), 1 (10 to 20 minutes), and 2 (more than 20 minutes). The availability score ranged from 0-6 and was classified into available (4-6) and not available (0-3).

Affordability consisted of three questions, where the first two questions had three response options: 0 (always), 1 (sometimes), and 2 (never). The third question also had three response options which were 0 (never), 1 (sometimes), and 2 (always). The affordability score ranged from 0-6 and was categorized into affordable (4-6) and not affordable (0-3).

Appropriateness comprised of three questions with three response options which were 0 (never), 1 (sometimes), and 2 (always). The appropriateness score ranged from 0-6 and was divided into appropriate (4-6) and not appropriate (0-3).

The total access to healthcare score ranged from 0-27 and was divided into three categories using the Best's average score division criteria (88): low (0-9), moderate

(10-18), and high (19-27). The Index of Item-Objective Congruence (IOC) in the current study for overall access to healthcare was 0.93, and Cronbach's alpha coefficient was 0.810.

Part 4: Mental Health Status

Mental health status was measured using the Depression, Anxiety and Stress Scale-21 (DASS-21), a validated self-administered instrument developed by Lovibond and Lovibond (89, 90). The scale includes 21 items equally distributed across three domains: depression, anxiety, and stress. Each item is scored on a 4-point Likert scale from 0 (did not apply to me at all) to 3 (applied to me very much or most of the time). Scores for each subscale were calculated by summing the scores of the relevant items and multiplying by 2 to align with the full DASS-42 scale.

Each domain scores ranged from 0-42 and depression was categorized into normal (0-9), mild (10-13), moderate (14-20), severe (21-27), and extremely severe (28 and above). Anxiety was classified as normal (0-7), mild (8-9), moderate (10-14), severe (15-19), and extremely severe (20 and above). Lastly, stress was divided into normal (0-14), mild (15-18), moderate (19-25), severe (26-33), and extremely severe (34 and above).

Regarding each subscale of the DASS-21 (depression, anxiety, and stress), the Index of Item-Objective Congruence (IOC) in the current study was 1.00 for all subscales, and the Cronbach's alpha coefficients were 0.836, 0.834, and 0.833, respectively.

Part 5: Social support

Social support was assessed using a questionnaire developed by the researcher based on the concept of Thoits (91). The instrument included 14 items covering support from family members, friends, and co-workers. Responses were scored using a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree).

For the family members' and friends' support, the score ranged from 5-25 and was divided into low (5-11), moderate (12-18), and high (19-25). The score of coworkers' support ranged from 4-20 and was categorized into low (4-9), moderate (10-15), and high (16-20).

The overall social support score ranged from 14-70 and was divided into low support (14-32), moderate support (33-51), and high support (52-70) using Best's

average score division criteria (88). The Index of Item-Objective Congruence (IOC) in the current study for overall social support was 1.00, and Cronbach's alpha coefficient was 0.850.

Part 6: Discrimination

Discrimination was assessed by the Everyday Discrimination Scale (EDS), which is a validated tool, developed by Williams et al. (92). The instrument contains 9 items scored on a 6-point Likert scale from 0 (never) to 5 (almost every day). The total score ranged from 0-45 and was categorized as low discrimination (0-15), moderate discrimination (16-30), and high discrimination (31-45) using the Best's average score division criteria (88). The Index of Item-Objective Congruence (IOC) in the current study was 1.00, and Cronbach's alpha coefficient was 0.890.

Part 7: Job Satisfaction

Job satisfaction was evaluated using the Generic Job Satisfaction Scale developed by Macdonald & MacIntyre (93). This 10-item scale evaluates different aspects of job satisfaction using a 5-point Likert response format, ranging from 1 (strongly disagree) to 5 (strongly agree). The scores ranged from 10-50 and job satisfaction was categorized as very low (10-26), low (27-31), average (32-38), high (39-41), and very high (42-50). The Index of Item-Objective Congruence (IOC) in the current study was 1.00, and Cronbach's alpha coefficient was 0.849.

3.8 Research Tools Development

3.8.1 Translation Process

The structured questionnaire development process was in English first which was then translated into Myanmar language using forward-backward method by fluent bilingual translators to ensure clarity, accuracy and cultural appropriateness for Myanmar migrant workers. The tools and questionnaires that were translated into Myanmar language in this study were Access to Healthcare Questionnaire, Social Support Questionnaire Based on Thoits Concept, Everyday Discrimination Scale (EDS), and Generic Job Satisfaction Scale.

3.8.2 Testing of Validity of Instruments

Content validity of the questionnaire was determined using the Index of Item-Objective Congruence (IOC) based on review by three experts in public health, psychology, and health behavior science. The questionnaire was revised according to the feedback and recommendations provided by the experts. Items with a score lower than 0.5 were removed from the questionnaire, those with scores between 0.5 and 0.7 were modified based on the reviewers' suggestions, and items with scores higher than 0.7 were retained in the final questionnaire, as presented in Appendix E.

3.8.3 Testing of Reliability of Instruments

The reliability of the Myanmar version of the questionnaire was pilot tested among 30 adult Myanmar migrant workers. The pilot study assessed the clarity of the language, the comprehensibility of the questions, and the logical flow of the questionnaire. Reliability was evaluated using Cronbach's alpha (α), with a value greater than 0.7 considered acceptable. Any necessary adjustments to the questionnaire were made based on the results of this trial to ensure its reliability and usability.

3.9 Data Collection

The data collection process commenced only after receiving ethical clearance from the Mae Fah Luang University Research Ethics Committee. To identify participants and obtain necessary permissions, coordination was conducted with local leaders, migrant worker organizations, and health services. Written informed consent was obtained from all selected participants to ensure they fully understand the purpose of the study, their role, and their rights. Participants were asked to sign the consent form before proceeding to the questionnaire phase. The data was collected by the researcher from September to October 2025.

Data was collected using self-administered structured questionnaires, which were distributed to participants in a private area to ensure their comfort and confidentiality. The questionnaire was designed to take approximately 20-30 minutes to complete. If participants had any questions during the data collection process, they were able to seek clarification from the researcher at any time. Once completed, the

questionnaires were reviewed to ensure completeness. However, for participants who cannot read or write in the Myanmar language but can understand spoken Burmese, data was collected through a face-to-face interview conducted by the researcher. To ensure the confidentiality and anonymity of participants, all collected data was entered into a secure database. The data was anonymized and stored safely, with access restricted to authorized personnel only.

Moreover, after the participants completed answering the questionnaire, they were provided with a brochure which included tips and information about healthcare, mental health, workers' rights, importance of social support and emergency contact numbers. The brochure was designed to not only express gratitude for their participation but also provide valuable resources to establish trust and enhance their well-being and quality of life.

After the data collection process was complete, scores were calculated, and results were summarized. These results were communicated back to the participants in an accessible format, either in the Myanmar language or through visual aids such as pictures or diagrams. Additionally, participants were provided with recommendations to help them improve their overall well-being and quality of life. This included guidance on self-care and addressing factors that may impact their health.

3.10 Data Analysis

3.10.1 Descriptive Analysis

Descriptive statistics described the characteristics of the study participants. Categorical variables were presented as frequencies and percentages. For continuous variables, the mean or median was used to describe central tendency, while variability was presented using the standard deviation or interquartile range.

3.10.2 Inferential Analysis

Inferential analysis was conducted to assess the associations between independent variables and quality of life. After QoL scores were derived from the WHOQOL-BREF instrument, the overall QoL variable was dichotomized for binary logistic regression analysis. Participants with “good” and “moderate” QoL scores were grouped together and compared with those with “poor” QoL scores, consistent with

previous studies (26, 32). Binary logistic regression was used to examine factors associated with poor quality of life. Univariable logistic regression analysis was performed to assess the association between each independent variable and poor quality of life. Crude odds ratios (cOR) with 95% confidence intervals (CI) were calculated. Variables with p-values <0.20 were considered for inclusion in the multivariable analysis. Multicollinearity among independent variables was assessed prior to multivariable analysis using correlation analysis. Variables with correlation coefficients greater than 0.70 were considered highly correlated and one variable was carefully chosen for the final model. Multivariable logistic regression analysis was then performed to identify independent factors associated with poor quality of life. Adjusted odds ratios (aOR) with 95% CI were reported. A p-value <0.05 was considered statistically significant.

3.11 Ethical Consideration

All research protocols were reviewed and approved by the Ethical Review Committee for Human Research, Mae Fah Luang University, Thailand (Protocol No: EC 25110-18; COA: 135/2025; Date of Approval: July 12, 2025) prior to administering the questionnaires to the participants. Participation was entirely voluntary. Participants were informed about the objectives and data collection methods of the study, and written informed consent was obtained before commencing the study. Participants were assured that they can withdraw at any time during the interview and may revoke their consent without any repercussions.

To ensure confidentiality, all responses were kept anonymous, and no permanent record of participants' names or identifying information were retained. Completed questionnaires and informed consent forms were stored separately to maintain anonymity. These documents were securely stored in a location accessible only to the primary investigator and destroyed upon data analysis and publication completion.

This study adhered to the three main ethical principles: beneficence, ensuring the well-being of participants; respect for human dignity, safeguarding their rights and autonomy; and justice, ensuring fair treatment of all participants.

All procedures in this study adhered to established ethical standards and complied with the Declaration of Helsinki (1975). The Declaration emphasizes informed consent, the protection of vulnerable populations, risk minimization, and the necessity for research to have scientific and societal value. It mandates that research involving human participants should be based on sound scientific principles, conducted by qualified professionals, and include measures to safeguard participants' health, dignity, and confidentiality (94).



CHAPTER 4

RESULTS

In this chapter, the findings and the results from the data analysis are presented, focusing on the quality of life and its four domains, intrapersonal level factors, interpersonal level factors, institutional level factors and community level factors contributing to quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand. The results are organized into the following topics:

- 4.1 Quality of life and its four domains
- 4.2 General characteristics of the participants
- 4.3 Subtypes from general characteristics of the participants
 - 4.3.1 Health insurance
 - 4.3.2 Chronic disease
 - 4.3.3 Family support, friend support and co-worker support
 - 4.3.4 Accessibility, acceptance, availability, affordability and appropriateness of healthcare
- 4.4 Univariable analysis to identify factors associated with poor quality of life
- 4.5 Multivariable analysis to identify factors associated with poor quality of life

4.1 Quality of Life and Its Four Domains

Among the 420 participants, the majority reported a moderate quality of life (68.6%), followed by poor quality of life (20.2%) and good quality of life (11.2%). Across the four domains of quality of life, most participants consistently reported scores in the moderate range. The environmental domain had the highest proportion of moderate responses (76.7%), followed by psychological and physical health (71.7% and 70.2% respectively). The social relationship and physical health domain showed a different pattern, with a relatively higher proportion reporting good level (28.1% and 25.0% respectively), compared with much smaller percentages of good scores in the psychological (6.9%), and environmental domains (5.2%). In terms of poor outcomes,

psychological (21.4%) had the largest proportion of participants in the poor category, whereas physical health had the lowest proportion of poor scores (4.8%) (Table 4.1).

Table 4.1 Quality of Life and Its Four Domains (n=420)

	n	%
Quality of Life		
Poor	85	20.2
Moderate	288	68.6
Good	47	11.2
Physical health		
Poor	20	4.8
Moderate	295	70.2
Good	105	25.0
Psychological health		
Poor	90	21.4
Moderate	301	71.7
Good	29	6.9
Social relationship		
Poor	48	11.4
Moderate	254	60.5
Good	118	28.1
Environmental health		
Poor	76	18.1
Moderate	322	76.7
Good	22	5.2

4.2 General Characteristics of the Participants

Regarding intrapersonal-level factors, a total of 420 participants were recruited, where 53.1% were males with the mean age of 32.3 years ($SD = 9.9$). The majority of the participants were Burma (91.2%), and 72.1% of the respondents were living with the family members in Thailand while 74.0% of the participants had their family members remaining and living in Myanmar. More than half of the participants did not have health insurance (52.1%). In terms of education, 61.7% of the participants had achieved secondary school in Myanmar. Approximately two-thirds of the respondents were married (65.5%) and 16.2% of the participants had chronic diseases like hypertension and diabetes mellitus. Regarding health risk behaviors, about one-fifth of them were currently drinking alcohol or smoking (18.8% and 22.6% respectively) and most of the respondents did not engage in exercise (65.7%). More than half of the participants (50.7%) had a duration of stay in Thailand of less than 3 years, resided in semi-urban areas (55.7%), and were currently living in rented accommodation (55.0%). As for the Thai language proficiency, although the vast majority of the respondents had no reading or writing skills (84.3% and 88.6% respectively), more than half of the participants had basic listening and speaking skills (58.3% and 54.5% respectively). Regarding documentation status of the participants, a total of 21.2% were undocumented. Most of the participants earned more than or equal 9000 Thai Baht per month (60.2%) where more than half of them reported their income as insufficient (59.5%). In terms of mental health status, 39.8% of participants reported moderate to extremely severe depressive symptoms, 35.4% reported moderate to extremely severe anxiety, and 14.0% reported moderate to extremely severe stress.

At the interpersonal level, nearly half of the participants (48.3%) reported moderate overall social support, followed by 45.3% with high social support and 6.4% with low social support. Regarding institutional-level factors, agriculture was the most common occupation in Myanmar (45.5%), whereas construction was most common in Thailand (45.8%). Nearly half worked indoors (48.6%), and 46.2% traveled to work by motorbike or bicycle. About one-third reported very low to low job satisfaction (29.8%). Just over half had been in their current job for one year or less (50.7%). In terms of overall access to healthcare, 54.1% of participants reported low to moderate access in

Thailand. Additionally, 10.3% reported moderate to high levels of discrimination (Table 4.2).

Table 4.2 General Characteristics of the participants (n=420)

Characteristics	n	%
Intrapersonal Level		
Age (years)		
18-33	258	61.4
34-50	138	32.9
≥ 51	24	5.7
Mean = 32.3, SD = 9.9, Min = 18, Max = 66		
Sex		
Male	223	53.1
Female	197	46.9
Ethnicity		
Burma	383	91.2
Karen	17	4.1
Shan	13	3.1
Mon/ Rakhine/ Akha/ Pa-O/ Lahu	7	1.6
Living arrangement in Thailand		
Family	303	72.1
Living alone	102	24.3
Friends	15	3.6
Family members in Myanmar		
Yes	311	74.0
No	109	26.0
Health insurance		
No	219	52.1
Yes	201	47.9

Table 4.2 (continued)

Characteristics	n	%
Educational attainment		
No formal education	26	6.1
Primary school	86	20.5
Secondary school	259	61.7
University or above	49	11.7
Marital status		
Married	275	65.5
Single	120	28.6
Separate/ Divorced/ Widowed	25	5.9
Chronic disease		
No	352	83.8
Yes	68	16.2
Alcohol consumption		
None	258	61.4
Ex-drinker	83	19.8
Current drinker	79	18.8
Smoking		
None	288	68.6
Ex-smoker	37	8.8
Current smoker	95	22.6
Exercise		
No	276	65.7
Yes	144	34.3
Duration of stay in Thailand (years)		
<3	213	50.7
3 – <10	103	24.5
≥10	104	24.8
Mean = 5.3, SD = 5.9, Min = 0.8, Max = 30		

Table 4.2 (continued)

Characteristics	n	%
Area of residence		
Semi-urban	234	55.7
Urban	186	44.3
Type of residence		
Rented house	231	55.0
Employer provided housing	153	36.4
On-site work compound	32	7.6
Shared housing with other families	4	1.0
Thai language proficiency (reading)		
None	354	84.3
Basic	57	13.6
Fluent	9	2.1
Thai language proficiency (listening)		
None	142	33.8
Basic	245	58.3
Fluent	33	7.9
Thai language proficiency (writing)		
None	372	88.6
Basic	40	9.5
Fluent	8	1.9
Thai language proficiency (speaking)		
None	158	37.6
Basic	229	54.5
Fluent	33	7.9
Documentation status		
Documented	331	78.8
Undocumented	89	21.2

Table 4.2 (continued)

Characteristics	n	%
Monthly income (baht)		
≥ 9000	253	60.2
< 9000	167	39.8
Mean = 9114.8, SD = 2732.1, Min = 2000, Max = 25000		
Monthly income sufficiency		
Insufficient	250	59.5
Sufficient	170	40.5
Depressive symptoms		
Normal	187	44.5
Mild	66	15.7
Moderate	138	32.9
Severe	19	4.5
Extremely severe	10	2.4
Anxiety		
Normal	225	53.6
Mild	46	11.0
Moderate	107	25.5
Severe	30	7.1
Extremely severe	12	2.8
Stress		
Normal	315	75.0
Mild	46	11.0
Moderate	50	11.9
Severe	9	2.1
Extremely severe	0	0.0

Table 4.2 (continued)

Characteristics	n	%
Interpersonal Level		
Overall social support		
Low	27	6.4
Moderate	203	48.3
High	190	45.3
Institutional Level		
Previous occupation in Myanmar		
Agriculture	191	45.5
Non-manual jobs	95	22.6
Dependent	60	14.3
Construction	57	13.6
Manufacturing	17	4.0
Current occupation in Thailand		
Construction	192	45.8
Service sector	147	35.0
Manufacturing	59	14.0
Agriculture	22	5.2
Work environment		
Indoor	204	48.6
Semi-indoor	111	26.4
Outdoor	105	25.0
Primary mode of transportation to the workplace		
Own motorbike or bicycle	194	46.2
On foot	167	39.8
Employer-provided vehicle	59	14.0

Table 4.2 (continued)

Characteristics	n	%
Job satisfaction		
Very low	30	7.2
Low	95	22.6
Average	192	45.7
High	63	15.0
Very high	40	9.5
Length of time in current job (years)		
≤1	213	50.7
>1 – 5	144	34.3
>5	63	15.0
Mean = 2.9, SD = 3.9, Min = 0.1, Max = 29		
Community Level		
Overall access to healthcare		
Low	49	11.7
Moderate	178	42.4
High	193	45.9
Discrimination		
Low	377	89.7
Moderate	39	9.3
High	4	1.0

4.3 Subtypes from General Characteristics of the Participants

4.3.1 Health Insurance

In this study, the most commonly reported health insurance scheme was the Social Security Scheme (SSS) (52.2%), followed by the Migrant Health Insurance Scheme (MHIS) (45.3%) (Table 4.3).

Table 4.3 Health insurance (n=201)

Health insurance	n	%
Social Security Scheme (SSS)	105	52.2
Migrant Health Insurance Scheme (MHIS)	91	45.3
Other (M-fund)	5	2.5

4.3.2 Chronic Disease

The types of chronic disease that were mostly found among the participants in this study were hypertension (51.5%), diabetes mellitus (10.3%), and gastritis (7.3%), respectively (Table 4.4).

Table 4.4 Chronic disease (n=68)

Chronic disease	n	%
Hypertension	35	51.5
Diabetes Mellitus	7	10.3
Gastritis	5	7.3
Gout	4	5.9
Kidney stone	3	4.3
Knee pain	3	4.3
Heart disease	2	2.9
Breast cancer	1	1.5
Cervical cancer	1	1.5
Thyroid cancer	1	1.5
Sinusitis	1	1.5
Allergy	1	1.5
Asthma	1	1.5
Bleeding per rectum	1	1.5
Back pain	1	1.5
Migraine	1	1.5

4.3.3 Family Support, Friend Support and Co-worker Support

In the current study, a few participants reported receiving low support from their families, friends, and co-workers (4.0%, 11.0% and 7.9% respectively). More than half of the participants received high support from their families and co-workers (66.2% and 53.6 % respectively) while 62.4 % of the respondents reported moderate support from their friends (Table 4.5)

Table 4.5 Family support, friend support and co-worker support (n=420)

Subtypes of social support	n	%
Family support		
Low	17	4.0
Moderate	125	29.8
High	278	66.2
Friend support		
Low	46	11.0
Moderate	262	62.4
High	112	26.6
Co-worker support		
Low	33	7.9
Moderate	162	38.5
High	225	53.6

4.3.4 Accessibility, Acceptance, Availability, Affordability and Appropriateness of healthcare

The vast majority of the participants reported the healthcare in Thailand as accessible, acceptable and appropriate (84.8%, 76.4% and 61.9% respectively). However, more than half of the respondents reported not available and not affordable (51.9% and 57.9% respectively) (Table 4.6).

Table 4.6 Accessibility, acceptance, availability, affordability and appropriateness of healthcare (n=420)

Subtypes of Access to Healthcare	n	%
Accessibility		
Not accessible	64	15.2
Accessible	356	84.8
Acceptance		
Not acceptable	99	23.6
Acceptable	321	76.4
Availability		
Not available	218	51.9
Available	202	48.1
Affordability		
Not affordable	243	57.9
Affordable	177	42.1
Appropriateness		
Not appropriate	160	38.1
Appropriate	260	61.9

4.4 Univariable Analysis to Identify Factors Associated with Poor Quality of Life

In univariable logistic regression, 18 variables were found to be significantly associated with poor quality of life among Myanmar migrant workers: family members in Myanmar, health insurance, marital status, chronic disease, duration of stay in Thailand, type of residence, Thai language proficiency (listening and speaking), documentation status, monthly income sufficiency, depressive symptoms, anxiety and stress, social support, current occupation in Thailand, job satisfaction, access to healthcare and discrimination (Table 4.7).

Table 4.7 Univariable Analysis to Identify Factors Associated with Poor Quality of Life (n=420)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor	Moderate			
	n (%)	/Good n (%)			
Intrapersonal Level					
Age (years)					
18-33	55 (21.3)	203 (78.7)	1.03	0.37-2.89	0.956
34-50	25 (18.1)	113 (81.9)	0.84	0.29-2.47	0.752
≥ 51	5 (20.8)	19 (79.2)	1.00		
Sex					
Female	40 (20.3)	157 (79.7)	1.01	0.63-1.62	0.975
Male	45 (20.2)	178 (79.8)	1.00		
Ethnicity					
Non-Burma	8 (21.6)	29 (78.4)	1.09	0.48-2.49	0.826
Burma	77 (20.1)	306 (79.9)	1.00		
Living arrangement in Thailand					
Living alone	24 (23.5)	78 (76.5)	1.29	0.76-2.22	0.343
Family/ Friends	61 (19.2)	257 (80.8)	1.00		
Family members in Myanmar					
Yes	84 (27.0)	227 (73.0)	39.97	5.49-290.87	<0.001*
No	1 (0.9)	108 (99.1)	1.00		
Health insurance					
No	58 (26.5)	161 (73.5)	2.32	1.40-3.85	0.001*
Yes	27 (13.4)	174 (86.6)	1.00		

Table 4.7 (continued)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor n (%)	Moderate /Good n (%)			
Educational attainment					
No formal education	6 (23.1)	20 (76.9)	1.33	0.42-4.27	0.628
Primary school	20 (23.3)	66 (76.7)	1.35	0.56-3.24	0.507
Secondary school	50 (19.3)	209 (80.7)	1.06	0.48-2.33	0.878
University or above	9 (18.4)	40 (81.6)	1.00		
Marital status					
Single	28 (23.3)	92 (76.7)	1.44	0.85-2.43	0.174
Separate/Divorced/ Widowed	9 (36.0)	16 (64.0)	2.66	1.11-6.38	0.028*
Married	48 (17.5)	227 (82.5)	1.00		
Chronic disease					
Yes	23 (33.8)	45 (66.2)	2.39	1.35-4.24	0.003*
No	62 (17.6)	290 (82.4)	1.00		
Alcohol consumption					
None	50 (19.4)	208 (80.6)	0.95	0.50-1.78	0.864
Ex-drinker	19 (22.9)	64 (77.1)	1.17	0.55-2.48	0.684
Current drinker	16 (20.3)	63 (79.7)	1.00		
Smoking					
None	59 (20.5)	229 (79.5)	1.03	0.58-1.82	0.919
Ex-smoker	7 (18.9)	30 (81.1)	0.93	0.36-2.45	0.888
Current smoker	19 (20.0)	76 (80.0)	1.00		
Exercise					
No	57 (20.7)	219 (79.3)	1.08	0.65-1.79	0.770
Yes	28 (19.4)	116 (80.6)	1.00		

Table 4.7(continued)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor n (%)	Moderate /Good n (%)			
Duration of stay in Thailand (years)					
<3	56 (26.3)	157 (73.7)	3.02	1.50-6.05	0.002*
3 – <10	18 (17.5)	85 (82.5)	1.79	0.80-4.01	0.157
≥10	11 (10.6)	93 (89.4)	1.00		
Area of residence					
Semi-urban	53 (22.6)	181 (77.4)	1.41	0.87-2.29	0.169
Urban	32 (17.2)	154 (82.8)	1.00		
Type of residence					
Employer- provided /Shared housing	47 (24.9)	142 (75.1)	1.68	1.04-2.72	0.034*
Rented house	38 (16.5)	193 (83.5)	1.00		
Thai language proficiency (reading)					
None	76 (21.5)	278 (78.5)	1.73	0.82-3.65	0.150
Basic to fluent	9 (13.6)	57 (86.4)	1.00		
Thai language proficiency (listening)					
None	43 (30.3)	99 (69.7)	2.44	1.50-3.97	<0.001*
Basic to fluent	42 (15.1)	236 (84.9)	1.00		
Thai language proficiency (writing)					
None	79 (21.2)	293 (78.8)	1.89	0.77-4.59	0.162
Basic to fluent	6 (12.5)	42 (87.5)	1.00		
Thai language proficiency (speaking)					
None	47 (29.7)	111 (70.3)	2.49	1.54-4.05	<0.001*
Basic to fluent	38 (14.5)	224 (85.5)	1.00		

Table 4.7 (continued)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor n (%)	Moderate /Good n (%)			
Documentation status					
Undocumented	34 (38.2)	55 (61.8)	3.39	2.02-5.72	<0.001*
Documented	51 (15.4)	280 (84.6)	1.00		
Monthly income (baht)					
<9000	39 (23.4)	128 (76.6)	1.37	0.85-2.22	0.198
≥9000	46 (18.2)	207 (81.8)	1.00		
Monthly income sufficiency					
Insufficient	62 (24.8)	188 (75.2)	2.11	1.25-3.56	0.005*
Sufficient	23 (13.5)	147 (86.5)	1.00		
Depressive symptoms					
Moderate to extremely severe	79 (47.3)	88 (52.7)	36.96	15.56-87.76	<0.001*
Normal to mild	6 (2.4)	247 (97.6)	1.00		
Anxiety					
Moderate to extremely severe	64 (43.0)	85 (57.0)	8.96	5.17-15.55	<0.001*
Normal to mild	21 (7.7)	250 (92.3)	1.00		
Stress					
Moderate to extremely severe	38 (64.4)	21 (35.6)	12.09	6.54-22.36	<0.001*
Normal to mild	47 (13.0)	314 (87.0)	1.00		

Table 4.7 (continued)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor	Moderate			
	n (%)	/Good n (%)			
Interpersonal Level					
Overall social support					
Low to moderate	79 (34.3)	151 (65.7)	16.04	6.81-37.82	<0.001*
High	6 (3.2)	184 (96.8)	1.00		
Institutional Level					
Previous occupation in Myanmar					
Non-manual jobs	21 (22.1)	74 (77.9)	1.11	0.61-2.01	0.742
Dependent	6 (10.0)	54 (90.0)	0.43	0.17-1.08	0.073
Construction	16 (28.1)	41 (71.9)	1.52	0.77-2.99	0.224
Manufacturing	3 (17.6)	14 (82.4)	0.84	0.23-3.05	0.785
Agriculture	39 (20.4)	152 (79.6)	1.00		
Current occupation in Thailand					
Construction	48 (25.0)	144 (75.0)	2.39	1.32-4.32	0.004*
Agriculture	6 (27.3)	16 (72.7)	2.69	0.931-7.76	0.068
Manufacturing	13 (22.0)	46 (78.0)	2.03	0.92-4.46	0.079
Service sector	18 (12.2)	129 (87.8)	1.00		
Work environment					
Semi-indoor	25 (22.5)	86 (77.5)	1.27	0.72-2.24	0.410
Outdoor	22 (21.0)	83 (79.0)	1.16	0.64-2.08	0.625
Indoor	38 (18.6)	166 (81.4)	1.00		

Table 4.7 (continued)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor n (%)	Moderate /Good n (%)			
Primary mode of transportation to the workplace					
Own motorbike or bicycle	37 (19.1)	157 (80.9)	1.16	0.54-2.49	0.714
On foot	38 (22.8)	129 (77.2)	1.44	0.67-0.54	0.350
Employer- provided vehicle	10 (16.9)	49 (83.1)	1.00		
Job satisfaction					
Very low to low	62 (49.6)	63 (50.4)	11.64	6.71-20.20	<0.001*
Average to very high	23 (7.8)	272 (92.2)	1.00		
Length of time in current job (years)					
≤1	52 (24.4)	161 (75.6)	2.22	0.99-4.97	0.052
>1 – 5	25 (17.4)	119 (82.6)	1.44	0.61-3.41	0.401
>5	8 (12.7)	55 (87.3)	1.00		
Community Level					
Overall access to healthcare					
Low to moderate	83 (36.6)	144 (63.4)	55.05	13.31-227.52	<0.001*
High	2 (1.0)	191 (99.0)	1.00		
Discrimination					
Moderate to high	25 (58.1)	18 (41.9)	7.34	3.77-14.28	<0.001*
Low	60 (15.9)	317 (84.1)	1.00		

Note *Statistically significant level at p-value < 0.05.

Remark: Non-Burma in ethnicity refers to ethnic groups including Karen, Shan, Mon, Rakhine, Akha, Pa-O, and Lahu. Employer-provided/ shared housing in type of residence refers to employer-provided housing, on-site work compound, and shared housing with other families.

4.5 Multivariable Analysis to Identify Factors Associated with Poor Quality of Life

In multivariable logistic regression, six variables were found to be significantly associated with poor quality of life: chronic disease, type of residence, depressive symptoms, social support, job satisfaction, and discrimination.

The odds of having poor quality of life were 2.96 times (95% CI = 1.29-6.81) higher for those who had chronic diseases like hypertension and diabetes mellitus compared to those who did not have any chronic diseases. Those who lived in house provided by employer, on-site work compound or shared housing with other families had a greater chance of poor quality of life than those who were staying in rented house with 3.59 times (95% CI = 1.75-7.38). Moreover, participants who had moderate to extremely severe depressive symptoms had 15.33 times (95% CI = 5.86-40.08) higher chance of poor quality of life compared to those who had no to mild depressive symptoms. Those who received low to moderate social support had a greater chance of having poor quality of life than those with high social support with 6.35 times (95% CI = 2.15-18.74). The odds of poor quality of life were 6.72 times (95% CI = 3.33-13.56) higher for the individuals who had very low to low job satisfaction compared to those who had average to very high job satisfaction. Lastly, participants who reported moderate to high discrimination had 3.50 times (95% CI = 1.44-8.53) higher odds of having poor quality of life compared to those who reported low discrimination (Table 4.8).

Table 4.8 Multivariable Analysis to Identify Factors Associated with Poor Quality of Life (n=420)

Characteristics	aOR	95%CI	p-value
Intrapersonal Level			
Chronic disease			
Yes	2.96	1.29-6.81	0.011*
No	1.00		
Type of residence			
Employer-provided/Shared housing	3.59	1.75-7.38	<0.001*
Rented house	1.00		
Depressive symptoms			
Moderate to extremely severe	15.33	5.86-40.08	<0.001*
Normal to mild	1.00		
Interpersonal Level			
Overall social support			
Low to moderate	6.35	2.15-18.74	<0.001*
High	1.00		
Institutional Level			
Job satisfaction			
Very low to low	6.72	3.33-13.56	<0.001*
Average to very High	1.00		
Community Level			
Discrimination			
Moderate to high	3.50	1.44-8.53	0.006*
Low	1.00		

Note *Statistically significant level at p-value < 0.05.

Remark: Employer-provided/ shared housing in type of residence refers to employer-provided housing, on-site work compound, and shared housing with other families.

CHAPTER 5

DISCUSSION AND CONCLUSION

This chapter presents the discussion, conclusion, and recommendations of the study. The study aimed to assess the quality of life and identify its associated factors among Myanmar migrant workers in Chiang Rai Province, Thailand.

5.1 Discussion of Quality of Life Among Migrant Workers

In the present study, approximately one in five Myanmar migrant workers in Chiang Rai Province, Thailand, had a poor quality of life (20.2%), while the majority reported moderate quality of life (68.6%) and a smaller proportion reported good quality of life (11.2%). In contrast to studies from several developing countries, including Bangladesh, where up to 94.0% of migrant workers reported low quality of life (23), and India, where more than half (54.0-62.0%) reported poor outcomes (24, 25), the proportion of poor quality of life in this study was considerably lower. Furthermore, a study conducted in China by Lu et al. (22) found that rural-to-urban migrant workers consistently scored lower quality of life across all domains than local residents. Compared with these contexts, the findings of the present study appear relatively more favorable. Only about one-fifth of participants reported poor quality of life, whereas most remained within the moderate category. This difference may be explained by differences in employment conditions (30, 95), access to health services including migrant health insurance schemes (96, 97), and social support in the study area (35). Differences in measurement instruments may also have contributed to the variation in findings, as some previous studies applied the Health Survey Short Form, SF-36, which differs in domain coverage and scoring compared with the WHOQOL-BREF used in this study (22, 53).

Regarding Thailand, the distribution observed in the current study is generally comparable to findings from previous studies conducted in the country, where moderate quality of life was consistently the most commonly reported level among migrant

workers. A study among Cambodian migrant workers in Thailand reported that most participants had a moderate quality of life (55.3%), followed by poor (34.5%) and high levels (10.1%) (32). Similarly, a study among Myanmar migrant workers in Samut Sakhon Province found that the majority reported moderate quality of life (94.0%), with only small proportions in the low (3.2%) and high (2.7%) categories (28). Findings from southern Thailand also showed that moderate quality of life was the most prevalent (85.7%), followed by good (11.4%) and poor (2.7%) levels (26). An earlier study conducted in Chiang Rai in 2009 reported a similar pattern, with over half (56.0%) of Myanmar migrant workers reporting moderate quality of life (27).

Although the predominance of moderate quality of life is consistent across these studies, the proportion of migrant workers reporting poor quality of life in the current study (20.2%) was substantially higher than that reported in Samut Sakhon and southern Thailand. This difference may be attributed to the unique vulnerabilities associated with border areas such as Chiang Rai, where migrant workers often experience greater socioeconomic insecurity, limited access to stable employment, and barriers to healthcare and social support services (98, 99). In addition, differences in occupational characteristics may contribute to this disparity, as migrant workers in border areas such as Chiang Rai are often concentrated in construction, livestock, and agriculture sectors, where employment may be lower paid, less stable, and associated with greater economic vulnerability (100, 101). However, consistent findings regarding moderate quality of life across Thailand may reflect shared migration policies (102), employment structures (30, 95), and access to health services experienced by migrant workers nationwide (96, 99, 103, 104), while regional disparities may influence the proportion of workers experiencing poor quality of life.

5.2 Discussion of Findings

Initially, 31 variables were tested for their association with quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand using univariable analysis in a binary logistic regression model. The analysis was conducted at a 95% confidence interval, with crude odds ratios and statistical significance set at a p -value < 0.05 . From the univariable analysis, 18 variables were found to be significantly associated with

poor quality of life among Myanmar migrant workers: family members in Myanmar, health insurance, marital status, chronic disease, duration of stay in Thailand, type of residence, Thai language proficiency (listening and speaking), documentation status, monthly income sufficiency, depressive symptoms, anxiety and stress at intrapersonal level, social support at interpersonal level, current occupation in Thailand and job satisfaction at institutional level, access to healthcare and discrimination at community level.

Subsequently, variables with a p -value < 0.20 in the univariable analysis were entered into the binary logistic regression model for the multivariable analysis. The model assumptions were assessed using the Hosmer–Lemeshow goodness-of-fit test to ensure that the final model was appropriate for the data. Before running the full model, correlation tests were performed to check for multicollinearity. If variables with a correlation coefficient greater than 0.70 were found, one was carefully chosen to put in the final model. The backward likelihood ratio (LR) method was then applied, step by step, removing the least significant variables until the final model was obtained. In the multivariable logistic regression analysis, 6 variables remained significantly associated with poor quality of life: chronic disease, type of residence and depressive symptoms at the intrapersonal level, social support at interpersonal level, job satisfaction at the institutional level and discrimination at the community level.

In this study, it was found that chronic disease, type of residence, depressive symptoms, social support, job satisfaction and discrimination were key factors influencing quality of life.

5.2.1 Intrapersonal Level Factors Associated with Poor Quality of Life

5.2.1.1 Chronic Disease

Participants with chronic diseases such as hypertension or diabetes mellitus had a greater chance of poor quality of life compared to those without chronic conditions in this study. This finding is also consistent with previous research from China showing that chronic illnesses negatively affect the wellbeing of migrant workers. A study among rural-to-urban migrant workers in China found that individuals with chronic illnesses had lower overall quality of life than those without such conditions (22). Research among white-collar migrant workers in China also showed that chronic diseases such as hyperlipidemia and cardiovascular conditions were linked to

significantly lower quality of life scores (34). Similar evidence from Bergmann et al. (63) reported that chronic conditions, including diabetes and ischemic heart disease, were associated with reduced physical and mental quality of life. Similarly, in the context of Myanmar migrant workers in this study, the poorer quality of life observed among those with chronic diseases may be due to the long-term nature of these conditions, which require continuous care and lifestyle management. Difficulties in accessing healthcare, financial limitations, and the challenge of managing chronic illness alongside demanding work conditions may increase both physical discomfort and psychological stress, leading to reduced quality of life (105, 106).

5.2.1.2 Type of Residence

In this study, participants who lived in employer-provided housing, work compounds, or shared housing had higher odds of poor quality of life than those living in rented housing. This finding is consistent with a study among Cambodian migrant workers in Thailand reported that those living in employer-provided housing were more likely to have poor quality of life than those in other housing types (32). However, this finding contrasts with a study among adult migrant garment workers in Dhaka City which found that participants living in work compound housing reported higher mean quality of life scores than those renting accommodation (23). Similarly, a study among Myanmar migrant workers in Samut Sakhon Province, Thailand reported higher quality of life among those lodging in work compounds (28). For Myanmar migrant workers in Thailand in this study, housing type may influence quality of life through differences in privacy, overcrowding, and living conditions. Rented housing may offer greater autonomy and a more stable living environment, whereas employer-provided or shared housing may limit personal space and family life, increase stress, and reduce overall wellbeing, contributing to poor quality of life (107–109).

5.2.1.3 Depressive symptoms

In the current study, participants with moderate to extremely severe depressive symptoms were more likely to experience poor quality of life compared to those with no to mild depressive symptoms. This finding is consistent with a study conducted in Australia demonstrated that depression was negatively associated with quality of life among older African migrants (110). According to a systemic review among migrant workers in Korea, one study also reported a significant negative

relationship between depression and quality of life among Indonesian migrant workers in South Korea (33, 37). Moreover, similar evidence from South of Thailand stated that Myanmar migrant workers with no depressive symptoms were more likely to have a good quality of life compared to those with depressive symptoms (26). In the same way, among Myanmar migrant workers in this study, depressive symptoms may reduce motivation, social interaction, and coping ability, which negatively affects daily functioning and overall wellbeing, resulting in poorer quality of life (111, 112).

5.2.2 Interpersonal Level Factor Associated with Poor Quality of Life

5.2.2.1 Social Support

In this study, participants with low to moderate social support had higher chance of poor quality of life than those with high social support. This finding is consistent with previous studies among migrant workers in China, which demonstrated a positive correlation between social support and quality of life (36, 69). A systematic review among migrant workers in Korea also identified social support as a key determinant of quality of life, with one study showing that higher support predicted better overall quality of life (33, 37). Similarly, a study among Myanmar women migrant workers in Central and Northern Thailand reported that both moderate and high levels of social support were associated with significantly higher quality of life scores compared to low support (35). Likewise, for Myanmar migrant workers in Thailand in this study, social support from family, friend, or coworker also plays an important role in reducing stress, depression and anxiety, sharing information, financial assistance, and strengthening coping capacity and resilience. Limited social support may increase psychological distress and vulnerability, ultimately leading to poorer quality of life (11, 113–115).

5.2.3 Institutional Level Factor Associated with Poor Quality of Life

5.2.3.1 Job Satisfaction

In the current study, participants who had very low to low job satisfaction had higher odds of poor quality of life compared to those who had average to very high job satisfaction. This finding is consistent with a study among migrant workers in Korea which mentioned that the higher the job satisfaction, the better the quality of life, with hope acting as a key mediator (37). Moreover, a study among Chinese rural-to-urban migrants also reported that job satisfaction significantly influenced their physical and

psychological health status (74). This pattern is also supported by a study among Myanmar migrant workers in Samut Sakhon, Thailand, which reported that workers experienced good quality of life due to having employment, feeling satisfied and proud of their work, and receiving standard wages (81). This may also be explained among Myanmar migrant workers in this study, where low job satisfaction may increase stress, burnout and feelings of job insecurity while weakening relationships in the workplace. These conditions can negatively affect psychological well-being and daily functioning, ultimately contributing to poorer quality of life (116, 117).

5.2.4 Community Level Factor Associated with Poor Quality of Life

5.2.4.1 Discrimination

In this study, participants who reported moderate to high discrimination were more likely to have poor quality of life compared to those who reported low discrimination. This finding is consistent with a research among migrants living in Chile which reported that perceived discrimination was inversely associated with their quality of life (78). A study conducted among Asian American immigrants also supports the association between racial discrimination and worse health-related quality of life (77). This finding is also supported by a study among Brazilian female immigrants in Portugal, which showed that higher perceived discrimination was associated with lower quality of life and had negative effects on both physical and mental health (79). Similarly, a study among rural-to-urban migrants in China found that discriminatory experiences had significant negative effects on both psychological distress and quality of life (80). This may also be explained among Myanmar migrant workers in this study by the fact that discrimination acts as a psychosocial stressor that can reduce self-esteem, limit social integration, and restrict access to resources and services, thereby contributing to poorer quality of life (118, 119).

5.3 Conclusion

This study found that 20.2% of Myanmar migrant workers in Chiang Rai Province had poor quality of life. Using the social-ecological model, poor quality of life was associated with chronic disease, type of housing, depressive symptoms, social support, job satisfaction and discrimination. These findings highlight the need for

integrated public health interventions addressing chronic disease management, improved housing conditions, screening and support for depressive symptoms, strengthened social support networks, enhanced job satisfaction, and prevention of workplace and social discrimination to improve overall well-being.

5.4 Limitations of the Study

A few limitations should be addressed in this study. First, the cross-sectional design limits the ability to establish temporal or causal relationships between the studied factors and quality of life. Second, the study was conducted in only two districts, which limits generalizability and may not represent Myanmar migrant workers across the whole of Chiang Rai Province. Third, the use of convenience sampling, a non-probability method, may have introduced selection bias. Finally, considerable information bias such as recall bias and social desirability bias may have influenced participants' responses, particularly because face-to-face interviews were conducted for some participants who were unable to read or write, which may have affected the accuracy of self-reported information.

Nevertheless, the study has important strengths. It successfully recruited a sizeable sample of Myanmar migrant workers, providing meaningful insights into their living conditions, health challenges, and wellbeing across different subgroups. The study also fills a gap in existing literature on migrant's quality of life by addressing a population that is often overlooked in research, particularly in Northern Thailand, thereby contributing important evidence to an underexplored area. Moreover, this study applied socio-ecological model to examine factors influencing quality of life across multiple levels. This multilevel approach provides a more complete understanding of the complex influences on migrants' quality of life, moving beyond individual-level explanations and offering stronger evidence to guide targeted public health interventions.

5.5 Recommendations

The study identified factors associated with quality of life among Myanmar migrant workers in Chiang Rai Province, Thailand. Based on the findings, the following recommendations are made.

5.5.1 Recommendations to Participants

Myanmar migrant workers should be encouraged to actively engage in the management of their physical and mental health. For individuals with chronic conditions, family members can play a crucial role in supporting treatment adherence, encouraging healthy behaviors, and assisting with access to care. Strengthening family involvement in disease management may help reduce complications and improve overall quality of life. In addition, maintaining regular health check-ups and seeking early care for emerging symptoms, including psychological distress, is important. Building and sustaining social connections with family, friends, and coworkers may enhance emotional resilience and reduce the risk of depressive symptoms. Regarding employment, although most participants reported acceptable levels of job satisfaction, workers should be encouraged, where feasible, to seek roles that align with their skills, experience, and personal interests. Improving communication with employers and developing problem-solving skills in the workplace may further support a positive work environment. Although reported levels of discrimination were not high, migrant workers should be aware of their rights and available support mechanisms. Developing coping strategies, seeking social support, and engaging with community networks may help mitigate the potential negative effects of discriminatory experiences.

5.5.2 Recommendations to Health Officers (Local/Community Level)

Health officers working in border areas such as Chiang Rai should prioritize integrated care approaches that address both physical and mental health needs of migrant populations. Routine screening for chronic diseases (e.g., diabetes, hypertension) and depressive symptoms should be incorporated into primary care and outreach services. Culturally and linguistically appropriate health education programs should be strengthened, with particular emphasis on chronic disease self-management, medication adherence, and mental health awareness. Involving family members in health education sessions may enhance long-term disease management and support

systems. Mobile clinics and community outreach activities should be expanded to improve access among hard-to-reach migrant populations. In addition, collaboration with migrant health volunteers and community leaders can help bridge communication gaps and improve service utilization. Clear referral pathways for both chronic disease complications and mental health conditions should be established to ensure continuity of care. Health officers should also be trained to provide basic mental health support and identify early signs of psychological distress.

5.5.2 Recommendations to Provincial Health Level

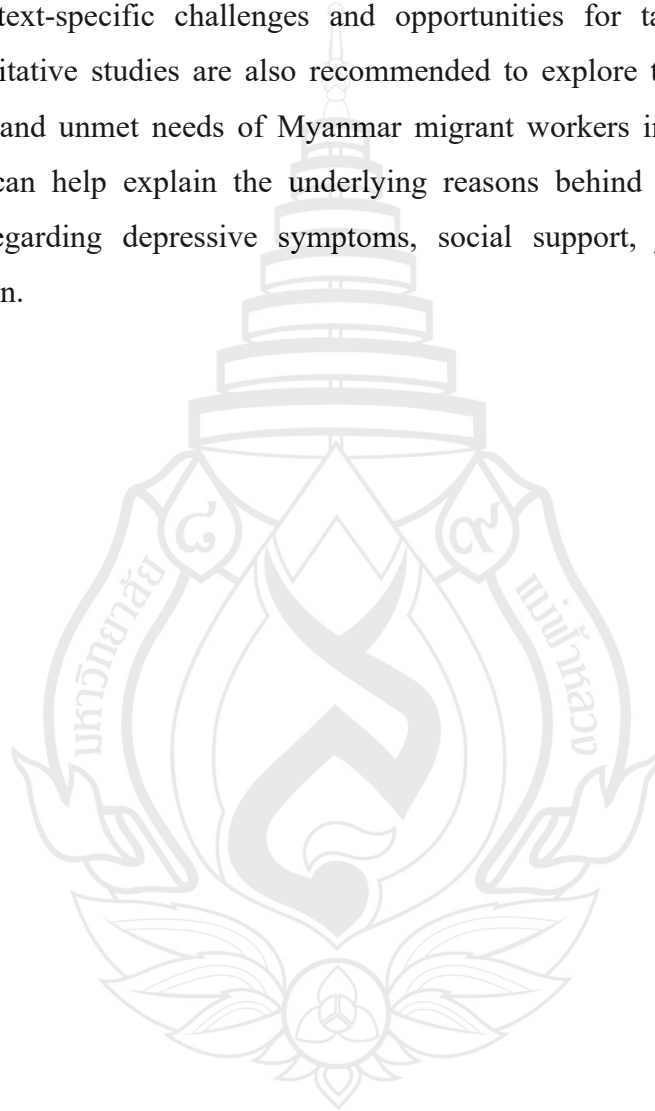
At the provincial level, health systems should strengthen coordinated service delivery for migrant workers by integrating chronic disease management and mental health services into existing programs. Expanding migrant-friendly services, including interpretation support and flexible service hours, may improve accessibility. Partnerships with employers should be promoted to facilitate workplace-based health promotion activities, such as periodic health screening and health education sessions. Improving living and working conditions through multisectoral collaboration remains important for sustaining health outcomes. In addition, community-based initiatives that promote social support such as peer groups or migrant networks should be encouraged to enhance psychological well-being and social integration.

5.5.3 Recommendations to Policy Maker

At the policy level, comprehensive strategies are needed to address the multilevel determinants of quality of life among Myanmar migrant workers. Policies should strengthen access to affordable healthcare and continuity of care for chronic diseases, including inclusive health insurance coverage and migrant-friendly services. National frameworks should also support the integration of mental health screening and treatment into primary care. Regulations that promote safe housing standards, fair employment practices, and job security are essential to improve job satisfaction and overall wellbeing. In addition, policies that encourage community-based social support programs and protect migrants from discrimination in workplaces and public services should be enforced. Strengthening legal protection, social inclusion, and equitable access to health and welfare services will be critical for improving the long-term quality of life of migrant populations.

5.5.4 Recommendations to Further Study

Future research should consider a longitudinal study design to monitor changes in quality of life among migrant workers over time, particularly as policies, work environments, and healthcare systems evolve. Conducting studies in other provinces with different migrant populations would allow for comparisons across regions, helping identify context-specific challenges and opportunities for targeted interventions. Finally, qualitative studies are also recommended to explore the lived experiences, perceptions, and unmet needs of Myanmar migrant workers in greater depth. Such approaches can help explain the underlying reasons behind quantitative findings, especially regarding depressive symptoms, social support, job satisfaction, and discrimination.



REFERENCES

1. International Organization for Migration (IOM). World migration report 2024 [Internet]. Geneva: IOM; 2024 [cited 2025 Feb 5]. Available from: <https://worldmigrationreport.iom.int/wmr-2024-interactive/>
2. Tun A. Migration in post-coup Myanmar: a critical determinant in shaping the country's future? [Internet]. Singapore: ISEAS–Yusof Ishak Institute; 2022 [cited 2025 Feb 5]. Available from: <https://www.iseas.edu.sg/articles-commentaries/iseas-perspective/2022-37-migration-in-post-coup-myanmar-a-critical-determinant-in-shaping-the-countrys-future-by-aung-tun/>
3. Ndegwa D, Guadagno L, Saw YM, Dimanche S. Migrants from Myanmar and risks faced abroad: a desk study [Internet]. Geneva: IOM; 2016 [cited 2025 Feb 5]. Available from: <https://publications.iom.int/books/migrants-myanmar-and-risks-faced-abroad-desk-study>
4. International Organization for Migration (IOM). Overview of Myanmar nationals in Thailand [Internet]. Bangkok: IOM Thailand; 2024 [cited 2025 Feb 5]. Available from: <https://thailand.iom.int/sites/g/files/tmzbd11371/files/documents/2024-10/overview-of-myanmar-nationals-in-thailand-october-24.pdf>
5. International Organization for Migration (IOM). Flow monitoring report: Thailand (February 2025). Bangkok: IOM Thailand; 2025.
6. International Organization for Migration (IOM). Mobility tracking Myanmar migrants (May–June 2024)[Internet]. Bangkok: IOM Thailand; 2024 [cited 2025 Feb 5]. Available from: <https://thailand.iom.int/resources/mobility-tracking-myanmar-migrants-may-june-2024>
7. Chiang Rai Provincial Employment Office. Cabinet resolution group (4 nationalities) [Internet]. 2024 [cited 2025 Mar 15]. Available from: https://www.doe.go.th/prd/chiangrai/custom/param/site/70/cat/40/sub/0/pull/detail/view/detail/object_id/2517
8. International Organization for Migration (IOM). Multi-sectoral assessment of needs: Chiang Rai factsheet. Bangkok: IOM Thailand; 2023.

9. Huguet JW. Thailand migration report 2014 [Internet]. Bangkok: IOM Thailand; 2014 [cited 2025 Feb 5]. Available from: <https://thailand.iom.int/resources/thailand-migration-report-2014>
10. World Bank. Labor migration in the Greater Mekong Subregion: synthesis report (phase 1) [Internet]. Washington, DC: World Bank; 2010 [cited 2025 Feb 5]. Available from: <https://documents.worldbank.org/en/publication/documents-reports/documentdetail/256041468749804342/>
11. Kyaw SM. Ecological system and psychosocial well-being of Myanmar migrant workers during the COVID-19 pandemic: a case of Mahachai [master's thesis on the Internet]. Bangkok: Chulalongkorn University; 2021 [cited 2026 Mar 6]. Available from: <https://digital.car.chula.ac.th/chulaetd/4758>
12. Ahonen EQ, Benavides FG, Benach J. Immigrant populations, work and health: a systematic literature review. *Scand J Work Environ Health*. 2007;33(2):96–104.
13. Naing S. Burmese refugee dies after discharge from shut US-funded clinic, says family [Internet]. Reuters. 2025 Feb 7 [cited 2025 Feb 21]. Available from: <https://www.reuters.com/world/asia-pacific/burmese-refugee-dies-after-discharge-shut-us-funded-clinic-says-family-2025-02-07/>
14. Wongcha-um P. US aid freeze is new threat for ailing Myanmar refugees on Thai border [Internet]. Reuters. 2025 Feb 5 [cited 2025 Feb 12]. Available from: <https://www.reuters.com/world/asia-pacific/us-aid-freeze-is-new-threat-ailing-myanmar-refugees-thai-border-2025-02-05/>
15. World Health Organization (WHO). WHOQOL: measuring quality of life [Internet]. Geneva: WHO; 2012 [cited 2025 Feb 5]. Available from: <https://www.who.int/tools/whoqol>
16. Phyo AZZ, Freak-Poli R, Craig H, Gasevic D, Stocks NP, Gonzalez-Chica DA, Ryan J. Quality of life and mortality in the general population: a systematic review and meta-analysis. *BMC Public Health*. 2020;20(1):1596.
17. Golics CJ, Basra MKA, Finlay AY, Salek S. The impact of disease on family members: a critical aspect of medical care. *J R Soc Med*. 2013;106(10):399–407.

18. Brunner B, Igic I, Keller AC, Wieser S. Who gains the most from improving working conditions? Health-related absenteeism and presenteeism due to stress at work. *Eur J Health Econ.* 2019;20(8):1165–80.
19. Bialowolski P, McNeely E, VanderWeele TJ, Weziak-Bialowolska D. Ill health and distraction at work: Costs and drivers for productivity loss. *PLoS One.* 2020;15(3):e0230562.
20. Buchcik J, Borutta J, Nickel S, von dem Knesebeck O, Westenhöfer J. Health-related quality of life among migrants and natives in Hamburg, Germany: An observational study. *J Migr Health.* 2021;3:100045.
21. Koseoglu Ornek O, Waibel J, Wullinger P, Weinmann T. Precarious employment and migrant workers' mental health: a systematic review of quantitative and qualitative studies. *Scand J Work Environ Health.* 2022;48(5):327-50.
22. Lu CH, Luo ZC, Wang JJ, Zhong JH, Wang PX. Health-related quality of life and health service utilization in Chinese rural-to-urban migrant workers. *Int J Environ Res Public Health.* 2015;12(2):2205-14.
23. Islam MM, Ahmed S, Sarker R, Farjana S, Akter A, Saha S. Health-related quality of life among adult migrant garment workers in Dhaka city. *Bangladesh Med J.* 2011;40(3):14–17.
24. Manikandan V, Jain R, Sandhiya RD, Arulmozhi P, Murugan A, K S, et al. Community-based cross-sectional study to assess the health problems and quality of life among migrant construction workers in Chennai. *J Clin Med Kaz.* 2024;21(4):46–51.
25. Zabeer S, Inbaraj LR, George CE, Norman G. Quality of life among migrant construction workers in Bangalore city: A cross-sectional study. *J Family Med Prim Care.* 2019;8(2):437-42.
26. Hnuploy K, Laohasiriwong W, Sornlorm K, Nutrawong T. Influence of mental health and social relationships on quality of life among Myanmar migrant workers in the south of Thailand. *Indian J Public Health Res Dev.* 2020;11:1272.

27. Tongprasert MM. Factors related to health-related quality of life among adult Myanmar migrant workers at Chiang Rai Regional Hospital and Pirom Clinic in Muang District, Chiang Rai Province, Thailand: a cross-sectional study [master's thesis on the Internet]. Bangkok: Chulalongkorn University; 2009.
28. Thein TL, Hongsranagon P, Havanond P. Nature of Accessibility to Health Care Services and Health-Related Quality of Life among Adult Myanmar Migrant Workers in Mahachai Sub-District, Samut Sakhon Province, Thailand. *J Health Res.* 2018;23(Suppl.):23-7.
29. Ti S, Somrongthong R. Health Related Quality of Life of Myanmar Migrants in Takuapa and Kuraburi Districts, Phang-Nga Province, Thailand. *J Health Res.* 2018;22(Suppl.):79-83.
30. Takhiansok T, Sawangwong B. The quality of work life in migrant workers in Thailand: a case study of Sri-Khema Market, Bangsue District, Bangkok. *PEOPLE: Int J Soc Sci.* 2020;6(1):827–39.
31. Khai TS, Asaduzzaman M. 'I Doubt Myself and Am Losing Everything I Have since COVID Came'-A Case Study of Mental Health and Coping Strategies among Undocumented Myanmar Migrant Workers in Thailand. *Int J Environ Res Public Health.* 2022;19(22):15022.
32. Laohasiriwong W, Chamroen P, Samphors S, Rachutorn T, Dewey RS, Pisey V. Mental health status and quality of life among Cambodian migrant workers in Thailand. *F1000Research.* 2020;9:1138.
33. Dineva RF, Choi H. Associations of acculturative stress, depression, and quality of life among Indonesian migrant workers in South Korea. *J Korean Acad Psychiatr Ment Health Nurs.* 2019;28(2):172–180.
34. Tsai SY. A study of the health-related quality of life and work-related stress of white-collar migrant workers. *Int J Environ Res Public Health.* 2012;9(10):3740-54.
35. Linn N, Chuemchit M, Boonshuyar C. Role of social support in improving quality of life among Myanmar women migrant workers in central and northern Thailand: implications for community nursing. *Int J Nurs Educ.* 2024;16(4):41–9.

36. Yang Y, Zhao S, Lin L, Qian J, Zhang H, Cai F. Social support and quality of life in migrant workers: Focusing on the mediating effect of healthy lifestyle. *Front Public Health*. 2023;11:1061579.
37. Cho HJ, Kang K, Park KY. Health-related quality of life of migrant workers: a systematic literature review. *BMC Public Health*. 2023;23(1):1004.
38. Acharya Samadarshi SC, Taechaboonsersak P, Tipayamongkhogul M, Yodmai K. Quality of life and associated factors amongst older adults in a remote community, Nepal. *J Health Res*. 2022;36(1):56–67.
39. McLeroy KR, Bibeau D, Steckler A, Glanz K. An ecological perspective on health promotion programs. *Health Educ Q*. 1988;15(4):351–77.
40. International Organization for Migration (IOM). Glossary on migration [Internet]. Geneva: IOM; 2019 [cited 2025 Feb 7]. Available from: https://publications.iom.int/system/files/pdf/iml_34_glossary.pdf
41. International Organization for Migration (IOM). Types of movements [Internet]. Geneva: IOM; [cited 2025 Feb 7]. Available from: <https://emm.iom.int/handbooks/global-context-international-migration/types-movements-0>
42. Hayashi M. Borders, divisions and mixed migration: complexity and dynamics of Myanmar migrants' lives in Chiang Rai, Thailand [Internet]. *FORSEA*; 2023 [cited 2025 Feb 19]. Available from: <https://forsea.co/complexity-and-dynamics-of-myanmar-migrants-lives-in-chiang-rai-thailand/>
43. International Organization for Migration (IOM). Migration context: Thailand [Internet]. Bangkok: IOM Thailand; [cited 2025 Feb 7]. Available from: <https://thailand.iom.int/migration-context>
44. International Organization for Migration (IOM). A world on the move: the benefits of migration [Internet]. Geneva: IOM; 2014 [cited 2025 Feb 21]. Available from: <https://www.iom.int/speeches-and-talks/world-move-benefits-migration>

45. International Organization for Migration (IOM). Myanmar migrant workers benefit from migration, need more protection: IOM survey [Internet]. Geneva: IOM; 2018 [cited 2025 Feb 21]. Available from: <https://www.iom.int/news/myanmar-migrant-workers-benefit-migration-need-more-protection-iom-survey>
46. United Nations Development Programme (UNDP). Migration in Myanmar: moving to cope [Internet]. New York: UNDP; 2024 Sep [cited 2025 Mar 18]. Available from: <https://www.undp.org/asia-pacific/publications/migration-myanmar-moving-cope>
47. Teoli D, Bhardwaj A. Quality of life [Internet]. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2023 Mar 27 [cited 2025 Feb 7]. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK536962/>
48. Sinha Roy S, Demarchi G, Rhoads E. A growing crisis: work, workers, and wellbeing in Myanmar [Internet]. Washington (DC): World Bank; 2023 Jun 15.
49. United Nations Development Programme (UNDP). Myanmar at a crossroads: past trends of human well-being and a future outlook [Internet]. Yangon: UNDP Myanmar; 2023 May [cited 2025 Mar 18]. Available from: <https://myanmar.un.org/en/235999-myanmar-crossroads-past-trends-human-well-being-and-future-outlook>
50. Swe YM, Sornlorm K, Laohasiriwong W. Association between Social Capital, Mental Health and Quality of Life among Migrant Workers in Myanmar. *Indian J Public Health Res Dev*. 2019;10(11):2242-7.
51. Anjara SG, Nellums LB, Bonetto C, Van Bortel T. Stress, health and quality of life of female migrant domestic workers in Singapore: a cross-sectional study. *BMC Womens Health*. 2017;17(1):98.
52. Aishvarya AR, Nagalingam M. A study on quality of life and working conditions of migrant workers in manufacturing industry. *Int J Recent Sci Res*. 2019;10(7):33670–4.
53. Coons SJ, Rao S, Keininger DL, Hays RD. A comparative review of generic quality-of-life instruments. *Pharmacoeconomics*. 2000;17(1):13-35.

54. Hunt SM, McKenna SP, McEwen J, Williams J, Papp E. The Nottingham Health Profile: subjective health status and medical consultations. *Soc Sci Med A*. 1981;15(3 Pt 1):221-9.
55. World Health Organization (WHO). WHOQOL: the World Health Organization quality of life assessment[Internet]. Geneva: WHO; 2012 [cited 2025 Feb 3]. Available from: <https://www.who.int/publications/i/item/WHO-HIS-HSI-Rev.2012.03>
56. August KJ, Rook KS. Social relationships. In: Gellman MD, Turner JR, editors. *Encyclopedia of behavioral medicine*. New York: Springer; 2013. p. 1838–42.
57. Elliott SJ. Environmental health. In: Kitchin R, Thrift N, editors. *International encyclopedia of human geography*. Oxford: Elsevier; 2009. p. 528–34.
58. Bronfenbrenner U. Ecological models of human development. In: Husen T, Postlethwaite TN, editors. *International encyclopedia of education*. 2nd ed. Oxford: Elsevier; 1994. p. 1643–47.
59. Alghzawi HM, Ghanem FK. Social ecological model and underage drinking: a theoretical review and evaluation. *Psychology*. 2021;12(5):817–28.
60. Bayram N, Thorburn D, Demirhan H, Bilgel N. Quality of life among Turkish immigrants in Sweden. *Qual Life Res*. 2007;16(8):1319-33.
61. Stein G, Teng TK, Tay WT, Richards AM, Doughty R, Dong Y, et al. Ethnic differences in quality of life and its association with survival in patients with heart failure. *Clin Cardiol*. 2020;43(9):976–85.
62. Kittipichai W, Arsa R, Jirapongsuwan A, Singhakant C. Quality of life among Thai workers in textile dyeing factories. *Glob J Health Sci*. 2014;7(3):274-82.
63. Bergmann N, Ballegaard S, Holmager P, Bech P, Hjalmarson A, Gyntelberg F, Faber J. Diabetes and ischemic heart disease: double jeopardy with regard to depressive mood and reduced quality of life. *Endocr Connect*. 2014;3(4):156-60.
64. Anokye NK, Trueman P, Green C, Pavey TG, Taylor RS. Physical activity and health related quality of life. *BMC Public Health*. 2012;12:624.

65. Posadzki P, Pieper D, Bajpai R, Makaruk H, Könsgen N, Neuhaus AL, Semwal M. Exercise/physical activity and health outcomes: an overview of Cochrane systematic reviews. *BMC Public Health*. 2020;20(1):1724.
66. Hongthong D, Somrongthong R, Ward P. Factors Influencing the Quality of Life (Qol) Among Thai Older People in a Rural Area of Thailand. *Iran J Public Health*. 2015;44(4):479-85.
67. Oo MY, Punpuing S, Chamchan C. Factors affecting quality of life of older people in Taungoo Township, Bago Region, Myanmar. *J Health Res*. 2015;29(4):235–42.
68. Burton-Jeangros C, Duvoisin A, Consoli L, Fakhoury J, Jackson Y. The well-being of newly regularized migrant workers: Determinants of their satisfaction with life as compared to undocumented migrant workers and regular local residents. *Comp Migr Stud*. 2021;9(1):42.
69. Xing H, Yu W, Chen S, Zhang D, Tan R. Influence of Social Support on Health-Related Quality of Life in New-Generation Migrant Workers in Eastern China. *Iran J Public Health*. 2013;42(8):806-12.
70. Kutlu S, Koruk İ. Migrant seasonal farmworkers: health-related quality of life and the factors that affect it. *Turk J Public Health*. 2014;12(2):80–90.
71. Fitzgerald S, Chen X, Qu H, Sheff MG. Occupational injury among migrant workers in China: a systematic review. *Inj Prev*. 2013;19(5):348-54.
72. Sabhlok A, Cheung H, Mishra Y. Narratives of health and well-being: migrant road workers in the upper Himalayas. *Econ Polit Wkly*. 2015;51(50).
73. Simkhada PP, Regmi PR, van Teijlingen E, Aryal N. Identifying the gaps in Nepalese migrant workers' health and well-being: a review of the literature. *J Travel Med*. 2017;24(4).
74. Liang D, Xu D. Health-related quality of life in Chinese rural-to-urban migrants: Investigating the roles of working conditions and job satisfaction. *J Community Psychol*. 2020;48(8):2663-77.
75. Charoensook P, Upala P, Anuwatnonthakate A, Ruanjai T, Apidechkul T. Pulmonary tuberculosis screening and quality of life among migrant workers, Northern Thailand. *J Infect Dev Ctries*. 2018;12(12):1052-61.

76. Molina KM, Estrella ML, Durazo-Arvizu R, Malcarne VL, Llabre MM, Isasi CR, et al. Perceived discrimination and physical health-related quality of life: The Hispanic Community Health Study/Study of Latinos (HCHS/SOL) Sociocultural Ancillary Study. *Soc Sci Med.* 2019;222:91–100.
77. Jung MY, Juon HS, Slopen N, He X, Thomas SB, Lee S. Racial Discrimination and Health-Related Quality of Life: An Examination Among Asian American Immigrants. *J Racial Ethn Health Disparities.* 2022;9(4):1262-75.
78. Urzúa A, Henríquez D, Hernández S, Caqueo-Úrizar A. The Sense of Coherence as a Mediator of the Negative Effect of Discrimination on the Quality of Life in the Migrant Population. *Healthcare (Basel).* 2025;13(4):366.
79. Oliveira EN, Neto F, Lima GF, Guimarães FR, Neto X, Pereira PA, et al. Discrimination and quality of life of Brazilian female immigrants in Portugal. *Int J Dev Res.* 2018;8.
80. Wang B, Li X, Stanton B, Fang X. The influence of social stigma and discriminatory experience on psychological distress and quality of life among rural-to-urban migrants in China. *Soc Sci Med.* 2010;71(1):84-92.
81. Sarapirom K, Muensakda P. Existence of quality of life among Myanmar migrant workers under Thai socio-cultural context in Samut Sakhon Province, Thailand. *Interdiscip Res Rev.* 2018;13(5):1–8.
82. Ko H, Withitwinyuchon N. The quality of life of legal Myanmar migrant laborers in Mae Sot, Thailand: the case of Mae Tao community. *Inya Econ J.* 2024;3(1):116–57.
83. Linn N, Chuemchit M, Mon AS, Boonshuyar C. Violence against women and its effects on mental health and quality of life: a study of Myanmar migrant workers in central Thailand. *J Migr Health.* 2024;10:100272.
84. Cochran WG. *Sampling Techniques.* 3rd ed. New York: John Wiley & Sons; 1977.
85. Min Z. Factors influencing health-seeking behavior among Myanmar migrant workers in Mueang District, Chiang Rai Province, Thailand [master's thesis]. Chiang Rai: Mae Fah Luang University; 2024.

86. Levesque JF, Harris MF, Russell G. Patient-centred access to health care: conceptualising access at the interface of health systems and populations. *Int J Equity Health*. 2013;12:18.
87. Suwan-Ampa T, Purksametanan T. The accessibility to reproductive healthcare services for teenagers in Bangkok's urban community. *Thai J Public Health*. 2024;54(2).
88. Best JW, Kahn J V. *Research in education*. New Jersey: Printice Hall Inc; 1997.
89. Lovibond SH, Lovibond PF. *Manual for the Depression Anxiety Stress Scales*. 2nd ed. Sydney, Australia: Psychology Foundation; 1995.
90. Nin Sar Aung ZM. Impact of COVID-19 pandemic on the mental health of health care personnel from government hospitals in Yangon Region, Myanmar [master's thesis on the Internet]. Bangkok: Chulalongkorn University; 2020.
91. Thoits PA. Social support as coping assistance. *J Consult Clin Psychol*. 1986;54(4):416–23.
92. Williams DR, Yu Y, Jackson JS, Anderson NB. Racial differences in physical and mental health: socioeconomic status, stress, and discrimination. *J Health Psychol*. 1997;2(3).
93. Macdonald S, MacIntyre P. The generic job satisfaction scale: scale development and its correlates. *Employee Assist Q*. 1997;13(2):1–16.
94. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles for medical research involving human participants. *JAMA*. 2024;333(1):71–4.
95. Thinbangtieo O. Employment conditions and quality of life of migrant workers in Saen Suk Municipality, Mueang District, Chonburi Province. *J Polit Adm Law*. 2024;16(1):51–70.
96. Kunpeuk W, Julchoo S, Phaiyarom M, Sinam P, Pudpong N, Loganathan T, et al. Access to healthcare and social protection among migrant workers in Thailand before and during COVID-19 era: a qualitative study. *Int J Environ Res Public Health*. 2022;19(5):3083.
97. Piancharoen P, Kosiyaporn H, Suphanchaimat R. Equity of Social Health Insurance Coverage for Migrants in Thailand: A Concentration Index Analysis. *Int J Environ Res Public Health*. 2021;19(1):64.

98. Min Z, Kanthawee P, Inchon P, Suwannaporn S, Azam M, Thanaisawanyangkoon S. Factors shaping health-seeking behavior among Myanmar migrant workers in Chiang Rai, Thailand. *BMC Public Health*. 2026;26(1):554.
99. Sathapornwajana T, Kitchanapiboo S, Kanthawee P, Suwannamee S. Factors associated with access to health services among migrant workers, Mae Sai District, Chiang Rai Province. *Chiangrai Med J*. 2025;17(1):59–74.
100. SU Yan. The problem of migrant workers in Thailand border for the development of greater Mekong Subregion's Economy. *J.HPLA*. 2022;8(3):389–402.
101. Jumpa N. The study of cross-border Myanmar migrant worker's labor market: policy implications for labor management in Chiang Rai City, Chiang Rai Province, Thailand. *Khon Kaen: Mekong Institute*; 2012.
102. International Organization for Migration (IOM). Thailand migration report 2019 [Internet]. Bangkok: IOM; 2019 [cited 2026 Mar 2]. Available from: <https://thailand.un.org/sites/default/files/2020-06/Thailand-Migration-Report-2019.pdf>
103. Radtajak J, Prasertchai A, Boromthanasat C. Accessibility to public health service among migrant workers in Pak Phanang District, Nakhon Si Thammarat Province. *J South Technol*. 2023;16(1):54–65.
104. Min Z, Kanthawee P, Inchon P, Suwannaporn S, Thaniasawanyakoon S, Wongwilairat R, et al. Exploring healthcare utilization disparities among Myanmar migrant workers in Mueang District, Chiang Rai, Thailand. *Chiangrai Med J*. 2024;16(3):19–34.
105. Uansri S, Kunpeuk W, Julchoo S, Sinam P, Phaiyarom M, Suphanchaimat R. Perceived Barriers of Accessing Healthcare among Migrant Workers in Thailand during the Coronavirus Disease 2019 (COVID-19) Pandemic: A Qualitative Study. *Int J Environ Res Public Health*. 2023;20(10):5781.
106. Wongsuwanphon S, Chottanapund S, Knust B, Wongjindanon N, Suphanchaimat R. Access to healthcare services and factors associated with unmet needs among migrants in Phuket Province, Thailand, 2023: a cross-sectional mixed-method study. *BMC Health Serv Res*. 2024;24(1):1161.

107. Rana K, Kent JL, Page A. Housing inequalities and health outcomes among migrant and refugee populations in high-income countries: a mixed-methods systematic review. *BMC Public Health*. 2025;25(1):1098.
108. Jabali O, Ayyoub AA, Jabali S, Saeedi M. Examining the nexus between housing conditions and health outcomes in Palestinian society: a mixed-method investigation. *BMC Public Health*. 2025;25(1):560.
109. Caxaj CS, Weiler AM, Martyniuk J. Housing Conditions and Health Implications for Migrant Agricultural Workers in Canada: A Scoping Review. *Can J Nurs Res*. 2024;56(1):16-28.
110. Dzando G, Ward PR, Mwanri L, Agbadi P, Ambagtsheer RC. Depression and social connectedness as mechanisms linking frailty to quality of life in older African migrants in Australia. *NPJ Aging*. 2025;11(1):98.
111. Elmer T, Stadtfeld C. Depressive symptoms are associated with social isolation in face-to-face interaction networks. *Sci Rep*. 2020;10(1):1444.
112. Guo T, Feng Y, Zhou J, Meng L, Zhu X, Chen X, Xiao L, Feng L, Zhang L, Xiang YT, Zhao YJ, Wang G. Unveiling the Interplay Between Depressive Symptoms' Alleviation and Quality of Life Improvement in Major Depressive Disorder: A Network Analysis Based on Longitudinal Data. *Neuropsychiatr Dis Treat*. 2024;20:1641-54.
113. Ma M, Zhao Y, Lai Y, Ma K, Jia S, Wang X, et al. Association of social support with depression and anxiety among the migrant population of Henan, China: Based on a large cross-sectional study. *Psychiatry Res*. 2024;342:116246.
114. Liu H, Chen X, Yao Y, He W, Zhang Q, Zeng H. Social support and depressive symptoms among migrant elderly following children: the chain mediating role of resilience and loneliness. *BMC Psychiatry*. 2024;24(1):898.
115. Khatiwada J, Muzembo BA, Wada K, Ikeda S. The effect of perceived social support on psychological distress and life satisfaction among Nepalese migrants in Japan. *PLoS One*. 2021;16(2):e0246271.
116. De Cuyper N, Pienaar J, De Witte H. Review of 30 years of longitudinal studies on the association between job insecurity and health and well-being: is there causal evidence? *Aust Psychol*. 2016;51(1):18–31.

117. Faragher EB, Cass M, Cooper CL. The relationship between job satisfaction and health: a meta-analysis. *Occup Environ Med.* 2005;62(2):105-12.
118. Jia X, Liu X, Shi B. Perceived Discrimination and Subjective Well-being in Chinese Migrant Adolescents: Collective and Personal Self-esteem as Mediators. *Front Psychol.* 2017;8:1213.
119. Tong L, Kawachi I. Experiences of discrimination and self-reported health in Chinese migrants: a structural equation model. *BMC Public Health.* 2020;20(1):1477.



APPENDIX A

ETHICAL APPROVAL CERTIFICATE (THAI VERSION)

 The Mae Fah Luang University Ethics Committee on Human Research 333 Moo 1, Thasud, Muang, Chiang Rai 57100 Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rechuman@mfu.ac.th	
หนังสือรับรองด้านจริยธรรมการวิจัย	
COA: 135/2025	รหัสโครงการวิจัย: EC 25110-18
ชื่อโครงการวิจัย:	คุณภาพชีวิตและปัจจัยที่เกี่ยวข้องของแรงงานข้ามชาติชาวพม่าในจังหวัดเชียงราย ประเทศไทย
ชื่อผู้วิจัยหลัก:	Miss Tin Mi Mi Ohn
สำนักวิชา:	วิทยาศาสตร์สุขภาพ
ผู้สนับสนุนการวิจัย:	ทุนส่วนตัว
การรับรอง :	
(1) โครงการวิจัย	ฉบับที่ 2 วันที่ 30 มิถุนายน 2568
(2) เอกสารข้อมูลและขอความยินยอมเข้าร่วมการวิจัย	ฉบับที่ 2 วันที่ 30 มิถุนายน 2568
(3) แบบสอบถาม	ฉบับที่ 1 วันที่ 6 พฤษภาคม 2568
(4) แบบประชาสัมพันธ์	ฉบับที่ 1 วันที่ 6 พฤษภาคม 2568
(5) ผู้วิจัย และผู้วิจัยร่วม	
- Miss Tin Mi Mi Ohn	- อาจารย์ ดร.ธนาภรณ์ เรือนใจ
- รองศาสตราจารย์ ดร.ธวัชชัย อภิเดชกุล	- ผู้ช่วยศาสตราจารย์ ดร.พิลาสินี วงษ์นุช
ขอรับรองว่าโครงการดังกล่าวข้างต้นได้ผ่านการพิจารณารับรองจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง ว่าสอดคล้องกับแนวทางจริยธรรมสากล ได้แก่ ปฏิญญาเฮลซิงกิ (Declaration of Helsinki) รายงานเบลมอนต์ (Belmont Report) แนวทางจริยธรรมสากลสำหรับการวิจัยในมนุษย์ของสภาองค์การสากลด้านวิทยาศาสตร์การแพทย์ (CIOMS) และแนวทางการปฏิบัติการวิจัยที่ดี (ICH-GCP)	
วันที่รับรองด้านจริยธรรมของโครงการวิจัย:	12 กรกฎาคม 2568
วันสิ้นสุดการรับรอง:	11 กรกฎาคม 2569
ความถี่ของการส่งรายงานความก้าวหน้าของการวิจัย:	1 ปี
ลงนาม (อาจารย์ นพ.จุลพงศ์ อจลพงศ์) ประธานคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง	
AL 02_1/2024 Certificate of Approval หน้า 1 จาก 4	



The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, Chiang Rai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rec.human@mfu.ac.th

ผู้วิจัยที่โครงการวิจัยผ่านการรับรองจากคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง
ต้องปฏิบัติตามต่อไปนี้

- (1) ดำเนินการวิจัยตามที่ระบุในโครงการวิจัยอย่างเคร่งครัด
- (2) ใช้เอกสารข้อมูลและขอความยินยอมเข้าร่วมการวิจัย / แบบสอบถาม / แบบบันทึกข้อมูล / เอกสาร
ประชาสัมพันธ์ ที่มีตราประทับของคณะกรรมการจริยธรรมการวิจัยในมนุษย์ มหาวิทยาลัยแม่ฟ้าหลวง เท่านั้น
- (3) ผู้วิจัยต้องส่งรายงานความก้าวหน้าของการวิจัย (AP 05/2024) ตามระยะเวลาที่คณะกรรมการฯ กำหนด และ
ภายใน 30 วัน ก่อนหมดอายุการรับรอง ในกรณีที่การวิจัยยังไม่เสร็จสิ้น ผู้วิจัยต้องส่งจดหมายขอต่ออายุ
การรับรอง
- (4) เมื่อมีการแก้ไขเพิ่มเติมโครงการวิจัย ผู้วิจัยต้องส่งรายงานส่วนแก้ไขเพิ่มเติมโครงการวิจัย (AP 06/2024) และ
โครงการวิจัยที่มีการแก้ไขเพิ่มเติม เพื่อแจ้งให้คณะกรรมการฯ พิจารณารับรองก่อนดำเนินการตามที่ได้แก้ไข
เพิ่มเติม (ยกเว้นในกรณีที่การแก้ไขเพิ่มเติมนั้นกระทำเพื่อความปลอดภัยของอาสาสมัคร)
- (5) เมื่อมีเหตุการณ์ไม่พึงประสงค์ชนิดร้ายแรง “ในสถาบัน” ผู้วิจัยต้องส่งรายงานเหตุการณ์ไม่พึงประสงค์ชนิด
ร้ายแรง (AP 07/2024) ตามข้อกำหนดของ ICH-GCP
- (6) เมื่อมีการเบี่ยงเบนหรือไม่ปฏิบัติตามโครงการวิจัยที่ได้รับการรับรอง ผู้วิจัยต้องส่งรายงานการการเบี่ยงเบน
หรือไม่ปฏิบัติตามข้อกำหนด (AP 08/2024)
- (7) เมื่อการวิจัยเสร็จสิ้น หรือ มีการยุติโครงการวิจัยก่อนกำหนดเวลาที่กำหนด ผู้วิจัยต้องส่งรายงาน
ปิดโครงการวิจัย (AP 09/2024)

หมายเหตุ สามารถ Download แบบรายงานต่าง ๆ ได้ที่ <https://ethic.mfu.ac.th>

ข้าพเจ้าในฐานะ ผู้วิจัย ยินยอมที่จะปฏิบัติตามข้อกำหนดดังกล่าว

(Miss Tin Mi Mi Ohn)

วันที่ 30.7.2025.

APPENDIX B

ETHICAL APPROVAL CERTIFICATE (ENGLISH VERSION)



The Mae Fah Luang University Ethics Committee on Human Research
333 Moo 1, Thasud, Muang, Chiang Rai 57100
Tel: (053) 917-170 to 71 Fax: (053) 917-170 E-mail: rec.human@mfu.ac.th

CERTIFICATE OF APPROVAL

COA: 135/2025

Protocol No: EC 25110-18

Title: Quality of life and its associated factors among Myanmar migrant workers in Chiang Rai province, Thailand

Principal investigator: Miss Tin Mi Mi Ohn

School: Health Science

Funding support: Personal budget

Approval:

- | | |
|---|---|
| 1) Research protocol | Version 2 Date June 30, 2025 |
| 2) Information sheet and informed consent documents | Version 2 Date June 30, 2025 |
| 3) Questionnaire | Version 1 Date May 6, 2025 |
| 4) Advertising information sheet | Version 1 Date May 6, 2025 |
| 5) Principal investigator and Co-investigators | |
| - Miss Tin Mi Mi Ohn | - Thapakorn Ruanjai, Ph.D. |
| - Assoc. Prof. Tawatchai Apidechkul, Ph.D. | - Asst. Prof. Pilasinee Wongnuch, Ph.D. |

The aforementioned documents have been reviewed and approved by the Mae Fah Luang University Ethics Committee on Human Research in compliance with international guidelines such as Declaration of Helsinki, the Belmont Report, CIOMS Guidelines and the International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use - Good Clinical Practice (ICH - GCP)

Date of Approval: July 12, 2025

Date of Expiration: July 11, 2026

Frequency of Continuing Review: 1 year

(Jullapong Achalapong, M.D.)

Chairperson of the Mae Fah Luang Ethics Committee on Human Research



The Mae Fah Luang University Ethics Committee on Human Research
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For research protocol approved by the Mae Fah Luang University Ethics Committee on Human Research (MFU EC), the investigators must comply with the followings:

1. Strictly conduct the research as required by the protocol.
2. Use only the information sheet, consent form, questionnaire, case record form and advertisement bearing the MFU EC stamp of approval.
3. Submit a progress report (AP 05/2024) for continuing review and for renewing the approval within 30 days before expiration date.
4. When there are changes of the protocol, the investigator must submit an amendment report (AP 06/2024) with amended protocol for MFU EC approval before implementing any changes in the research (unless those changes are required urgently for the safety of the research subjects).
5. When there is any unanticipated problem or serious adverse event, the investigator must submit a safety report (AP 07/2024) as set forth in the ICH-GCP.
6. When there is any deviation or non-compliance with the approved protocol, the investigator must submit a protocol deviation/non-compliance report (AP 08/2024).
7. When the research is complete or terminated, the investigator must submit a closing report (AP 09/2024).

Please go to <https://ethic.mfu.ac.th> to download MFU EC forms for reporting.

I, as an investigator, agree to comply with the above obligation.

(Miss Tin Mi Mi Ohn)

Date 30.7.2025

APPENDIX C

INFORMATION SHEET AND INFORMED CONSENT (ENGLISH VERSION)

Version 2 Date 30/6/2025

AP 03_1/2024

Information Sheet and Informed Consent

Research Project Title: QUALITY OF LIFE AND ITS ASSOCIATED FACTORS AMONG MYANMAR MIGRANT WORKERS IN CHIANG RAI PROVINCE, THAILAND

Principal investigator: Miss Tin Mi Mi Ohn

Affiliation: School of Health Science, Mae Fah Luang University

Advisor: Dr. Thapakorn Runjai

Source of Research Funding/Sponsor: Mae Fah Luang University

1. Introduction and Project Summary

My name is Tin Mi Mi Ohn, and I am a master's student in Public Health at Mae Fah Luang University, Thailand. I am conducting a study to learn more about the quality of life of Myanmar migrant workers in Chiang Rai Province, how they live, work, feel, and what things affect their lives. I would like to invite you to take part in this study and would like to provide you with more information.

This is a research project and participation in this study is entirely voluntary. If you choose not to participate, it will not affect your access to healthcare or any other rights. You may also withdraw at any time without any negative consequences. You can ask me any questions; I'm happy to explain everything.

In this study, we want to understand what "quality of life" means to migrant workers. This includes how you feel about your health, your emotions, your relationships, your workplace, and your living conditions. This is important because many migrant workers face difficult jobs, unsafe conditions, unfair treatment, and language problems. All of these can affect how they feel and how healthy they are.

The goals of this study are to learn about the quality of life of Myanmar migrant workers living in Chiang Rai, Thailand and to find out what factors affect their quality of life (such as work conditions, social support, or health). What we learn from this study will help public health workers and the government better understand the lives and needs of Myanmar migrant workers. The results may help make it easier for migrant workers to get healthcare, improve working conditions, support mental health, reduce unfair treatment, and build stronger support systems.

This study hopes to give useful information to those who make decisions such as government officers, healthcare providers, and community leaders so that they can create better programs and services that treat all people fairly and equally.

The study will take about 20 to 30 minutes of your time. You will be asked to answer a set of questions, either by filling out the form by yourself or, if you cannot read or write in the

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Myanmar language but can understand spoken Burmese, the researcher will ask you the questions face-to-face and record your answers. These questions will ask about things like your background, mental health, family and social support, working conditions, access to healthcare, and whether you have faced unfair treatment or discrimination. You will complete the questions in Myanmar language, in a private and quiet place, to make sure you feel comfortable and safe. Everything you share will be kept private and confidential. Your answers will be used only for research and public health purposes, and your name or personal identity will not be shared with anyone.

There are no physical or medical risks from joining this study. Some of the questions might feel personal or sensitive, especially those about your feelings or life situation. But because you will answer the questions in a private place, this is not likely to cause discomfort. If you do feel uncomfortable at any time, you can skip any question, stop answering, or leave the study. If you experience emotional distress, mental health support, referral and contact information for local counseling services will be provided.

There may be no direct benefit to you, but your participation will help us understand more about the lives and challenges of Myanmar migrant workers in Chiang Rai. The information from this study may help create better health programs and services to improve the well-being of migrant workers in the future.

If you do not want to participate in a research study as a participant, you can inform the researcher. The refusal of participation will not affect your access to healthcare or any other rights and your decision will be respected.

If you have any questions or worries at any time, please feel free to ask the researcher. We promise to do our best to protect your rights, take care of your well-being, and treat you with respect during the whole study.

2. A statement indicating that this is a research project and that the participation in this research is voluntary

You are invited to participate in this research. Please take time to read this document as it provides information about your involvement in the research. The decision to participate is entirely voluntary. If you choose not to participate, your healthcare and rights you are entitled to will not be changed.

Your participation in this research is based on your voluntary decision.

- You have the freedom to decide whether to participate in this research or not.
- You can consult with your family or your physician before making decision. You may also ask any questions; the researcher will provide explanations and answers until you have a clear understanding.
- After deciding to participate in this research, you still have the right to withdraw at any time.

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3. Rationale and Significance of the Research

This research is important because it addresses a significant gap in understanding the quality of life (QoL) among Myanmar migrant workers in Chiang Rai Province, a region with a rapidly increasing migrant population. Despite their essential contributions to Thailand's economy, these migrant workers often face poor living conditions, limited access to healthcare, and various social challenges that negatively affect their overall well-being. By exploring the determinants of QoL through a social-ecological lens, this study can provide valuable insights into the intrapersonal, interpersonal, institutional, and community factors influencing their lives. The findings will not only help guide more effective, evidence-based interventions but also support policy development aimed at improving the health, rights, and social integration of migrant populations in Thailand.

4. Qualifications and Number of Participants

You can take part in this study if you are a Myanmar migrant worker, no matter what your legal status is. You need to be 18 years old or older and have lived in Chiang Rai Province for at least six months. You should also be able to read and write in the Myanmar language, and be willing to join the study after understanding the information provided. If you cannot read or write but you can understand spoken Burmese, the researcher will help by asking the questions face-to-face and recording your answers. However, you cannot join the study if you are very sick or have a health problem that makes it difficult for you to answer the questions. You also cannot join if you have trouble understanding or thinking clearly, which would make it hard for you to take part. In total, about 420 people will be invited to join this study.

5. Research Objectives

The objectives of this research are to assess the quality of life (QoL) and to identify its associated factors among Myanmar migrant workers in Chiang Rai Province, Thailand.

6. Research Design

Data will be collected using a self-administered structured questionnaire, allowing participants to complete the survey independently in a private setting. For participants who are unable to read or write in the Myanmar language but can understand spoken Burmese, the researcher will conduct a face-to-face interview to ensure their inclusion and comfort. The study will employ a community-based cross-sectional design to assess the quality of life of Myanmar migrant workers in Chiang Rai Province, Thailand, while identifying key factors that influence their quality of life. A three-step sampling strategy will be used to ensure a representative sample of the Myanmar migrant population in Mueang Chiang Rai and Mae Sai Districts of Chiang Rai Province. First, simple random sampling will be conducted to select four communities from each district, two large and two small, out of a total of 19 communities. In Mueang Chiang Rai District, communities with a population of 200 or more will be considered large, and those with fewer than 200 will be classified as small. In Mae Sai District, communities with a population greater than

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200 will be classified as large, while those with 200 or fewer will be categorized as small. In the second step, proportional allocation will be applied to distribute the sample size among the selected communities based on their population size, ensuring that larger communities contribute more participants while maintaining representativeness. Finally, participants who meet the study's inclusion criteria will be selected, ensuring a balanced and representative sample while minimizing selection bias. During the research period, if a selected community is unavailable or declines to provide research data, another community will be randomly selected from the list to maintain study continuity.

7. Research Procedure and Duration of Participation

I am inviting all Myanmar migrant workers aged 18 years or older who reside in Mueang Chiang Rai and Mae Sai districts of Chiang Rai Province, Thailand to participate in this study. Your involvement will entail completing a self-administered structured questionnaire or answering face to face interview in a private setting, which should take approximately 20-30 minutes to complete independently. The questionnaire will gather data related to your quality of life, including health status, living conditions, socioeconomic status, work-related status and access to healthcare. Please be assured that the information you provide will be kept strictly confidential and will not be disclosed to anyone.

8. Potential Risks and Discomfort from Participating in the Research

Your participation in this study may involve psychological discomfort that could arise when answering personal or sensitive questions, particularly those related to your quality of life, such as mental health, or chronic illnesses. Discussing these topics may make you feel uneasy. If at any point during the study you feel uncomfortable, you have the right to withdraw from the study at any time, and doing so will not result in any negative consequences.

Should you experience any distress or discomfort during the study, the researcher will be available to support you. If necessary, referrals to professional mental health services and counselling can be provided. Throughout the study, a safe and confidential environment will be maintained to ensure you feel comfortable and respected.

9. Potential Benefits of Participating in the Research

By participating in this study, you will not receive direct benefits. However, you may gain valuable knowledge and resources related to your own quality of life, mental health, and access to healthcare. Based on the study's findings, you may receive recommendations that could help improve your well-being.

Additionally, you will receive educational materials such as brochures containing tips and information about healthcare access, mental health support, workers' rights, importance of social support and emergency contact numbers.

While participation may not directly improve your health, the results of this research could have broader benefits. The findings may help identify important health challenges faced by

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migrant workers and provide insights that can guide policymakers and public health professionals in developing more effective healthcare interventions. These improvements could ultimately benefit the wider community in the long term.

10. Alternatives if Choosing NOT to Participate

Participation in this study is entirely voluntary. If you choose not to participate, it will not affect your access to healthcare or any other rights. You may also withdraw at any time without any negative consequences. Should you decide not to take part, you will still have access to healthcare services through the contacts provided in the brochure. It is recommended that you consult with your physician to discuss any treatment options that may be more suitable for your needs. This study is not intended to replace medical advice, and other available healthcare options may be more appropriate depending on your individual situation.

11. Guidelines for Managing Situations that May Arise during the Research

Situations	Guidelines
If you decide to withdraw during the research	You have the right to withdraw from the research at any time, for any reason, without any penalty or negative consequences. If you decide to withdraw, you can simply inform the researcher, and your participation will end immediately. Any data collected from you before withdrawal will be kept confidential and will not be used in the research.
If there is new information regarding the research or your safety	If new information becomes available that could affect your decision to participate or your safety, the researcher will inform you promptly. You will then have the option to continue in the study or withdraw.
The criteria for ending participation may include completion of the study protocol, reaching a predetermined time limit, or achieving a target sample size.	If any of these criteria are met, the researcher will notify participants accordingly and conclude their participation in the research. All data collected up to that point will be securely stored and included in the final analysis, in accordance with data protection and ethical guidelines.

12. Potential Benefits after the Completion of the Research

After the completion of the research, there may not be direct benefits for participants from their involvement in the study. However, participants will be informed of the study's findings in an accessible format once the research has been completed. The results will be communicated in the Myanmar language or through visual aids, such as pictures or diagrams, to ensure clarity.

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Additionally, participants will receive recommendations based on the study's findings to help improve their overall well-being and quality of life. These recommendations will include guidance on self-care, as well as advice on addressing factors that may impact their health, such as lifestyle changes, mental health resources, and available healthcare options.

13. Confidentiality of Data and Limitations

After you participate in this study, your privacy and confidentiality will be a top priority. To protect your personal information, all data collected will be anonymized. This means that personal identifiers such as your name or address will not be linked to your responses. Instead, you will be assigned a unique code, ensuring that there is no direct connection between your identity and the data provided. Your informed consent forms and survey responses will be stored separately to further protect your confidentiality. All electronic data will be securely encrypted and stored on password-protected computers, accessible only by the principal investigator. Any physical research materials will be stored in a locked filing system within a secure research facility.

While confidentiality will be maintained, please note that certain individuals or groups, such as the ethics committee, research coordinators, research supervisors, and authorized personnel from governmental institutions or auditing organizations, may need access to your data. This access is necessary to verify the accuracy of the data and research procedures. Once the study is completed, your data will be kept for the duration required by research ethics guidelines before being permanently deleted. The research findings will be disseminated publicly through seminars or publications, allowing professionals, implementers, and policymakers to learn and apply relevant insights. Confidential information will not be disclosed or shared in any form.

This study follows ethical guidelines that respect your privacy and ensure that your rights and dignity are protected throughout the process.

14. Reimbursement for Participation

Participants will receive a brochure containing practical tips and information about healthcare services, mental health resources, workers' rights, the importance of social support, and emergency contact numbers, all aimed at improving their well-being and quality of life. In addition, light refreshments such as a milk or juice carton and cookies will be offered as a small token of appreciation and a gesture of gratitude for their voluntary participation in the study.

15. Expenses that the participants must bear

There are no expenses that the participants must bear in this study.

16. Care and Compensation Guidelines if the participants experience harm or adverse effects from participating in the research

In the unlikely event that participants experience any harm or adverse effects during the course of this research, the principal investigator is committed to providing appropriate care and support. There is a possibility of emotional or psychological discomfort due to the sensitive nature

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of topics such as mental health, chronic illness, and quality of life. Should any participant experience such distress, they will be promptly referred to appropriate medical professionals or local counseling services for further evaluation and care. Participants will be supported throughout the study in a non-judgmental and compassionate manner, with full respect for their dignity and autonomy. Every precaution has been taken to minimize potential risks, and in the event of any adverse effects, necessary steps will be implemented to ensure participants' safety and access to appropriate support services. They will also be clearly informed that participation is entirely voluntary, and they may withdraw from the study at any time without facing any negative consequences or impact on their access to healthcare or other rights. If there are any side effects or undesirable events occur from this research, the researcher will make the care responsible for all costs of treatment and rehabilitation.

17. Contact Person in Case of Questions or Concerns

If you have any questions or concerns regarding the research or safety during participation, you can ask the researcher directly.

Principal investigator

Name: Tin Mi Mi Ohn

Mobile: 0637541501

Email: 6751804018@lamduan.mfu.ac.th

Advisor

Name: Lect. Dr. Thapakorn Ruanjai

Mobile: 0657539596

Email: thapakorn.rua@mfu.ac.th

If you have questions regarding your rights, you can contact the Mae Fah Luang University Ethics Committee on Human Research at the Academic Service building (AS), 4th floor, tel. (053) 917-170 to 1 or (053) 916-551, fax. (053) 917-170, or e-mail: rec.human@mfu.ac.th to ensure that your rights, your safety, and your well-being are protected under the international standards of human-research ethics.



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Informed Consent Form

I, _____, have decided to participate in the research project titled "Quality of Life and Its Associated Factors Among Myanmar Migrant Workers in Chiang Rai Province, Thailand." I have received information and explanations about this research, and I have had the opportunity to ask questions and receive satisfactory answers. I have had sufficient time to read and understand the information provided in the documents thoroughly and have decided to participate in this research.

I understand that I have the freedom to choose not to participate in this research, and I can withdraw from this research at any time without any impact on my care or rights that I am entitled to.

By signing this document, I do not waive any rights that I am entitled to under the law, and after signing, I will receive a copy of the information sheet and the informed consent.

Participant's Signature _____ Date _____
()

..... (For illiterate participants who can understand though listening)	
I cannot read, but the researcher has read this information sheet and informed consent form to me, and I understand it well. Therefore, I voluntarily sign or place my fingerprint.	
Participant's signature/fingerprint _____ ()	Date _____

Signature of the person requesting consent _____ Date _____
()



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Testimony of a witness who is not a stakeholder in the research (If the participant cannot read but can understand through listening)

I have been present during the consent request process and confirm that the person requesting consent has read / explained the information sheet to _____. The aforementioned person had the opportunity to ask questions and decided to participate voluntarily after understanding the information in this document.

Witness's signature _____ Date _____
(_____)



APPENDIX D

INFORMATION SHEET AND INFORMED CONSENT (MYANMAR VERSION)

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သုတေသနအချက်အလက်နှင့် သဘောတူညီမှု

သုတေသနခေါင်းစဉ်: ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်း အလုပ်သမားများ အကြား လူနေမှုဘဝအရည်အသွေးနှင့် ဆက်နွှယ်သက်ဆိုင်သော အကြောင်းအရာများ အဓိက စုံစမ်းစစ်ဆေးသူ: မတင်မီမီအုန်း တက္ကသိုလ်ဌာနအဖွဲ့အစည်း: မယ့်ဖာလုံတက္ကသိုလ်

သုတေသနအကြံပေးပုဂ္ဂိုလ်: ဒေါက်တာ Thapakorn Runjai သုတေသနပုံစံ: ကူညီမှုအရင်းအမြစ်: မယ့်ဖာလုံတက္ကသိုလ်

၁။ နိဒါန်းနှင့် သုတေသနအကျဉ်းချုပ်

ကျွန်ုပ်တို့သည် တင်မီမီအုန်း ဖြစ်ပြီး၊ ထိုင်းနိုင်ငံ မယ့်ဖာလုံတက္ကသိုလ်ရှိ ပြည်သူ့ကျန်းမာရေးမေဂျာမှမဟာကျောင်းသားတစ်ဦးဖြစ်ပါသည်။ ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်း အလုပ်သမားများအကြား လူနေမှုဘဝအရည်အသွေး၊ နေထိုင်ပုံ၊ အလုပ်၊ ခံစားချက်နှင့် ၎င်းတို့၏ ဘဝအပေါ် မည်သို့သော အရာများ သက်ရောက်မှုရှိသည်ကို ပိုမိုလေ့လာရန် သုတေသနပြုလုပ်နေပါသည်။ ဤလေ့လာမှုတွင် ပါဝင်ရန် သင့်အား ဖိတ်ခေါ်ပြီး နောက်ထပ် အချက်အလက်များကို ပေးလိုပါသည်။

ဤလေ့လာမှုတွင် ပါဝင်ခြင်းသည် လုံးဝဆန္ဒအလျောက်ဖြစ်သည်။ မပါဝင်ရန် ရွေးချယ် ပါကသင်၏ ကျန်းမာရေးစောင့်ရှောက်မှုသို့ ဝင်ရောက်ခွင့်သို့ မဟုတ်အခြား အခွင့်အရေးများကို ထိခိုက်မည်မဟုတ်ပါ။ အပျက်သဘောဆောင်သည့် အကျိုးဆက်များမရှိဘဲ အချိန်မရွေး ရုပ်သိမ်းနိုင်ပါသည်။ ကျေးဇူးပြု၍ မည်သည့်မေးခွန်းများရှိသည်ဖြစ်စေ၊ ရှင်းလင်းမှုလိုအပ်ပါက လည်း မေးမြန်းနိုင်ပါသည်။ ကျွန်ုပ်တို့သည် သင့်အား ကူညီရန်အတွက် အဆင်သင့်ရှိနေပါသည်။

ဤလေ့လာမှုတွင် ရွှေ့ပြောင်းအလုပ်သမားများအတွက် “ဘဝအရည်အသွေး” ဆိုသည်မှာ မည်ကဲ့သို့ အဓိပ္ပာယ်ရှိသည်ကို ကျွန်ုပ်တို့ နားလည်လိုပါသည်။ ၎င်းတွင် သင့်ကျန်းမာရေး၊ သင့်စိတ်ခံစားမှုများ၊ သင့်ဆက်ဆံရေး၊ သင့်လုပ်ငန်းခွင်နှင့် သင့်နေထိုင်မှုအခြေအနေတို့ ပါဝင်သည်။ ရွှေ့ပြောင်းအလုပ်သမားများစွာသည် ခက်ခဲသောအလုပ်များ၊ မလိုအပ်သောအခြေအနေများ၊ တရားမျှတမှုမရှိသော ဆက်ဆံမှုနှင့် ဘာသာစကားပြဿနာများကို ရင်ဆိုင်ရသောကြောင့် ၎င်းသည် အရေးကြီးပါသည်။

ဒါတွေအကုန်လုံးက သူတို့ဘယ်လိုခံစားရသလဲ နှင့် သူတို့ ဘယ်လောက်ကျန်းမာနေလဲဆိုတာ သက်ရောက်မှုရှိနိုင်ပါ သည်။

ဤလေ့လာမှု၏ရည်ရွယ်ချက်မှာထိုင်းနိုင်ငံ၊ချင်းလိုင်းပြည်နယ်ရှိမြန်မာရွှေ့ပြောင်းအလုပ်သမားများ၏လူနေမှုဘဝအရည်အသွေးကိုအကဲဖြတ်ရန်နှင့်၎င်းနှင့်ဆက်စပ်နေသည့်အချက်များ (ဥပမာ အလုပ်အခြေအနေ၊ လူမှုရေးပံ့ပိုးမှု သို့မဟုတ် ကျန်းမာရေး) ကိုဖော်ထုတ်ရန်ဖြစ်သည်။ဤလေ့လာမှုမှတွေ့ရှိချက်များသည်ကျန်းမာရေးစောင့်ရှောက်မှုလက်လှမ်းမီနိုင်မှု တိုးတက်စေရန်၊ လုပ်ငန်းခွင်ပတ်ဝန်းကျင်ကို မြှင့်တင်ရန်၊ လူမှုရေးဆိုင်ရာပံ့ပိုးမှုစနစ်များ အားကောင်းလာစေရန်၊ ရွှေ့ပြောင်းအလုပ်သမားများအပေါ် ခွဲခြားဆက်ဆံမှုလျော့ချစေရန်နှင့်စိတ်ကျန်းမာရေးတိုးတက်မှုကိုမြှင့်တင်ပေးမည့်ပြည်သူ့ကျန်းမာရေးဆိုင်ရာအချက်အလက်များနှင့်အထောက်အထားအခြေပြုထိုးထွင်းသိမြင်မှုများကိုပေးဆောင်မည်ဖြစ်သည်။ အဆုံးစွန်အားဖြင့်၊ ဤလေ့လာမှုသည်သာတူညီမျှမှုနှင့်အားလုံးပါဝင်မှုကိုမြှင့်တင်ပေးသည့်ပစ်မှတ်ထားသောဆောင်ရွက်မှုများကိုဖော်ဆောင်ရာတွင် မူဝါဒချမှတ်သူများနှင့် သက်ဆိုင်သူများကို အသိပေးရန် ကူညီပေးပါမည်။

လေ့လာမှုသည် သင့်အချိန်၏ မိနစ် ၂၀ မှ ၃၀ ခန့် ကြာမည်ဖြစ်သည်။ ဖောင်ကို ကိုယ်တိုင်ဖြည့်သွင်း၍ဖြစ်စေ မြန်မာဘာသာဖြင့် မရေးနိုင်မဖတ်နိုင်သော်လည်း မြန်မာဘာသာစကားကို နားလည်နိုင်လျှင် သုတေသီမှ မေးခွန်းများကို မျက်နှာချင်းဆိုင် မေးပြီး အဖြေများကို မှတ်တမ်းတင်ပါမည်။ ဤကာလအတွင်းတွင် ပါဝင်သူများသည် ဒေတာစုဆောင်းခြင်းလုပ်ငန်းစဉ်၏ တစ်စိတ်တစ်ပိုင်းအဖြစ် ဖွဲ့စည်းတည်ဆောက်ထားသော မေးခွန်းလွှာကိုလွတ်လပ်စွာဖြည့်သွင်းရမည်ဖြစ်သည်။မေးခွန်းလွှာတွင်သင်၏နောက်ခံစိတ် ကျန်းမာရေး၊လူမှုရေးပံ့ပိုးမှု၊အလုပ်နှင့်ပတ်သက်သည့်အချက်များ၊ကျန်းမာရေးစောင့်ရှောက်မှုရရှိမှုနှင့်ခွဲခြားဆက်ဆံမှုစသည့်အကြောင်းအရာများ ပါဝင်မည်ဖြစ်သည်။ သင်၏ သက်တောင့်သက်သာဖြစ်မှု နှင့် ကိုယ်ရေးကိုယ်တာ လုံခြုံမှုကို သေချာစေမည့် ဒေတာများကို မြန်မာဘာသာဖြင့် သီးသန့် နေရာတွင် စုဆောင်းပါမည်။ သင့်အဖြေများကို သုတေသနနှင့် ပြည်သူ့ကျန်းမာရေးရည်ရွယ်ချက်များအတွက်သာ အသုံးပြုမည်ဖြစ်ပြီး သင့်အမည် သို့မဟုတ် ကိုယ်ရေးကိုယ်တာအထောက်အထားများကို မည်သူနှင့်မျှ မျှဝေမည်မဟုတ်ပါ။

ဤသုတေသနတွင်ပါဝင်ခြင်းကြောင့်ရုပ်ပိုင်းဆိုင်ရာသို့မဟုတ်ဆေးဘက်ဆိုင်ရာအန္တရာယ်များမရှိပါ။ အချို့သောမေးခွန်းများသည် ထိလွယ်ရှလွယ်ဖြစ်နိုင်ပြီး စိတ်ကျန်းမာရေးသို့မဟုတ် ကိုယ်ရေးကိုယ်တာအခြေအနေများနှင့်ပတ်သက်သည့် အကြောင်းအရာများကို ဆွေးနွေးရာတွင် စိတ်မသက်မသာခံစားရနိုင်သော်လည်း ၎င်းကို သီးသန့်ဆက်တင်တွင် ပြုလုပ်မည်ဖြစ်သောကြောင့်ယင်းသည် ဖြစ်လာနိုင်ဖွယ်မရှိပါ။ သို့သော်လည်း လုပ်ငန်းစဉ်အတွင်းမည်သည့်နေရာ၌မဆိုအဆင်မပြေခံစားရပါက၊ အချိန်မရွေးဖြေဆိုခြင်းကို ရပ်တန့်ခြင်း၊ မေးခွန်းများကို ကျော်သွားခြင်း သို့မဟုတ် လေ့လာမှုမှ လုံးဝနှုတ်ထွက်ခြင်းကို ပြုလုပ်နိုင်သည်။ အကယ်၍သင်သည်စိတ်ခံစားမှုဆိုင်ရာပြဿနာများဖြစ်ပါကစိတ်ကျန်းမာရေးပံ့ပိုးမှုလွှဲပြောင်းမှုနှင့်ဒေသခံစိတ်ကျန်းမာရေးအထောက်အပံ့အကြံဉာဏ်ဝန်ဆောင်မှုများအတွက်ဆက်သွယ်ရန်အချက်အလက်များကို ပံ့ပိုးပေးမည်ဖြစ်သည်။

သင့်အတွက် တိုက်ရိုက်အကျိုးခံစားခွင့်များ မရှိသော်လည်း သင်၏ပါဝင်မှုသည် ထိုင်းနိုင်ငံ၊ ချင်းလိုင်းပြည်နယ်ရှိမြန်မာရွှေ့ပြောင်းအလုပ်သမားများကြားတွင်၎င်း၏ဘဝအရည်အသွေးနှင့်၎င်း၏ဆက်စပ်နေသောအချက်များကိုပိုမိုကောင်းမွန်စွာနားလည်နိုင်စေရန် ကူညီပေးမည်ဖြစ်ပါသည်။ ဤသုတေသနပြုချက်သည်အထောက်အထားအခြေပြု ထိုးထွင်းသိမြင်မှုများကို ပံ့ပိုးပေးပြီး ရွှေ့ပြောင်းအလုပ်သမားများ၏ ကျန်းမာရေးနှင့် သုခချမ်းသာမှုကိုမြှင့်တင်ရန်အတွက်အနာဂတ်အစီအစဉ်များ၊ မူဝါဒများနှင့်ပြည်သူ့ကျန်းမာရေးဗျူဟာများ ဖွံ့ဖြိုးတိုးတက်လာစေရန် ကူညီပေးနိုင်ပါသည်။

သုတေသနလေ့လာမှုတွင် ပါဝင်သူတစ်ဦးအနေဖြင့် မပါဝင်လိုပါက သုတေသီအား အကြောင်းကြားနိုင်ပါသည်။ ပါဝင်ခြင်းကိုငြင်းဆိုခြင်းသည်သင့်ကျန်းမာရေးစောင့်ရှောက်မှုသို့ ဝင်ရောက်ခွင့် သို့မဟုတ် အခြားအခွင့်အရေးများကို ထိခိုက်စေမည်မဟုတ်သည့်အပြင် သင်၏ဆုံးဖြတ်ချက်ကိုလေးစားမည်ဖြစ်သည်။

မည်သည့်အဆင့်တွင်မဆိုမေးခွန်းများသို့မဟုတ် စိုးရိမ်ပူပန်မှုများရှိပါက သုတေသီထံ ဆက်သွယ်ရန် တုံ့ဆိုင်းမနေပါနှင့်။ ဤလေ့လာမှုတစ်လျှောက်လုံး သင်၏အခွင့်အရေးများ၊ ကျန်းမာရေးနှင့် ဂုဏ်သိက္ခာတို့ကို အကာအကွယ်ပေးထားကြောင်း သေချာစေရန် ကျွန်ုပ်တို့ကတိပြုပါသည်။

ထိရောက်စွာအထောက်အပံ့ပေးနိုင်သော သက်သေပြအချက်အလက်များပေးနိုင်မည်ဖြစ်ပြီး၊
 ထိုင်းနိုင်ငံရှိ ရွှေ့ပြောင်းအလုပ်သမားများ၏ ကျန်းမာရေး၊ ရပိုင်ခွင့်များ၊ အခွင့်အရေးများနှင့်
 လူမှုသဟဇာတဖြစ်မှုကို တိုးတက်အောင်မြင်လုပ်နိုင်ရန် မူဝါဒဖွံ့ဖြိုးရေးများအတွက်လည်း
 အထောက်အကူပြုနိုင်ပါသည်။

၄။ သုတေသနတွင်ပါဝင်ရန်အရည်အချင်းများနှင့် ပါဝင်သူအရေအတွက်

သင်သည်မြန်မာနိုင်ငံသားရွှေ့ပြောင်းအလုပ်သမားဖြစ်ပါကသင်၏နေထိုင်မှု
 အထောက်အထား မည်သို့ပင်ရှိစေကာမူ ဤလေ့လာမှုတွင် ပါဝင်နိုင်ပါသည်။ သင်သည်
 အသက် ၁၈ နှစ်နှင့်အထက် ဖြစ်ရန်လိုအပ်ပြီး ချင်းရိုင်းခရိုင်တွင် အနည်းဆုံး ခြောက်လ
 နေထိုင်ခဲ့ရမည်။ မြန်မာဘာသာဖြင့် ရေးတတ်ဖတ်တတ်နိုင်ပြီး ပေးထားသော
 အချက်အလက်များကို နားလည်ပြီးနောက် လေ့လာမှုတွင် ပါဝင်လိုစိတ်ရှိရမည်။
 စာမေးရေးတတ်မဖတ်တတ်သော်လည်း မြန်မာစကားကို နားလည်နိုင်လျှင် သုတေသီသည်
 မေးခွန်းများကို မျက်နှာချင်းဆိုင်မေးပြီး အဖြေများကို မှတ်တမ်းတင်ခြင်းဖြင့်
 ကူညီပါလိမ့်မည်။ သို့သော် သင်သည် အလွန်ဖျားနာခြင်း သို့မဟုတ် မေးခွန်းများကိုဖြေဆိုရန်
 ခက်ခဲစေသော ကျန်းမာရေးပြဿနာရှိလျှင် လေ့လာမှုတွင် မပါဝင်နိုင်ပါ။ နားလည်မှု
 သို့မဟုတ် ရှင်းရှင်းလင်းလင်းတွေးခေါ်ရန် ခက်ခဲနေပါက ပါဝင်ရန် ခက်ခဲစေမည့် သင်လည်း
 မပါဝင်နိုင်ပါ။ စုစုပေါင်း လူ ၄၂၀ ကို ဤလေ့လာမှုတွင် ပါဝင်ရန် ဖိတ်ကြားမည်ဖြစ်သည်။

၅။ သုတေသန ရည်ရွယ်ချက်များ

ဤသုတေသန၏ရည်ရွယ်ချက်မှာထိုင်းနိုင်ငံ၊ချင်းလိုင်းပြည်နယ်ရှိမြန်မာရွှေ့ပြောင်း
 အလုပ်သမားများကြား၎င်း၏လူနေမှုဘဝအရည်အသွေးကိုအကဲဖြတ်ပြီး၊၎င်းတို့၏
 ဘဝအရည်အသွေးကိုသက်ရောက်စေသောအကြောင်းအရင်းများကိုရှာဖွေခြင်း ဖြစ်ပါသည်။

၆။ သုတေသနဒီဇိုင်း

ပါဝင်သူများကို သီးသန့်နေရာတွင် လွတ်လပ်စွာ စစ်တမ်းကောက်ယူနိုင်စေမည့်
 ကိုယ်တိုင်ဖြေဆိုမှုစနစ်ပုံစံမေးခွန်းလွှာကို အသုံးပြု၍ ဒေတာစုဆောင်းမည်ဖြစ်သည်။
 မြန်မာဘာသာစကားဖြင့် စာမေးရေးနိုင်မဖတ်နိုင်သော်လည်း မြန်မာဘာသာစကားကို
 နားလည်နိုင်သော ပါဝင်သူများအတွက် သုတေသီသည် ပါဝင်မှုနှင့်
 သက်တောင့်သက်သာရှိစေရန် မျက်နှာချင်းဆိုင် မေးခွန်းများမေး၍ အင်တာဗျူး

ပြုလုပ်ပေးမည်ဖြစ်ပါသည်။ ဤသုတေသနသည် ထိုင်းနိုင်ငံ၊ ချင်းလိုင်ပြည်နယ်ရှိ မြန်မာရွှေ့ပြောင်းအလုပ်သမားများ၏ ဘဝအရည်အသွေးကိုအကဲဖြတ်ရန်အချိန်အပိုင်းအခြားတစ်ခုအတွင်းမှအချက်အလက်များ အပေါ်အခြေခံသောရပ်ရွာအခြေပြုသုတေသနဒီဇိုင်းကိုအသုံးပြုမည်ဖြစ်ပြီး၎င်းတို့၏ဘဝအ ရည်အသွေးကိုလွှမ်းမိုးနိုင်သည့်အဓိကအချက်များကိုဖော်ထုတ်ပေးမည်ဖြစ်ပါသည်။

အဆင့်သုံးဆင့်နမူနာနည်းဗျူဟာကိုချင်းလိုင်ပြည်နယ်မောင်းခရိုင်များနှင့် မယ့်ဆိုင်ခရိုင်များရှိမြန်မာရွှေ့ပြောင်းနေထိုင်သူများ၏ကိုယ်စားပြုနမူနာကိုသေချာစေရန်အ တွက်အသုံးပြုမည်ဖြစ်ပါသည်။ပထမဦးစွာအသိုက်အဝန်း၁၉ခုအနက်မှအသိုက်အဝန်းကြီး နှစ်ခုနှင့်အသေးစားနှစ်ခုကိုရွေးချယ်ရန်အတွက်ရိုးရှင်းသောကျပ်နမူနာကို ပြုလုပ်မည်ဖြစ်ပါသည်။မောင်းခရိုင်တွင်လူဦးရေ၂၀၀၀၀ကျော်၂၀၀၀ကျော်ပိုသောအသိုက် အဝန်းများကိုအသိုက်အဝန်းကြီးဟုသတ်မှတ်မည်ဖြစ်ပြီး၂၀၀၀ကျော်နည်းသောသူများကိုအ သေးစား အသိုက်အဝန်းအဖြစ် ခွဲခြားသတ်မှတ်မည်ဖြစ်ပါသည်။ မယ့်ဆိုင်ခရိုင်တွင် လူဦးရေ ၂၀၀၀နှင့်အထက်ရှိသောအသိုက်အဝန်းများကိုအသိုက်အဝန်းကြီးအဖြစ်ခွဲခြားသတ်မှတ်မည် ဖြစ်ပြီး၂၀၀၀အောက်သို့မဟုတ်၂၀၀၀ကျော်နည်းသောအသိုက်အဝန်းများကိုအသေးစားအသိုက် အဝန်းဟုခွဲခြားသတ်မှတ်မည်ဖြစ်ပါသည်။ဒုတိယအဆင့်တွင်ကြီးမားသောအသိုက်အဝန်း သည်ကိုယ်စားပြုမှုဆက်လက်ထိန်းသိမ်းထားစဉ်တွင်ပိုမိုပါဝင်လာစေရန်အတွက်ရွေးချယ် ထားသောအသိုက်အဝန်းအရွယ်အစားပေါ်အခြေခံ၍နမူနာအရွယ်အစားကိုအချိုးကျဖြန့်ဝေ မည်ဖြစ်ပါသည်။နောက်ဆုံးတွင်လေ့လာမှု၏ပါဝင်မှုနှုန်းများနှင့်ကိုက်ညီသောပါဝင်သူများ ကို ရွေးချယ်ရာတွင် ဘက်လိုက်မှုနည်းပါးစေပြီး ဟန်ချက်ညီပြီး ကိုယ်စားလှယ်နမူနာကို သေချာစေကာရွေးချယ်မည်ဖြစ်ပါသည်။သုတေသနကာလအတွင်းရွေးချယ်ထားသောအသိုက် အဝန်းသည် မရရှိနိုင်ပါက သို့မဟုတ် သုတေသနအချက်အလက်များကို ပံ့ပိုးပေးရန် ငြင်းဆိုပါက၊ လေ့လာမှုအဆက်မပြတ်ဆက်လက်ထိန်းသိမ်းထားရန် အခြားအသိုက်အဝန်းကို စာရင်းမှ ကျပ်နမူနာရွေးချယ်သွားမည်ဖြစ်ပါသည်။

၇။ သုတေသနလုပ်ထုံးလုပ်နည်းနှင့် ပါဝင်မှုကြာချိန်

ထိုင်းနိုင်ငံ ချင်းလိုင်ပြည်နယ်မောင်းခရိုင်များနှင့် မယ့်ဆိုင်ခရိုင်များတွင် နေထိုင်သော အသက် (၁၈)နှ့် အထက် မြန်မာရွှေ့ပြောင်း အလုပ်သမားအားလုံးကို ဒီလေ့လာမှုမှာ ပါဝင်ရန်

ဖိတ်ခေါ်အပ်ပါသည်။သင်၏ပါဝင်မှုသည်သီးသန့်နေရာတစ်ခုတွင်ကိုယ်တိုင်ဖြေကြားမှုစနစ်ပုံစံမေးခွန်းလွှာတစ်ခုကို အမှီအခိုကင်းစွာ ဖြည့်သွင်းရန် သို့မဟုတ် သုတေသီ၏ မေးခွန်းများကို ဖြေကြားရန်လိုအပ်ပြီးမိနစ် ၂၀မှ ၃၀ခန့်ကြာသင့်လိမ့်မည်ဖြစ်သည်။မေးခွန်းလွှာသည်ကျန်းမာရေးအခြေအနေ၊နေထိုင်မှုအခြေအနေ၊လူမှုစီးပွားရေးအခြေအနေ၊အလုပ်နှင့်ပတ်သက်သည့် အခြေအနေများနှင့်ကျန်းမာရေးစောင့်ရှောက်မှုလက်လှမ်းမီမှုအပါအဝင်သင့်ဘဝအရည်အသွေးနှင့်သက်ဆိုင်သည့် အချက်အလက်များကို စုဆောင်းမည်ဖြစ်သည်။ သင်ပေးသော အချက်အလက်အားလုံးကို

လုံးဝလျှို့ဝှက်ထားမည်ဖြစ်ပြီး၊မည်သူ့နှင့်မဆိုမမျှဝေပါ။သင်၏ကိုယ်ရေးကိုယ်တာအချက်အလက်များကို ထိန်းသိမ်းကာကွယ်ပြီး လေ့လာမှုအတွက်သာ အသုံးပြုမည်ဖြစ်သည်။

၈။ သုတေသနတွင် ပါဝင်ခြင်းမှ ဖြစ်ပေါ်လာနိုင်သော အန္တရာယ်များနှင့် အဆင်မပြေမှုများ

ဤလေ့လာမှုတွင်သင်၏ပါဝင်မှုသည်ဖြစ်နိုင်ချေရှိသောအန္တရာယ်အချို့ပါဝင်နိုင်သည်။အန္တရာယ်တစ်ခုမှာအထူးသဖြင့်စိတ်ကျန်းမာရေးသို့မဟုတ်နာတာရှည်ဖျားနာမှုများကဲ့သို့ သောသင်၏ဘဝအရည်အသွေးနှင့်သက်ဆိုင်သည့်ကိုယ်ရေးကိုယ်တာသို့မဟုတ်ထိလွယ်ရှလွယ်မေးခွန်းများကိုဖြေဆိုသည့်အခါဖြစ်ပေါ်လာနိုင်သည့်စိတ်ပိုင်းဆိုင်ရာအဆင်မပြေမှုများဖြစ်သည်။ဤအကြောင်းအရာများကိုဆွေးနွေးခြင်းသည်သင့်အားစိတ်မသက်သာမှုဖြစ်စေနိုင်သည်။ဖြေဆိုနေချိန်အတွင်းအဆင်မပြေမှုတစ်ခုခုခံစားရပါကအချိန်မရွေးလေ့လာမှုမှ နှုတ်ထွက်ခွင့်ရှိပြီးထိုသို့လုပ်ဆောင်ခြင်းသည်မည်သည့်ဆိုးကျိုးများဖြစ်ပေါ်စေမည်မဟုတ်ပါ။

လေ့လာမှုအတွင်းအဆင်မပြေမှုသို့မဟုတ်စိတ်ဖိစီးမှုကြုံတွေ့ပါကသုတေသနပြုသူသည်သင့်အားကူညီပံ့ပိုးပေးမည်ဖြစ်သည်။ လိုအပ်ပါက စိတ်ကျန်းမာရေး ဝန်ဆောင်မှုများထံ လွှဲပြောင်းပေးနိုင်ပါသည်။လေ့လာမှုတစ်လျှောက်လုံးတွင်သင်သည်သက်တောင့်သက်သာရှိပြီး လေးစားခံရကြောင်း သေချာစေရန်အတွက် ဘေးကင်းပြီး လျှို့ဝှက်သောပတ်ဝန်းကျင်ကို ထိန်းသိမ်းပေးထားမည်ဖြစ်သည်။

၉။ သုတေသနတွင် ပါဝင်ခြင်းကြောင့် ဖြစ်နိုင်သော အကျိုးကျေးဇူးများ

ဤသုတေသနတွင် ပါဝင်ခြင်းအားဖြင့် သင်သည် တိုက်ရိုက်အကျိုးခံစားခွင့်မရနိုင်ပါ။ သို့သော်သင်၏ကိုယ်ပိုင်ဘဝအရည်အချင်း၊စိတ်ကျန်းမာရေး၊ကျန်းမာရေးဝန်ဆောင်မှုရယူမှု

THE MAE FAH LUANG UNIVERSITY ETHICS COMMITTEE ON HUMAN RESEARCH
12 JUL 2025
APPROVED

နှင့်သက်ဆိုင်သောအသိပညာနှင့်အရင်းအမြစ်များကိုသိရှိနိုင်မည်ဖြစ်ပါသည်။ သုတေသန၏ တွေ့ရှိချက်ရလဒ်များအပေါ်အခြေခံ၍သင့်ကျန်းမာရေးနှင့်ဘဝအရည်အသွေးကိုတိုးတက်စေ ရန်အတွက် အကြံပြုချက်များကိုလည်း သင်ရရှိနိုင်ပါသည်။

ထို့အပြင်သင်သည်ကျန်းမာရေးဆိုင်ရာအသုံးဝင်သောအကြံပြုချက်များ၊ကျန်းမာရေး ဝန်ဆောင်မှုရရှိနိုင်မှုအကြောင်းအရာများ၊စိတ်ကျန်းမာရေးပံ့ပိုးမှု၊အလုပ်သမားအခွင့်အရေး နှင့်အရေးပေါ်ဆက်သွယ်ရမည့်ဖုန်းနံပါတ်များပါဝင်သည့်စာစောင်များကဲ့သို့သောပညာရေး ဆိုင်ရာပစ္စည်းများကိုလည်း လက်ခံရရှိမည်ဖြစ်ပါသည်။

သုတေသနတွင် ပါဝင်ခြင်းသည် သင်၏ ကျန်းမာရေးကို တိုက်ရိုက်တိုးတက်စေမည် မဟုတ်နိုင်သော်လည်း၊ဤသုတေသနရလဒ်များသည်ပိုမိုကျယ်ပြန့်သောအကျိုးကျေးဇူးများ ရရှိနိုင်ပါသည်။တွေ့ရှိချက်များသည်ရွှေ့ပြောင်းအလုပ်သမားများကြုံတွေ့နေရသည့်ကျန်းမာ ရေးဆိုင်ရာအခက်အခဲများကိုဖော်ထုတ်ပေးနိုင်ပြီး၊ကျန်းမာရေးမူဝါဒရေးဆွဲသူများနှင့်ပြည် သူ့ကျန်းမာရေးပညာရှင်များအတွက်ထိရောက်သောကျန်းမာရေးလုပ်ငန်းစဉ်များဖန်တီးရာ တွင်အသုံးဝင်သည့်အထောက်အထားများပံ့ပိုးပေးနိုင်ပါသည်။ဤကဲ့သို့ပြုပြင်ပြောင်းလဲမှု များသည်ရေရှည်တွင်တစ်စုံတစ်ဦးအတွက်သာမကလူ့အဖွဲ့အစည်းတစ်ရပ်လုံးအတွက် အကျိုးပြုနိုင်ပါသည်။

၁၀။ သုတေသနတွင် မပါဝင်ပါက အခြားရွေးချယ်စရာများ

ဤသုတေသနတွင်ပါဝင်ခြင်းမှာလုံးဝဆန္ဒအလျောက်ဖြစ်သည်။ သင်သည် မပါဝင်ရန် ရွေးချယ်ပါက၊ သင့်၏ ကျန်းမာရေးဝန်ဆောင်မှုရယူခွင့် သို့မဟုတ် တခြားအခွင့်အရေးများကို ထိခိုက်မည်မဟုတ်ပါ။ထို့အပြင်သင်သည်သုတေသနမှအချိန်မရွေးရုပ်သိမ်းနိုင်ပြီး၊ ထိုဆုံးဖြတ်ချက်ကြောင့်သင်အတွက်မကောင်းသောအကျိုးသက်ရောက်မှုမရှိပါ။သင်သည်မ ပါဝင်ရန်ဆုံးဖြတ်ပါက၊သင်ထံပေးအပ်မည့်လက်ကမ်းစာစောင်တွင်ပေးထားသည့်အဆက်အ သွယ်များမှတစ်ဆင့်ကျန်းမာရေးဝန်ဆောင်မှုများကိုဆက်လက်ရရှိနိုင်ပါသည်။သင့်လိုအပ်ချ က်အတွက်ပိုမိုသင့်လျော်မည့်ကုသမှုရွေးချယ်စရာများကိုဆွေးနွေးရန်သင့်ဆရာဝန်နှင့် တိုင်ပင်ရန် အကြံပြုအပ်ပါသည်။ဤသုတေသနသည် ဆေးဘက်ဆိုင်ရာ အကြံဉာဏ်များကို အစားထိုးရန်ရည်ရွယ်ခြင်းမဟုတ်ပါ။သင့်တစ်ဦးချင်းစီ၏အခြေအနေပေါ်မူတည်၍အခြား ရရှိနိုင်သောကျန်းမာရေးစောင့်ရှောက်မှုရွေးချယ်မှုများသည် ပိုမိုသင့်လျော်နိုင်ပါသည်။

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၁၁။ သုတေသနအတွင်း ဖြစ်ပေါ်နိုင်သော အခြေအနေများနှင့် စီမံခန့်ခွဲရန် လမ်းညွှန်ချက်များ

ဖြစ်ပေါ်နိုင်သောအခြေအနေ	စီမံခန့်ခွဲရန် လမ်းညွှန်ချက်များ
▪ သုတေသနအတွင်း သင်သည် ဆုတ်ခွာလိုပါက	သင်သည်မည်သည့်အချိန်တွင်မဆို၊ မည်သည့်အကြောင်းပြချက်ဖြင့်မဆို သုတေသနမှဆုတ်ခွာခွင့်ရှိပါသည်။ထိုကဲ့သို့ ဆုတ်ခွာလိုပါကသုတေသနပြုသူထံတွင် ရှိခွင့်အသိပေးနိုင်ပြီးသင်၏ပါဝင်မှု ချက်ချင်း ပြီးဆုံးပါမည်။ ဆုတ်ခွာခြင်းမပြုမီ သင့်ထံမှစုဆောင်းထားသောမည်သည့် အချက်အလက်များကိုမဆို လျှို့ဝှက်ထားမည်ဖြစ်ပြီးသုတေသနတွင် အသုံးပြုမည်မဟုတ်ပါ။
▪ သုတေသနနှင့်သက်ဆိုင်သည့် သတင်းအချက်အလက်သစ် သို့မဟုတ် သင့်ဘေးကင်းရေးဆိုင်ရာ အချက်အလက်အသစ်များရှိပါက	သင်၏ ပါဝင်မှုဆိုင်ရာ ဆုံးဖြတ်ချက် သို့မဟုတ် လုံခြုံရေးအပေါ်သက်ရောက်စေနိုင်သော သတင်းအချက်အလက်အသစ်တစ်စုံတစ်ခု ရရှိလာပါကသုတေသနပြုသူမှသင်အား ချက်ချင်းအသိပေးပါမည်။ ထိုသတင်းအချက်အလက်အပေါ်မူတည်၍ သင်သည်ဆက်လက်ပါဝင်ခြင်းသို့မဟုတ် ဆုတ်ခွာခြင်းကို ဆုံးဖြတ်နိုင်ပါသည်။

▪ သုတေသနမှပါဝင်မှုအဆုံးသတ်ခြင်းအတွက် စံသတ်မှတ်ချက်များတွင် သုတေသနလုပ်ငန်းစဉ်ပြီးဆုံးခြင်း၊ သတ်မှတ်ထားသော အချိန်ကန့်သတ်ချက်သို့ရောက်ရှိခြင်း သို့မဟုတ် ရည်မှန်းထားသော နမူနာအရေအတွက် ပြည့်မီခြင်းတို့ ပါဝင်နိုင်ပါသည်။	ဤစံနှုန်းများနှင့်ကိုက်ညီပါက သုတေသီသည်ပါဝင်သူများကို သင့်လျော်စွာအသိပေးပြီး သုတေသနတွင်ဝင်ရောက်မှုကို နိဂုံးချုပ်မည်ဖြစ်သည်။ ထိုအချက်အထိ စုဆောင်းရရှိထားသော ဒေတာအားလုံးကို လုံခြုံစွာသိမ်းဆည်းပြီး ဒေတာကာကွယ်ရေးနှင့် ကျင့်ဝတ်ဆိုင်ရာ လမ်းညွှန်ချက်များနှင့်အညီ နောက်ဆုံးခွဲခြမ်းစိတ်ဖြာမှုတွင် ထည့်သွင်းအသုံးပြုမည်ဖြစ်သည်။
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၁၂။ သုတေသနပြီးဆုံးပြီးနောက် ရရှိနိုင်သော အကျိုးအမြတ်များ

သုတေသနပြီးဆုံးပြီးနောက်တွင်လေ့လာမှုတွင်ပါဝင်သူများအတွက်တိုက်ရိုက်အကျိုးအမြတ်မရှိနိုင်ပါ။သို့သော်လည်းသုတေသနပြုပြီးသည်နှင့်သုတေသနရလဒ်များကိုပါဝင်သူများသိရှိနိုင်ရန်လက်လှမ်းမီနိုင်သောပုံစံဖြင့်အသိပေးသွားမည်ဖြစ်ပါသည်။ရလဒ်များကိုမြန်မာဘာသာဖြင့်ရှင်းလင်းပြသမည်ဖြစ်ပြီး၊ရုပ်ပုံများသို့မဟုတ်ကိုယ်တိုင်ကြည့်လေ့လာနိုင်သောပုံကြမ်းများဖြင့်လည်းရှင်းပြပေးမည်ဖြစ်သည်။ထို့အပြင်၊သုတေသနရလဒ်များအပေါ်အခြေခံ၍ပါဝင်သူများ၏ကျန်းမာရေးနှင့်ဘဝအရည်အသွေး တိုးတက်စေရန်အတွက်အကြံဉာဏ်များကိုလည်းပေးအပ်သွားမည်ဖြစ်သည်။ ဤအကြံပြုချက်များတွင်မိမိကိုယ်ကိုပြုစုစောင့်ရှောက်ခြင်းဆိုင်ရာလမ်းညွှန်ချက်အပြင်လူနေမှုပုံစံပြောင်းလဲခြင်း၊စိတ်ကျန်းမာရေးဆိုင်ရာအရင်းအမြစ်များနှင့် ရရှိနိုင်သောကျန်းမာရေးစောင့်ရှောက်မှုရွေးချယ်စရာများစသည်တို့ပါဝင်မည် ဖြစ်ပါသည်။

၁၃။ ဒေတာ၏ လျှို့ဝှက်မှုနှင့် အကန့်အသတ်များ

ဤသုတေသနတွင်သင်ပါဝင်ပြီးနောက်၊သင်၏ကိုယ်ရေးကိုယ်တာနှင့် လျှို့ဝှက်ထားမှုသည်ထိပ်တန်းဦးစားပေးဖြစ်သည်။သင်၏ကိုယ်ရေးကိုယ်တာအချက်အလက်

က်များကိုကာကွယ်ရန်စုဆောင်းထားသောအချက်အလက်အားလုံးကို
 အမည်ပေးထားပါမည်။ဆိုလိုသည်မှာသင့်အမည်သို့မဟုတ်လိပ်စာကဲ့သို့သော
 ကိုယ်ရေးကိုယ်တာအချက်အလက်များကိုသင့်အဖြေတို့ပြန်မှုများနှင့်ချိတ်ဆက်မည်
 မဟုတ်ပါ။ထိုအစားသင်၏အထောက်အထားနှင့်ပေးထားသည့်အချက်အလက်များကြားတွင်
 တိုက်ရိုက်ချိတ်ဆက်မှုမရှိကြောင်းသေချာစေရန်အတွက်သီးခြားအမှတ်
 အသားကုဒ်တစ်ခုသတ်မှတ်ပေးမည်ဖြစ်သည်။သင်၏လျှို့ဝှက်ချက်ကိုပိုမိုကာကွယ်ရန်အတွက်
 ကံသင်၏အသိပေးသဘောတူညီချက်ပုံစံများနှင့်စစ်တမ်းတို့ပြန်ချက်များကိုသီးခြားသိမ်းဆည်း
 ထားမည်ဖြစ်သည်။အီလက်ထရောနစ်အချက်အလက်အားလုံးကိုလုံခြုံစွာကုဒ်ပေးပြီးသိမ်း
 ဆည်းထားမည်ဖြစ်ပြီး၊အဓိကစုံစမ်းစစ်ဆေးသူမှသာလျှင်
 ဝင်ရောက်နိုင်မည်ဖြစ်သည်။စာရွက်ပုံစံများနှင့်သုတေသနအထောက်အထားများကိုလည်းလုံ
 ခြုံသောနေရာတွင်ဖိုင်စနစ်ဖြင့်သိမ်းဆည်းထားမည်ဖြစ်ပါသည်။
 သို့သော်လည်း၊သင်၏ဒေတာအားစစ်ဆေးရန်အတွက်လိုအပ်သောအချို့သောသူများ
 သို့မဟုတ်အဖွဲ့အစည်းများ(ဥပမာ-စည်းကမ်းချုပ်ကြည့်ရှုရေးကော်မတီ၊
 သုတေသနညှိနှိုင်းသူများ၊ သုတေသနမှူးများ၊ အစိုးရအဖွဲ့အစည်းများ သို့မဟုတ်
 စစ်ဆေးရေးအဖွဲ့အစည်းများမှတာဝန်ရှိသူများ)သည်သင်၏ဒေတာအားဝင်ရောက်
 ကြည့်ရှုရန်လိုအပ်နိုင်ပါသည်။၎င်းသည်သုတေသနလုပ်ငန်းစဉ်များနှင့်ဒေတာတိကျမှုအား
 တည်ပြုရန်အတွက်သာဖြစ်ပါသည်။သုတေသနပြီးဆုံးပြီးနောက်တွင်
 သုတေသနသဘောတူညီချက်နှင့်စည်းကမ်းများအရလိုအပ်သည့်အချိန်ကြာမြင့်စွာ
 သင်၏ဒေတာကိုထိန်းသိမ်းထားပြီးနောက်၊ သက်တမ်းကုန်ဆုံးသောအခါ မှန်ကန်သော
 နည်းလမ်းဖြင့်အပြီးအပိုင်ဖျက်သိမ်းမည်ဖြစ်ပါသည်။ သုတေသနတွေ့ရှိချက်များနှင့်
 ရလဒ်များကိုကျွမ်းကျင်ပညာရှင်များ၊အကောင်အထည်ဖော်သူများနှင့်မူဝါဒရေးဆွဲသူများအ
 တွက်အသုံးဝင်သော အသိပညာအဖြစ် အသိပေးနိုင်ရန်အတွက် ဆွေးနွေးပွဲများ
 သို့မဟုတ်သုတေသနဆောင်းပါးများမှတစ်ဆင့်ပြည်သူအများသို့ဖြန့်ဝေသွားမည်ဖြစ်သည်။
 သို့သော်ပါဝင်သူများ၏ ကိုယ်ရေးအချက်အလက်များကို မည်သည့်ပုံစံဖြင့်မဆို
 ထုတ်ဖော်ခြင်း သို့မဟုတ် ဖြန့်ဝေခြင်း ပြုလုပ်မည်မဟုတ်ပါ။

ဤလေ့လာမှုသည်သင့်ကိုယ်ရေးကိုယ်တာအချက်အလက်များကိုလေးစားလိုက်နာပြီး သင့်အခွင့်အရေးနှင့်ဂုဏ်သိက္ခာကိုလုပ်ငန်းစဉ်တစ်လျှောက်လုံးကာကွယ်ထားကြောင်းသေချာစေသည့် ကျင့်ဝတ်ဆိုင်ရာလမ်းညွှန်ချက်များကို လိုက်နာပါသည်။

၁၄။ သုတေသနတွင် ပါဝင်မှုအတွက် ပြန်လည်ပေးဆပ်ခြင်း။

ပါဝင်သူများအားကျန်းမာရေးနှင့်သက်ဆိုင်သောအသုံးဝင်သောအကြံပြုချက်များ၊ ကျန်းမာရေးစောင့်ရှောက်မှုဝန်ဆောင်မှုများ၊စိတ်ကျန်းမာရေးအရင်းအမြစ်များ၊ အလုပ်သမားအခွင့်အရေးများ၊လူမှုပုံစံကိုကူညီမှု၏အရေးကြီးမှုနှင့်အရေးပေါ်ဆက်သွယ်ရန်ဖုန်းနံပါတ်များပါဝင်သည့်လက်ကမ်းစာစောင်တစ်ခုကိုဖြန့်ဝေသွားမည်ဖြစ်ပါသည်။ဤအချက်အလက်များသည်ပါဝင်သူများ၏ဘဝအရည်အသွေးနှင့်ကျန်းမာရေးတိုးတက်စေရန် ရည်ရွယ်ထားသည်။ ထို့အပြင်၊ နို့ သို့မဟုတ် ဖျော်ရည်နှင့် ကွတ်ကီးကဲ့သို့သောပေါ့ပါးသောမုန့်ပဲသရေစာများကိုလေ့လာမှုတွင်၎င်းတို့၏ဆန္ဒအလျောက်ပါဝင်မှုအတွက်ကျေးဇူးတင်ကြောင်းအမူအရာအဖြစ်ကမ်းလှမ်းမည်ဖြစ်သည်။

၁၅။ ပါဝင်သူများ ပေးဆောင်ရမည့် ကုန်ကျစရိတ်များ

ဤသုတေသနတွင် ပါဝင်သူများ ပေးဆောင်ရမည့် ကုန်ကျစရိတ်မရှိပါ။

၁၆။ သုတေသနတွင် ပါဝင်ခြင်းကြောင့် ထိခိုက်မှု (သို့) ဆိုးကျိုးများ ကြုံတွေ့ပါက ထောက်ပံ့မှုနှင့် ဖြည့်ဆည်းမှုဆိုင်ရာ လမ်းညွှန်ချက်များ

ပါဝင်သူများသည် ဤသုတေသနပြုစဉ်အတွင်း ထိခိုက်မှု သို့မဟုတ် အန္တရာယ်များကြုံတွေ့ရဖွယ်ရှိသည့်အခြေအနေမျိုးတွင်၊အဓိကစုံစမ်းစစ်ဆေးသူ သည် သင့်လျော်သောစောင့်ရှောက်မှုနှင့် ပံ့ပိုးကူညီမှုပေးရန် ကတိပြုပါသည်။ စိတ်ကျန်းမာရေး၊နာတာရှည်ဖျားနာမှုနှင့်ဘဝအရည်အသွေးစသည့်အကြောင်းအရာများ၏ ထိလွယ်ရှလွယ်သဘောသဘာဝကြောင့် မေးခွန်းဖြေဆိုရာတွင် စိတ်ပိုင်းဆိုင်ရာ အဆင်မပြေဖြစ်နိုင်ခြေရှိသည်။ ပါဝင်သူများထံတွင် ထိုသို့ စိတ်ဖိစီးမှုများ ဖြစ်ပေါ်ပါကဆရာဝန်များသို့မဟုတ်ဒေသခံစိတ်ကျန်းမာရေးအကြံဉာဏ်ပေးဝန်ဆောင်မှုများထံသို့ ချက်ချင်း လွှဲပြောင်းညွှန်ကြားပေးမည်ဖြစ်သည်။လေ့လာမှုအတွင်း ပါဝင်သူများအား မျှတမှုရှိစွာ နှင့် သနားမှုဖြင့် ဆက်ဆံမည်ဖြစ်ပြီး၊ ၎င်းတို့၏ ဂုဏ်သိက္ခာနှင့်လွတ်လပ်စွာဆုံးဖြတ်ခွင့်ကိုအပြည့်အဝလေးစားမည်ဖြစ်သည်။

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ဖြစ်နိုင်ခြေရှိသောအန္တရာယ်များကိုလျော့နည်းစေရန်အကောင်းဆုံးကြံတင်ကာကွယ်မှုများ ပြုလုပ်ထားပြီးမည်သည့် မတော်တဆဖြစ်ပွားမှုမျှ ဖြစ်ပေါ်ပါက ပါဝင်သူများ၏ ဘေးကင်းလိုခြံမှုနှင့် သင့်လျော်သော ကုသမှုဝန်ဆောင်မှုများ လက်လှမ်းမီအောင် လိုအပ်သောအဆင့်ဆင့်များကို ချက်ချင်းအရေးယူမည်ဖြစ်သည်။

လေ့လာမှုတွင်ပါဝင်ခြင်းမှာ လုံးဝဆန္ဒအလျောက်ဖြစ်ကြောင်း ရှင်းရှင်းလင်းလင်း အသိပေးထားပြီး ၎င်းတို့သည် ၎င်းတို့၏ ကျန်းမာရေးစောင့်ရှောက်မှု သို့မဟုတ် အခြားအခွင့်အရေးများရရှိမှုအပေါ် မည်သည့်ဆိုးကျိုးများ သို့မဟုတ် ထိခိုက်မှုများ မကြုံတွေ့ရဘဲ အချိန်မရွေး လေ့လာမှုမှ နုတ်ထွက်နိုင်သည်။ ဤသုတေသနမှ ဘေးထွက်ဆိုးကျိုးများ သို့မဟုတ် မလိုလားအပ်သော အဖြစ်အပျက်များ ဖြစ်ပေါ်လာပါက၊ သုတေသီသည် ကုသမှုနှင့် ပြန်လည်ထူထောင်ရေးဆိုင်ရာ ကုန်ကျစရိတ်အားလုံးကို တာဝန်ယူမည်ဖြစ်သည်။

၁၇။ မေးခွန်း (သို့) စိုးရိမ်စရာရှိပါက ဆက်သွယ်ရန် ပုဂ္ဂိုလ်

ပါဝင်ဆောင်ရွက်နေစဉ်အတွင်းသုတေသနသို့မဟုတ်ဘေးကင်းရေးဆိုင်ရာမေးခွန်း များသို့မဟုတ်စိုးရိမ်ပူပန်မှုများရှိပါကသုတေသနပြုသူအားတိုက်ရိုက်မေးမြန်းနိုင်ပါသည်။

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သင်၏အခွင့်အရေးများနှင့်သက်ဆိုင်သောမေးခွန်းများရှိပါက၊သင်၏အခွင့်အရေး များ၊လိုခြံမှုနှင့်ကျန်းမာရေးကိုနိုင်ငံတကာစံနှုန်းများအောက်တွင်လူသားသုတေသန ကျင့်ဝတ်များနှင့်အညီကာကွယ်ပေးနိုင်ရန်အတွက် Mae Fah Luang တက္ကသိုလ် လူ့ကျင့်ဝတ်ဆိုင်ရာ သုတေသနကော်မတီ (AS) သို့ ဆက်သွယ်နိုင်ပါသည်။

หน้า 22 จาก 26

THE MAE FAH LUANG UNIVERSITY
ETHICS COMMITTEE ON HUMAN RESEARCH

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ဆက်သွယ်ရန်လိပ်စာ – Mae Fah Luang တက္ကသိုလ် လူ့ကျင့်ဝတ်ဆိုင်ရာ သုတေသနကော်မတီ (AS)၊

၄လွှာ

ဖုန်း – (၀၅၃) ၉၁၇-၁၇၀ သို့ ၁ သို့မဟုတ် (၀၅၃) ၉၁၆-၅၅၁

ဖက်စ် – (၀၅၃) ၉၁၇-၁၇၀

အီးမေးလ် – rec.human@mfl.ac.th



သဘောတူညီချက်ပုံစံ

ကျွန်ုပ် _____ ထိုင်းနိုင်ငံ၊ ချင်းရှိုင်ခရိုင်ရှိ
မြန်မာရွှေ့ပြောင်းအလုပ်သမားများကြားတွင်အရည်အသွေးနှင့်ယင်း၏ဆက်စပ်နေသော
အချက်များ ခေါင်းစဉ်ဖြင့် သုတေသနပရောဂျက်တွင် ပါဝင်ရန်
ဆုံးဖြတ်ခဲ့သည်။ ကျွန်ုပ်သည် ဤသုတေသနနှင့်ပတ်သက်သောသတင်းအချက်အလက်နှင့်
င်းလင်းချက်များကိုလက်ခံရရှိထားပြီး၊ မေးခွန်းများမေးရန်နှင့်ကျေနပ်လောက်သောအဖြေ
များကိုကျွန်ုပ်ရရှိခဲ့ပါသည်။ ကျွန်ုပ်သည် စာရွက်စာတမ်းများတွင်ပေးထားသည့်အချက်အလက်များကို
စေ့စေ့စပ်စပ် ဖတ်ရှုနားလည်ရန် အချိန်အလုံအလောက်ရှိခဲ့ပြီး ဤသုတေသနတွင်
ပါဝင်ရန် ဆုံးဖြတ်ခဲ့သည်။

ဤသုတေသနတွင်မပါဝင်ရန်လွတ်လပ်စွာရွေးချယ်ပိုင်ခွင့်ရှိသည်နှင့်ကျွန်ုပ်၏စောင့်
ရှောက်မှု သို့မဟုတ် ရပိုင်ခွင့်များပေါ်တွင် ထိခိုက်မှုတစ်စုံတစ်ရာမရှိဘဲ ဤသုတေသနမှ
အချိန်မရွေး နှုတ်ထွက်နိုင်သည်ကို ကျွန်ုပ်နားလည်ပါသည်။

ဤစာတမ်းကို လက်မှတ်ရေးထိုးခြင်းဖြင့် ကျွန်ုပ်သည် ဥပဒေအရ
ရသင့်ရထိုက်သောအခွင့်အရေးများကိုလက်လွှတ်မခံဘဲလက်မှတ်ရေးထိုးပြီးနောက်အချက်
အလက်စာရွက် မိတ္တူနှင့် အသိပေးသဘောတူညီချက်ကို ကျွန်ုပ်ရရှိပါမည်။

ပါဝင်သူ၏ လက်မှတ် _____ ရက်စွဲ _____
(_____)

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Version 2 Date 30/6/2025

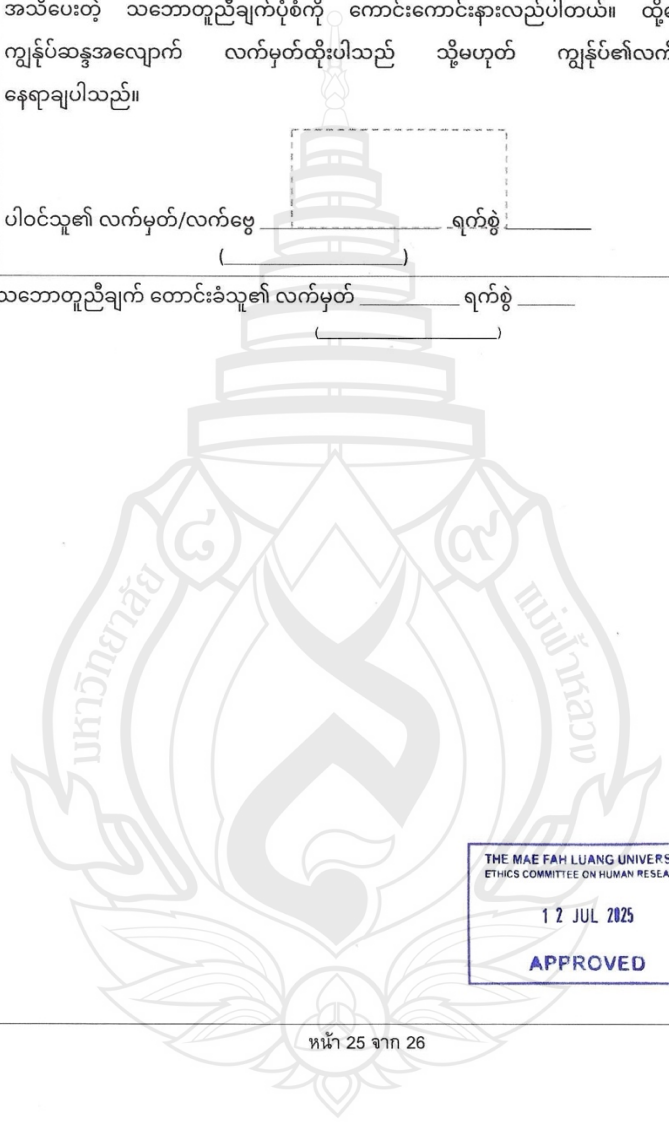
AP 03_1/2024

.....(မဖတ်နိုင်သော်လည်းနားထောင်ခြင်းဖြင့်နားလည်နိုင်သော စာမတတ်သူများအတွက်)

ကျွန်တော် မဖတ်နိုင်ပေမယ့် သုတေသီက ဒီအချက်အလက်စာရွက်ကို ဖတ်ပြီး ကျွန်တော့်ဆီ အသိပေးတဲ့ သဘောတူညီချက်ပုံစံကို ကောင်းကောင်းနားလည်ပါတယ်။ ထို့ကြောင့် ကျွန်ုပ်ဆန္ဒအလျောက် လက်မှတ်ထိုးပါသည် သို့မဟုတ် ကျွန်ုပ်၏လက်ဗွေကို နေရာချပါသည်။

ပါဝင်သူ၏ လက်မှတ်/လက်ဗွေ _____ ရက်စွဲ _____
()

သဘောတူညီချက် တောင်းခံသူ၏ လက်မှတ် _____ ရက်စွဲ _____
()



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သုတေသနတွင် ပါဝင်ပတ်သက်သူမဟုတ်သော သက်သေတစ်ဦး၏ သက်သေခံချက်
(ပါဝင်သူသည် မဖတ်နိုင်သော်လည်း နားထောင်ခြင်းဖြင့် နားလည်နိုင်လျှင်)

သဘောတူညီချက်တောင်းဆိုမှုလုပ်ငန်းစဉ်အတွင်းကျွန်ုပ်တို့၏ရရှိခဲ့ပြီး
သဘောတူညီချက်တောင်းခံသူသည်အချက်အလက်စာရွက်ကိုဖတ်/ရှင်းပြခဲ့သည်ကို
အတည်ပြုကြောင်း အတည်ပြုပါသည်။ အထက်ဖော်ပြပါ ပုဂ္ဂိုလ်သည် မေးခွန်းများမေးခွင့်
ရခဲ့ပြီး ဤစာတမ်းပါ အချက်အလက်များကို နားလည်ပြီးနောက် စိတ်ဆန္ဒအလျောက်
ပါဝင်ရန် ဆုံးဖြတ်ခဲ့သည်။

သက်သေခံလက်မှတ် _____ ရက်စွဲ _____
()



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APPENDIX E

VALIDITY ASSESSMENT OF QUESTIONNAIRE

The validity of the questionnaire was assessed by three experts who provided evaluation scores using the Item-Objective Congruence (IOC) method. The questionnaire was categorized into seven parts: general characteristics, quality of life (WHOQOL-BREF), access to healthcare, mental health status, social support, discrimination, and job satisfaction.

Expert 1

Name: Dr. Natnaree Aimyong

Designation: Assistant Professor

Institution: Faculty of Public Health, Mahidol University

Email: natnaree.aim@mahidol.ac.th

Expert 2

Name: Dr. Sittichai Thongworn

Designation: Assistant Professor

Institution: Faculty of Social Sciences and Humanities, Mahidol University

Email: sittichai.tho@mahidol.ac.th

Expert 3

Name: Dr. Sunaree Tanapek

Designation: Assistant Professor

Institution: Faculty of Public Health, Ramkhamhaeng university

Email: sunareemu@gmail.com

1. Quality of Life Questionnaire (WHOQOL-BREF)

No.	Expert 1			Expert 2			Expert 3			Total score	IOC	Result
	-1	0	1	-1	0	1	-1	0	1			
1			✓			✓			✓	3	1	valid
2			✓			✓			✓	3	1	valid
3			✓			✓			✓	3	1	valid
4			✓			✓			✓	3	1	valid
5			✓			✓			✓	3	1	valid
6			✓			✓			✓	3	1	valid
7			✓			✓			✓	3	1	valid
8			✓			✓			✓	3	1	valid
9			✓			✓			✓	3	1	valid
10			✓			✓			✓	3	1	valid
11			✓			✓			✓	3	1	valid
12			✓			✓			✓	3	1	valid
13			✓			✓			✓	3	1	valid
14			✓			✓			✓	3	1	valid
15			✓			✓			✓	3	1	valid
16			✓			✓			✓	3	1	valid
17			✓			✓			✓	3	1	valid
18			✓			✓			✓	3	1	valid
19			✓			✓			✓	3	1	valid
20			✓			✓			✓	3	1	valid
21			✓			✓			✓	3	1	valid
22			✓			✓			✓	3	1	valid
23			✓			✓			✓	3	1	valid
24			✓			✓			✓	3	1	valid
25			✓			✓			✓	3	1	valid
26			✓			✓			✓	3	1	valid

2. Access to Healthcare Questionnaire

No.	Expert 1			Expert 2			Expert 3			Total score	IOC	Result
	-1	0	1	-1	0	1	-1	0	1			
1			✓			✓			✓	3	1	valid
2			✓			✓		✓		2	0.67	valid
3			✓			✓			✓	3	1	valid
4			✓			✓			✓	3	1	valid
5			✓			✓			✓	3	1	valid
6			✓			✓			✓	3	1	valid
7			✓			✓		✓		2	0.67	valid
8			✓			✓		✓		2	0.67	valid
9			✓			✓			✓	3	1	valid
10			✓			✓			✓	3	1	valid
11			✓			✓			✓	3	1	valid
12			✓			✓			✓	3	1	valid
13			✓			✓			✓	3	1	valid
14			✓			✓			✓	3	1	valid
15			✓			✓			✓	3	1	valid

Where;

$$\text{IOC} = \frac{1+0.67+1+1+1+1+0.67+0.67+1+1+1+1+1+1+1}{15}$$

$$\text{IOC} = \frac{14.01}{15}$$

$$\text{IOC} = 0.93$$

Remarks

Question number 2 was revised according to the expert's comment.

Question number 7 was revised according to the expert's comment.

Question number 8 was revised according to the expert's comment.

3. Mental Health Status Questionnaire (DASS-21)

No.	Expert 1			Expert 2			Expert 3			Total score	IOC	Result
	-1	0	1	-1	0	1	-1	0	1			
1			✓			✓			✓	3	1	valid
2			✓			✓			✓	3	1	valid
3			✓			✓			✓	3	1	valid
4			✓			✓			✓	3	1	valid
5			✓			✓			✓	3	1	valid
6			✓			✓			✓	3	1	valid
7			✓			✓			✓	3	1	valid
8			✓			✓			✓	3	1	valid
9			✓			✓			✓	3	1	valid
10			✓			✓			✓	3	1	valid
11			✓			✓			✓	3	1	valid
12			✓			✓			✓	3	1	valid
13			✓			✓			✓	3	1	valid
14			✓			✓			✓	3	1	valid
15			✓			✓			✓	3	1	valid
16			✓			✓			✓	3	1	valid
17			✓			✓			✓	3	1	valid
18			✓			✓			✓	3	1	valid
19			✓			✓			✓	3	1	valid
20			✓			✓			✓	3	1	valid
21			✓			✓			✓	3	1	valid

Where;

$$\text{IOC} = \frac{1+1}{21}$$

$$\text{IOC} = \frac{21}{21}$$

$$\text{IOC} = 1$$

4. Social Support Questionnaire

No.	Expert 1			Expert 2			Expert 3			Total score	IOC	Result
	-1	0	1	-1	0	1	-1	0	1			
1			✓			✓			✓	3	1	valid
2			✓			✓			✓	3	1	valid
3			✓			✓			✓	3	1	valid
4			✓			✓			✓	3	1	valid
5			✓			✓			✓	3	1	valid
6			✓			✓			✓	3	1	valid
7			✓			✓			✓	3	1	valid
8			✓			✓			✓	3	1	valid
9			✓			✓			✓	3	1	valid
10			✓			✓			✓	3	1	valid
11			✓			✓			✓	3	1	valid
12			✓			✓			✓	3	1	valid
13			✓			✓			✓	3	1	valid
14			✓			✓			✓	3	1	valid

Where;

$$\text{IOC} = \frac{1+1+1+1+1+1+1+1+1+1+1+1+1+1}{14}$$

$$\text{IOC} = \frac{14}{14}$$

$$\text{IOC} = 1$$

5. Discrimination Questionnaire (EDS)

No.	Expert 1			Expert 2			Expert 3			Total score	IOC	Result
	-1	0	1	-1	0	1	-1	0	1			
1			✓			✓			✓	3	1	valid
2			✓			✓			✓	3	1	valid
3			✓			✓			✓	3	1	valid
4			✓			✓			✓	3	1	valid
5			✓			✓			✓	3	1	valid
6			✓			✓			✓	3	1	valid
7			✓			✓			✓	3	1	valid
8			✓			✓			✓	3	1	valid
9			✓			✓			✓	3	1	valid

Where;

$$IOC = \frac{1+1+1+1+1+1+1+1+1}{9}$$

$$IOC = \frac{9}{9}$$

$$IOC = 1$$

6. Job Satisfaction Questionnaire (Generic Job Satisfaction Scale)

No.	Expert 1			Expert 2			Expert 3			Total score	IOC	Result
	-1	0	1	-1	0	1	-1	0	1			
1			✓			✓			✓	3	1	valid
2			✓			✓			✓	3	1	valid
3			✓			✓			✓	3	1	valid
4			✓			✓			✓	3	1	valid
5			✓			✓			✓	3	1	valid
6			✓			✓			✓	3	1	valid
7			✓			✓			✓	3	1	valid
8			✓			✓			✓	3	1	valid
9			✓			✓			✓	3	1	valid
10			✓			✓			✓	3	1	valid

Where;

$$IOC = \frac{1+1+1+1+1+1+1+1+1+1}{10}$$

$$IOC = \frac{10}{10}$$

$$IOC = 1$$

APPENDIX F

QUESTIONNAIRE (ENGLISH VERSION)

Version 2 Date 1/8/2025

QUESTIONNAIRE

Community.....

Research Code.....

Interviewer.....

Date.....

This questionnaire consists of 7 parts as follows.

Part 1: General Characteristics Questionnaire

Part 2: Assessment of Quality of Life Among Myanmar Migrant Workers

Part 3: Access to Health Care Questionnaire

Part 4: Assessment of Mental Health Status

Part 5: Assessment of Social Support

Part 6: Assessment of Discrimination

Part 7: Assessment of Job Satisfaction

Part 1: General Characteristics Questionnaires

Please read the following questions and choose the most appropriate answers in your own opinion.

1. Ageyears

2. Sex

☐ 1. Male

☐ 2. Female

3. Ethnicity

☐ 1. Myanmar

☐ 2. Karen

☐ 3. Mon

☐ 4. Shan

☐ 5. Other

4. Who do you currently live with?

☐ 1. Living alone

☐ 2. Family members

☐ 3. Other (please specify)

.....

If you chose 'Living alone,' please proceed to question number 5. If not, skip question number 5 and proceed to question number 6.

5. If you live alone, do your family members stay in Myanmar?

☐ 1. No

☐ 2. Yes

6. Do you have health insurance?

☐ 1. No insurance

☐ 2. Migrant Health Insurance Scheme (MHIS)

☐ 3. Social Security Scheme (SSS)

☐ 4. Other (please specify)

7. What is your highest level of educational attainment?

☐ 1. No formal education

☐ 2. Primary school

☐ 3. Secondary school

☐ 4. University or above

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8. What is your marital status?

- ☐ 1. Single ☐ 2. Married ☐ 3. Separate ☐ 3. Divorced
☐ 4. Widowed

9. Do you have any chronic diseases?

- ☐ 1. Do not have ☐ 2. Hypertension ☐ 3. Diabetes Mellitus
☐ 4. Other (please specify)

10. Health Risk Behavior**10.1 Have you ever consumed alcohol?**

- ☐ 1. None ☐ 2. Ex-drinker ☐ 3. Current drinker

10.2 Have you ever smoked cigarette or tobacco?

- ☐ 1. None ☐ 2. Ex-smoker ☐ 3. Current smoker

10.3 Do you engage in exercise for 30 minutes at least three times per week?

- ☐ 1. No ☐ 2. Yes

11. What is your duration of stay in Thailand?months/ years**12. What is your current housing area?**

- ☐ 1. Rent house/dormitory ☐ 2. House/dormitory provided by employer
☐ 3. Living in work compound ☐ 4. Shared housing with other families
☐ 5. Others (please specify)

13. How would you rate your Thai language skill?

- 13.1 Reading** ☐ 1. None ☐ 2. Basic ☐ 3. Fluent
13.2 Listening ☐ 1. None ☐ 2. Basic ☐ 3. Fluent
13.3 Writing ☐ 1. None ☐ 2. Basic ☐ 3. Fluent
13.4 Speaking ☐ 1. None ☐ 2. Basic ☐ 3. Fluent

14. What is your current legal status?

- ☐ 1. Undocumented ☐ 2. documented

15. What is your approximate monthly income?baht

- ☐ 1. My monthly income is sufficient .
☐ 2. My monthly income is not sufficient

16. What is your occupation?**Previous occupation in Myanmar**

- ☐ 1. Agriculture ☐ 2. Construction
☐ 3. Manufacturing ☐ 4. Other

Current occupation in Thailand

- ☐ 1. Agriculture ☐ 2. Construction
☐ 3. Manufacturing ☐ 4. Other

17. What is your primary work environment?

- ☐ 1. Indoor ☐ 2. Semi-indoor ☐ 3. Outdoor



Version 2 Date 1/8/2025

18. What is your primary mode of transportation to your workplace facility on a daily basis?

- ☐ 1. By foot ☐ 2. By own motorbike/ bicycle
☐ 3. By employer's vehicle

19. How long have you been working at your current job? months/ years

Part 2: Quality of Life (WHOQOL-BREF) Questionnaires

This assessment asks how you feel about your quality of life, health, or other areas of your life. Please answer all the questions. If you are unsure about which response to give to a question, please choose the one that appears most appropriate. This can often be your first response. Please keep in mind your standards, hopes, pleasures and concerns. We ask that you think about your life in the last four weeks.

		Very poor	Poor	Neither poor nor good	Good	Very good
1.	How would you rate your quality of life?	1	2	3	4	5

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2.	How satisfied are you with your health?	1	2	3	4	5

The following questions ask about how much you have experienced certain things in the last four weeks.

		Not at all	A little	A moderate amount	Very much	An extreme amount
3.	To what extent do you feel that (physical) pain prevents you from doing what you need to do?	1	2	3	4	5
4.	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5.	How much do you enjoy life?	1	2	3	4	5
6.	To what extent do you feel your life to be meaningful?	1	2	3	4	5

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		Not at all	A little	A moderate amount	Very much	Extremely
7.	How well are you able to concentrate?	1	2	3	4	5
8.	How safe do you feel in your daily life?	1	2	3	4	5
9.	How healthy is your physical environment?	1	2	3	4	5

The following questions ask about how completely you experience or were able to do certain things in the last four weeks.

		Not at all	A little	Moderately	Mostly	Completely
10.	Do you have enough energy for everyday life?	1	2	3	4	5
11.	Are you able to accept your bodily appearance?	1	2	3	4	5
12.	Have you enough money to meet your needs?	1	2	3	4	5
13.	How available to you is the information that you need in your day-to-day life?	1	2	3	4	5
14.	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5

		Very poor	Poor	Neither poor nor good	Good	Very good
15.	How well are you able to get around?	1	2	3	4	5

The following questions ask you to say how good or satisfied you have felt about various aspects of your life over the last four weeks.

		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
16.	How satisfied are you with your sleep?	1	2	3	4	5
17.	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5

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18.	How satisfied are you with your capacity for work?	1	2	3	4	5
19.	How satisfied are you with yourself?	1	2	3	4	5
20.	How satisfied are you with your personal relationships?	1	2	3	4	5
21.	How satisfied are you with your sex life?	1	2	3	4	5
22.	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23.	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24.	How satisfied are you with your access to health services?	1	2	3	4	5
25.	How satisfied are you with your transport?	1	2	3	4	5

The following question refers to how often you have felt or experienced certain things in the last four weeks.

		Never	Seldom	Quite often	Very often	Always
26.	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

Part 3: Access to Health Care Questionnaires

Please read each statement carefully and circle a number 0, 1, or 2 which indicates how much the statement applied to you.

Accessibility			
1. How far is the health facility from your residence?	 minutes/ hours		
2. Is there a road directly connecting your residence to the health facility?	No	Yes	
	0	1	
3. Does the health facility have access to public transportation?	No	Yes	
	0	1	
Acceptance			
4. Services are non-discriminatory.	Never	Sometimes	Always
	0	1	2

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5. I trust the staff's expertise.	Never	Sometimes	Always
	0	1	2
6. I feel respected and understood by the healthcare providers.	Never	Sometimes	Always
	0	1	2
Availability			
7. Is the health facility consistently stocked with the drugs you need?	Never	Sometimes	Always
	0	1	2
8. How long do you have to wait to receive health services?	More than 1 hour	30 minutes to 1 hour	Less than 30 minutes
	0	1	2
9. How much time did the healthcare provider spend on your check-up?	Less than 10 minutes	10 minutes to 20 minutes	More than 20 minutes
	0	1	2
Affordability			
10. Are there times when you do not take drugs prescribed by health worker because of their cost during the time of illness?	Never	Sometimes	Always
	2	1	0
11. Are there times when you do not take lab test or examination because of their cost during the time of illness?	Never	Sometimes	Always
	2	1	0
12. Do you receive any financial support or allowances from the government for healthcare expenses?	Never	Sometimes	Always
	0	1	2
Appropriateness			
13. I am very satisfied with the care I receive from health care professional.	Never	Sometimes	Always
	0	1	2
14. I can access all needed services at the health center or hospital.	Never	Sometimes	Always
	0	1	2
15. Staff give helpful and understandable advice.	Never	Sometimes	Always
	0	1	2



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Part 4: Mental Health Status Questionnaires

Please read each statement and circle a number 0, 1, 2, or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

- 0- Did not apply to me at all
 1- Applied to me to some degree, or some of the time
 2- Applied to me to a considerable degree or a good part of time
 3- Applied to me very much or most of the time

1. I found it hard to wind down.	0	1	2	3
2. I was aware of dryness of my mouth.	0	1	2	3
3. I couldn't seem to experience any positive feeling at all.	0	1	2	3
4. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion).	0	1	2	3
5. I found it difficult to work up the initiative to do things.	0	1	2	3
6. I tended to over-react to situations.	0	1	2	3
7. I experienced trembling (e.g. in the hands).	0	1	2	3
8. I felt that I was using a lot of nervous energy.	0	1	2	3
9. I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
10. I felt that I had nothing to look forward to.	0	1	2	3
11. I found myself getting agitated.	0	1	2	3
12. I found it difficult to relax.	0	1	2	3
13. I felt down-hearted and blue.	0	1	2	3
14. I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
15. I felt I was close to panic.	0	1	2	3
16. I was unable to become enthusiastic about anything.	0	1	2	3
17. I felt I wasn't worth much as a person.	0	1	2	3
18. I felt that I was rather touchy.	0	1	2	3
19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat).	0	1	2	3
20. I felt scared without any good reason.	0	1	2	3
21. I felt that life was meaningless.	0	1	2	3

Part 5: Social Support Questionnaire

We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement. Please circle a number 1, 2, 3, 4, or 5 which agree with you for each question.



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Items	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
From family members	1	2	3	4	5
1. My family provides me with emotional support when I need it.					
2. I feel comfortable talking about my problems with my family.	1	2	3	4	5
3. My family is willing to help me make decisions.	1	2	3	4	5
4. I got love and affection from my family.	1	2	3	4	5
5. My family helps me when I am sick in bed.	1	2	3	4	5
From friends/ peers	1	2	3	4	5
6. I get invitations from my friends to socialize and engage in activities.					
7. I can talk about financial and health-related problems with my friends, and they provide useful information.	1	2	3	4	5
8. I have at least one friend I can trust to share my joys and sorrows.	1	2	3	4	5
9. My friends help me with daily tasks (e.g., cooking, housework, childcare).	1	2	3	4	5
10. My friends take me to doctor when I am sick.	1	2	3	4	5
From coworkers	1	2	3	4	5
11. My coworkers provide helpful information or advice about work-related issues.					
12. My coworkers listen to my concerns and offer helpful suggestions.	1	2	3	4	5
13. My coworkers give me useful feedback that helps me improve my work.	1	2	3	4	5
14. My coworkers assist me when I need help at work.	1	2	3	4	5

Part 6: Discrimination Questionnaires

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Please read each statement carefully and circle a number 0, 1, 2, 3, 4, or 5 which best reflects you. In your day-to-day life, how often do any of the following things happen to you?

	Never	Less than once a year	A few times a year	A few times a month	At least once a week	Almost everyday
1. You are treated with less courtesy than other people are.	0	1	2	3	4	5
2. You are treated with less respect than other people are.	0	1	2	3	4	5
3. You receive poorer service than other people at restaurants or stores.	0	1	2	3	4	5
4. People act as if they think you are not smart.	0	1	2	3	4	5
5. People act as if they are afraid of you.	0	1	2	3	4	5
6. People act as if they think you are dishonest.	0	1	2	3	4	5
7. People act as if they're better than you are.	0	1	2	3	4	5
8. You are called names or insulted.	0	1	2	3	4	5
9. You are threatened or harassed.	0	1	2	3	4	5

Part 7: Job Satisfaction Questionnaires

For each statement, please read carefully and circle the number 1, 2, 3, 4, or 5 to indicate your degree of agreement.

	Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree
1. I receive recognition for a job well done.	1	2	3	4	5
2. I feel close to the people at work.	1	2	3	4	5
3. I feel good about working at this company.	1	2	3	4	5
4. I feel secure about my job.	1	2	3	4	5
5. I believe management is concerned about me.	1	2	3	4	5
6. On the whole, I believe work is good for my physical health.	1	2	3	4	5
7. My wages are good.	1	2	3	4	5
8. All my talents and skills are used at work.	1	2	3	4	5
9. I get along with my supervisors.	1	2	3	4	5



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10. I feel good about my job.	1	2	3	4	5
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Do you have any opinion about your quality of life?

.....

.....

.....

.....

Thank you so much for your participation.



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APPENDIX G

QUESTIONNAIRE (MYANMAR VERSION)

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မေးခွန်းလွှာ

အသိုင်းအဝိုင်း.....

သုတေသနကုဒ်.....

အင်တာဗျူးသူ.....

ရက်စွဲ.....

ဤမေးခွန်းလွှာတွင် အောက်ပါအတိုင်း အပိုင်း ၇ ပိုင်း ပါဝင်ပါသည်။

အပိုင်း ၁- ယေဘုယျ လက္ခဏာရပ် မေးခွန်းများ။

အပိုင်း ၂- လူနေမှုဘဝအရည်အသွေး အကဲဖြတ်ခြင်း မေးခွန်းများ။

အပိုင်း ၃- ကျန်းမာရေးစောင့်ရှောက်မှု ရယူခြင်း မေးခွန်းများ။

အပိုင်း ၄- စိတ်ကျန်းမာရေး အခြေအနေကို အကဲဖြတ်ခြင်း မေးခွန်းများ။

အပိုင်း ၅- လူမှုပိုင်းမှအကဲဖြတ်ခြင်း မေးခွန်းများ။

အပိုင်း ၆- ခွဲခြားဆက်ဆံမှု အကဲဖြတ်ခြင်း မေးခွန်းများ။

အပိုင်း ၇- အလုပ်ကျေနပ်မှုကို အကဲဖြတ်ခြင်း မေးခွန်းများ။

အပိုင်း ၁- ယေဘုယျ လက္ခဏာရပ် မေးခွန်းများ။

အောက်ပါမေးခွန်းများကို ဖတ်ရှုပြီး သင့်ကိုယ်ပိုင်ထင်မြင်ချက်ဖြင့် အသင့်လျော်ဆုံးအဖြေကို ရွေးချယ်ပါ။

၁။ အသက်.....နှစ်

၂။ လိင်

☐ (၁) ကျား

☐ (၂) မ

၃။ လူမျိုးစု

☐ (၁) မြန်မာ

☐ (၂) ကရင်

☐ (၃) မွန်

☐ (၄) ရှမ်း

☐ (၅) အခြား

၄။ သင်လက်ရှိမည်သူနှင့်နေထိုင်သနည်း။

☐ (၁) တစ်ဦးတည်း

☐ (၂) မိသားစုဝင်နှင့်အတူ

☐ (၃) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပေးပါ)

အကယ်၍ သင်သည် 'တစ်ယောက်တည်းနေထိုင်ခြင်း' ကိုရွေးချယ်ပါက မေးခွန်းနံပါတ် ၅ သို့ဆက်သွားပါ။

မဟုတ်ပါက မေးခွန်းနံပါတ် ၅ ကိုကျော်ပြီး မေးခွန်းနံပါတ် ၆ သို့ဆက်သွားပါ။

၅။ သင်တစ်ဦးတည်းနေထိုင်ပါက သင့်မိသားစုဝင်များသည် မြန်မာနိုင်ငံတွင် နှိုင်းယှဉ်ပါသလား။

☐ (၁) မရှိပါ

☐ (၂) ရှိပါသည်

၆။ သင်တွင် ကျန်းမာရေးအာမခံရှိပါသလား။

☐ (၁) မရှိပါ

☐ (၂) ရှေ့ပြောင်းကျန်းမာရေးအာမခံအစီအစဉ်

☐ (၃) လူမှုဖူလုံရေးအစီအစဉ်

☐ (၄) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပေးပါ)

၇။ သင့်၏ အမြင့်ဆုံးပညာရေးအဆင့်။

☐ (၁) တရားဝင်ပညာရေး မရှိပါ

☐ (၂) မူလတန်းကျောင်း

☐ (၃) အလယ်တန်းနှင့် အထက်တန်းကျောင်း

☐ (၄) တက္ကသိုလ်နှင့်အထက်

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၈။ သင့်အိမ်ထောင်ရေးအခြေအနေ။

- ☐ (၁) လူလွတ် ☐ (၂) အိမ်ထောင်သည် ☐ (၃) သီးခြားစီ ☐ (၄) ကွာရှင်းပြတ်စဲခြင်း
- ☐ (၅) မုဆိုးမ/ မုဆိုးမိ ☐ (၆) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပါ)

၉။ သင့်တွင် နာတာရှည်ရောဂါများ ရှိပါသလား။

- ☐ (၁) မရှိပါ ☐ (၂) သွေးတိုး ☐ (၃) ဆီးချိုသွေးချိုရောဂါ
- ☐ (၄) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပါ)

၁၀။ ကျန်းမာရေးအန္တရာယ်ဖြစ်စေသော အပြုအမူများ

၁၀.၁။ အရက်သောက်ဖူးပါသလား။

- ☐ (၁) မသောက်ဖူးပါ ☐ (၂) အရက်အရက်သောက်ခဲ့ဖူးပါသည် ☐ (၃) လက်ရှိသောက်နေသူ

၁၀.၂။ ဆေးလိပ် သို့မဟုတ် အခြားအမျိုးအစားများ ဆေးလိပ်သောက်ဖူးပါသလား။

- ☐ (၁) မသောက်ဖူးပါ ☐ (၂) အရက်သောက်ခဲ့ဖူးပါသည် ☐ (၃) လက်ရှိသောက်နေသူ

၁၀.၃။ တစ်ပတ်ကို အနည်းဆုံး သုံးကြိမ် မိနစ် ၃၀ ခန့် လေ့ကျင့်ခန်းလုပ်ပါသလား။

- ☐ (၁) မလုပ်ပါ ☐ (၂) လုပ်ပါသည်

၁၁။ ထိုင်းနိုင်ငံတွင် သင်နေထိုင်သည့်အချိန်။ လ/နှစ်

၁၂။ သင်လက်ရှိနေထိုင်နေသည့်နေရာ။

- ☐ (၁) ငှားရမ်းထားသော အိမ်
- ☐ (၂) အလုပ်ရှင်မှ ပံ့ပိုးပေးသော အိမ်
- ☐ (၃) အလုပ်လုပ်သည့်နေရာမှတွင် နေထိုင်ခြင်း
- ☐ (၄) အခြားမိသားစုများနှင့် မျှဝေထားသော အိမ်ရာများ
- ☐ (၅) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပါ)

၁၃။ သင်၏ ထိုင်းဘာသာစကားကျွမ်းကျင်မှုကို သင်မည်ကဲ့သို့ အဆင့်သတ်မှတ်မည်နည်း။

- ၁၃.၁။ စာဖတ်ခြင်း။** ☐ (၁) မတတ်ပါ ☐ (၂) အခြေခံ ☐ (၃) ကျွမ်းကျင်
- ၁၃.၂။ နားထောင်ခြင်း။** ☐ (၁) မတတ်ပါ ☐ (၂) အခြေခံ ☐ (၃) ကျွမ်းကျင်
- ၁၃.၃။ အရေးအသား** ☐ (၁) မတတ်ပါ ☐ (၂) အခြေခံ ☐ (၃) ကျွမ်းကျင်
- ၁၃.၄။ စကားပြောခြင်း။** ☐ (၁) မတတ်ပါ ☐ (၂) အခြေခံ ☐ (၃) ကျွမ်းကျင်

၁၄။ သင်လက်ရှိတရားဝင်နေထိုင်မှုအခြေအနေ။

- ☐ (၁) အထောက်အထားမဲ့ ☐ (၂) အထောက်အထားရှိ

၁၅။ သင်လစဉ်ခန့်မှန်းခြေဝင်ငွေကုန်လောက်လဲ။ဘတ်

- ☐ (၁) လစဉ်ဝင်ငွေသည်လုံလောက်ပါသည် ☐ (၂) လစဉ်ဝင်ငွေသည်မလုံလောက်ပါ

၁၆။ သင်၏ အလုပ်အကိုင်။

မြန်မာနိုင်ငံတွင် ယခင် အလုပ်အကိုင်

- ☐ (၁) စိုက်ပျိုးရေး ☐ (၂) ဆောက်လုပ်ရေး ☐ (၃) ကုန်ထုတ်လုပ်မှု
- ☐ (၄) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပါ)

ထိုင်းနိုင်ငံတွင် လက်ရှိ အလုပ်အကိုင်

- ☐ (၁) စိုက်ပျိုးရေး ☐ (၂) ဆောက်လုပ်ရေး ☐ (၃) ကုန်ထုတ်လုပ်မှု
- ☐ (၄) အခြား (ကျေးဇူးပြု၍ ဖော်ပြပါ)

THE MAE FAH LUANG UNIVERSITY ETHICS COMMITTEE ON HUMAN RESEARCH 16 SEP 2025 APPROVED
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၁၇။ သင်၏အဓိကအလုပ်ပတ်ဝန်းကျင်။

☐ (၁) အိမ်/အဆောက်အဦးအတွင်း ☐ (၂) အိမ်/အဆောက်အဦး အတွင်းမကျ အပြင်မကျ
☐ (၃) ပြင်ပ

၁၈။ နေ့စဉ်နေ့တိုင်း သင့်လုပ်ငန်းခွင်သို့ သယ်ယူပို့ဆောင်ရေး၏ အဓိကနည်းလမ်းမှာ အဘယ်နည်း။

☐ (၁) လမ်းလျှောက် ☐ (၂) ကိုယ်ပိုင်ဆိုင်ကယ်/စက်ဘီးဖြင့် ☐ (၃) အလုပ်ရှင်၏ယာဉ်ဖြင့်

၁၉။ သင်လက်ရှိအလုပ်မှာ ဘယ်လောက်ကြာကြာ အလုပ်လုပ်နေသနည်း။ လ/နှစ်

အပိုင်း ၂- လူနေမှုဘဝအရည်အသွေးဆိုင်ရာ မေးခွန်းများ

အောက်ပါမေးခွန်းများသည် သင်၏ဘဝအရည်အသွေးနှင့်ပတ်သက်သော မေးခွန်းများဖြစ်ပါသည်။ ကျေးဇူးပြု၍ မေးခွန်းများအားလုံးကို ဖြေဆိုပေးပါ။ သင့်အတွက် အသင့်လျော်ဆုံးသော အဖြေတစ်ခုကို ရွေးချယ်ပါ။ လွန်ခဲ့သော (၄)ပတ်အတွင်း ခံစားရခြင်းနှင့်ပတ်သက်၍ဖြေကြားပေးပါ။

		အလွန် ဆိုးသည်	ဆိုးသည်	အသင့် အတင့်	ကောင်း သည်	အလွန် ကောင်း
၁	သင်၏ ဘဝအရည်အသွေးကို သင်မည်ကဲ့သို့အဆင့်သတ်မှတ်မည်နည်း။					
၂	သင်၏ကျန်းမာရေးအခြေအနေကို သင်မည်မျှကျေနပ်အားရမှု ရှိပါသလဲ။					

အောက်ပါမေးခွန်းများသည် လွန်ခဲ့သော (၄) ပတ်အတွင်းသင်တွေ့ကြုံခံစားခဲ့ရသည်နှင့် ပတ်သက်၍မေးထားပါသည်။

		လုံးဝ မရှိ	အနည်း ငယ်ရှိ	အသင့် အတင့်	အလွန်ရှိ	အများအ ပြားရှိ
၃	ကိုယ်လက်ကိုက်ခံမှုကြောင့်အလုပ်ကို မည်မျှအဟန့်အတားဖြစ်စေသနည်း။					
၄	သင့်တန့်တာလုပ်ငန်းများကိုဆောင်ရွက်ရန် ဆေးဝါးသောက်သုံးမှုမည်မျှလိုအပ်ပါသနည်း။					
၅	ဘဝကို သင်မည်မျှပျော်ရွှင်ပါသနည်း။					
၆	သင့်ဘဝအဓိပ္ပာယ်ပြည့်စုံသည်ဟု မည်မျှထင်ပါသနည်း။					
၇	သင်မည်မျှကောင်းစွာအာရုံစိုက်နိုင်သနည်း။					
၈	သင့်ဘဝလိုခြံမြို့ မည်မျှရှိသနည်း။					
၉	သင်၏အိမ်နှင့်အလုပ်ပတ်ဝန်းကျင်သည် သင်၏ကျန်းမာရေးအတွက် မည်မျှကောင်းမွန် ပါသနည်း။					
၁၀	သင်၏တန့်တာလုပ်ဆောင်ချက်များအတွက် အင်အားအလုံအလောက်ရှိပါသလား။					
၁၁	သင့်ရုပ်အဆင်းကို သင်ကျေနပ်မှုရှိပါသလား။					
၁၂	သင်၏လိုအပ်ချက်များကို ဖြည့်ဆည်းရန် ငွေကြေးအလုံအလောက်ရှိပါသလား။					

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အပိုင်း ၃- ကျန်းမာရေးစောင့်ရှောက်မှု ရယူခြင်း မေးခွန်းများ
ကျေးဇူးပြု၍ ဖော်ပြချက်တစ်ခုစီကို ဂရုတစိုက်ဖတ်ပြီး သင့်အတွက် မည်မျှသက်ရောက်ကြောင်းဖော်ပြသော နံပါတ်
၀၊ ၁ သို့မဟုတ် ၂ ကို ဝိုင်းထားပါ။

သုံးစွဲနိုင်မှု			
၁။ သင့်နေထိုင်သည့်နေရာသည် ကျန်းမာရေးဌာန (ဆေးရုံ၊ဆေးခန်း) နှင့် မည်မျှဝေးသနည်း။	 မိနစ်/နာရီ		
၂။ သင့်နေထိုင်သည့်နေရာမှ ကျန်းမာရေးဌာန (ဆေးရုံ၊ဆေးခန်း) ဆီသို့ တိုက်ရိုက်ချိတ်ဆက်ထားသော လမ်းရှိပါသလား။	မရှိပါ	ရှိပါသည်	
	၀	၁	
၃။ ကျန်းမာရေးဌာန (ဆေးရုံ၊ဆေးခန်း) သို့ ပြည်သူ့အသွားအလာယာဉ်များ ရောက်ရှိနိုင်ပါသလား။	မရောက်ရှိနိုင်ပါ	ရောက်ရှိနိုင်ပါသည်	
	၀	၁	
လက်ခံမှု			
၄။ ဝန်ဆောင်မှုများသည် ခွဲခြားဆက်ဆံမှုမရှိပါ။	ရှိသည်	တစ်ခါတစ်လေမှ ရှိသည်	အမြဲ မရှိပါ
	၀	၁	၂
၅။ ဝန်ထမ်းတွေရဲ့ ကျွမ်းကျင်မှုကို ယုံကြည်ပါသည်။	မယုံကြည်ပါ	တစ်ခါတစ်လေမှ ယုံကြည်ပါသည်	အမြဲယုံကြည်ပါသည်
	၀	၁	၂
၆။ ကျွန်ုပ်တို့သည် ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူများ၏ လေးစားနားလည်မှုကို ခံစားရသည်။	မခံစားရပါ	တစ်ခါတစ်လေမှ ခံစားရသည်	အမြဲခံစားရပါသည်
	၀	၁	၂
ရရှိနိုင်မှု			
၇။ ကျန်းမာရေးဌာန (ဆေးရုံ၊ဆေးခန်း) တွင် သင်လိုအပ်သော ဆေးဝါးများ အမြဲရှိပါသလား။	မရှိပါ	တစ်ခါတစ်လေမှ ရှိသည်	အမြဲရှိပါသည်
	၀	၁	၂
၈။ ကျန်းမာရေးဝန်ဆောင်မှုများရရှိရန် အချိန်မည်မျှစောင့်ဆိုင်းရသနည်း။	၁နာရီနှင့်အထက်	မိနစ်၃၀ မှ ၁နာရီ	မိနစ်၃၀အောက်
	၀	၁	၂
၉။ ကျန်းမာရေးစောင့်ရှောက်မှုပေးသူသည် သင့်ကျန်းမာရေးစစ်ဆေးမှုအတွက် အချိန်မည်မျှပေးသနည်း။	၁၀မိနစ်အောက်	၁၀မိနစ်မှ ၂၀မိနစ်	မိနစ်၂၀နှင့်အထက်
	၀	၁	၂
တတ်နိုင်မှု			
၁၀။ ဖျားနာနေစဉ်အတွင်းကျန်းမာရေးဝန်ထမ်းမှသတ်မှတ်ထားသောဆေးဝါးများကို ၎င်းတို့၏ကုန်ကျစရိတ်ကြောင့် သင်မသောက်သည့်အချိန်များရှိပါသလား။	ဘယ်တော့မှ မရှိပါ	တစ်ခါတစ်လေ ရှိသည်	အမြဲရှိပါသည်
	၂	၁	၀

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၁၁။ ဖျားနာနေစဉ်အတွင်း စာတ်ခွဲခန်းစမ်းသပ်မှုများ သို့မဟုတ် စစ်ဆေးမှုများ ကို၎င်းတို့၏ကုန်ကျစရိတ်ကြောင့် မပြုလုပ်ဘဲ ရပ်တန့်ခဲ့ရသော အချိန်များရှိပါသလား။	ဘယ်တော့မှ မရှိပါ	တစ်ခါတစ်လေ ရှိသည်	အမြဲရှိပါသည်
	၂	၁	၀
၁၂။ ကျန်းမာရေးစောင့်ရှောက်မှုကုန်ကျစရိတ်အတွက် အစိုးရထံမှ ငွေကြေးပံ့ပိုးမှု သို့မဟုတ် ထောက်ပံ့ကြေးများကို သင်ရရှိပါသလား။	ဘယ်တော့မှ မရှိပါ	တစ်ခါတစ်လေ ရှိသည်	အမြဲရှိပါသည်
	၀	၁	၂
သင့်လျော်မှု			
၁၃။ ကျွန်ုပ်တို့သည် ကျန်းမာရေးစောင့်ရှောက်မှုပညာရှင်များထံမှ ရရှိသည့်စောင့်ရှောက်မှုကို အလွန်ကျေနပ်ပါသည်။	ဘယ်တော့မှ	တစ်ခါတစ်လေ	အမြဲ
	၀	၁	၂
၁၄။ ကျန်းမာရေးဌာန သို့မဟုတ် ဆေးရုံတွင် လိုအပ်သော ဝန်ဆောင်မှုများအားလုံးကို ကျွန်ုပ်တို့ ရယူနိုင်ပါသည်။	ဘယ်တော့မှ	တစ်ခါတစ်လေ	အမြဲ
	၀	၁	၂
၁၅။ ဝန်ထမ်းများသည် အထောက်အကူဖြစ်စေပြီး နားလည်နိုင်သော အကြံဉာဏ်များပေးပါသည်။	ဘယ်တော့မှ	တစ်ခါတစ်လေ	အမြဲ
	၀	၁	၂

အပိုင်း ၄- စိတ်ကျန်းမာရေးအခြေအနေကို အကဲဖြတ်ခြင်းမေးခွန်းများ

ဤဆန်းစစ်လွှာတွင် ဖော်ပြထားသောအချက်များကို သေချာစွာဖတ်ပြီးလျှင် လွန်ခဲ့သော ရက်သတ္တပတ်တစ်ပါးအတွင်း သင်ခံစားခဲ့ရမှုများနှင့် ကိုက်ညီသော အခြေအနေအတိုင်း အမှန်စဉ် “၀”၊ “၁”၊ “၂” သို့မဟုတ် “၃” တစ်ခုခုကို ရွေးချယ်ပြီး ဝိုင်းပေးပါ။ အဖြေမှန်၊ အဖြေမှား ဟူ၍ မရှိပါ။ အချိန်ကြာမြင့်စွာ မစဉ်းစားပါနှင့်။
 အမှတ်စဉ် “၀”၊ “၁”၊ “၂” သို့မဟုတ် “၃” ၏သတ်မှတ်ချက်မှာ အောက်ပါအတိုင်းဖြစ်သည်။

- “၀” ၊ ကျွန်ုပ်တို့နှင့် လုံးဝမသက်ဆိုင်ပါ။
- “၁” ၊ အနည်းငယ်ခံစားရပါသည်။ သို့မဟုတ်၊ တစ်ခါတစ်ရံ ခံစားရပါသည်။
- “၂” ၊ အတော်အတန်ခံစားရပါသည်။ သို့မဟုတ်၊ အချိန်တော်တော်ခံစားရပါသည်။
- “၃” ၊ အလွန်ခံစားရပါသည်။ သို့မဟုတ်၊ အချိန်တိုင်းလိုလိုခံစားရပါသည်။

စဉ်	အကြောင်းအရာ	အဖြေ			
၁	ကျွန်ုပ်တို့သည် စိတ်အေးလက်အေး မနေနိုင်ခဲ့ပါ။	၀	၁	၂	၃
၂	ကျွန်ုပ်တို့သည် အာခေါင် ခြောက်နေတတ်သည်ကို သတိထားမိခဲ့သည်။	၀	၁	၂	၃
၃	ကျွန်ုပ်တို့သည် စိတ်ပျော်ရွှင်ကျေနပ်မှုများ လုံးဝမခံစားခဲ့ရဟု ထင်မိသည်။	၀	၁	၂	၃
၄	ကျွန်ုပ်တို့သည် အသက်ရှူရခက်ခဲသလို (ကိုယ်လက်လှုပ်ရှားမှု မပြုလုပ်ဘဲ၊ အသက်ရှူမြန်လွန်းနေသလို၊ အသက်ရှူ မဝသလို) ခံစားခဲ့ရသည်။	၀	၁	၂	၃
၅	ကျွန်ုပ်တို့သည် လုပ်ဆောင်ရမည့်ကိစ္စများကို ကိုယ်တိုင်အစပြု လုပ်ဆောင်ရန် ခက်ခဲသည်။	၀	၁	၂	၃
၆	ကျွန်ုပ်တို့သည် အခြေအနေကိုစွဲရပ်မှုများကို လိုအပ်သည်ထက် ပို၍တုံ့ပြန်လိုခဲ့ မိသည်။	၀	၁	၂	၃
၇	ကျွန်ုပ်တို့သည် တုန်တုန်ယင်ယင် ခံစားခဲ့ရသည်။ (ဥပမာ ၊ လက်တုန်ခြင်း)	၀	၁	၂	၃
၈	ကျွန်ုပ်တို့သည် စိတ်လှုပ်ရှားပြီး စိတ်အင်အား၊ ကိုယ်အင်အား များစွာ စိုက်ထုတ်ရသည်ဟု ခံစားခဲ့ရသည်။	၀	၁	၂	၃

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၉	ကျွန်ုပ်တို့သည် အလွန်အမင်း ကြောက်ရွံ့သွားပြီး၊ စိတ်လွတ်၍ အဆင်အခြင်မဲ့ပြုမူလိုက်မည်ကို စိုးရိမ်နေခဲ့မိသည်။	၀	၁	၂	၃
၁၀	ကျွန်ုပ်တို့သည် မျှော်လင့်ဖွယ်ရာ လုံးဝမရှိတော့ဟု ခံစားခဲ့ရသည်။	၀	၁	၂	၃
၁၁	ကျွန်ုပ်တို့သည် စိတ်ဝင်စားမှုမရှိ ဖြစ်လွယ်နေခဲ့သည်။	၀	၁	၂	၃
၁၂	ကျွန်ုပ်တို့သည် စိတ်ကို ဖြေလျှော့ရန် ခက်ခဲခဲ့သည်။	၀	၁	၂	၃
၁၃	ကျွန်ုပ်တို့သည် စိတ်ပျက်အားလျော့သလို၊ စိတ်ညှိုးငယ်သလို ခံစားခဲ့ရသည်။	၀	၁	၂	၃
၁၄	ကျွန်ုပ်တို့သည် လုပ်ဆောင်နေသည့်ကိစ္စများ ရှေ့ဆက်မရအောင် ဟန့်တားမှုမှန်သမျှကို သည်းမခံ နိုင်ခဲ့ပါ။	၀	၁	၂	၃
၁၅	ကျွန်ုပ်တို့သည် ရုတ်တရက်အလွန်အမင်း ကြောက်လန့်သလို ဖြစ်လုနီးပါး ခံစားခဲ့ရသည်။	၀	၁	၂	၃
၁၆	ကျွန်ုပ်တို့သည် မည်သည့်အရာကိုမျှ တက်တက်ကြွကြွမရှိခဲ့ပါ။	၀	၁	၂	၃
၁၇	ကျွန်ုပ်တို့သည် ကိုယ့်ကိုယ်ကို တန်ဖိုးမရှိသူတစ်ယောက်ကဲ့သို့ ခံစားခဲ့ရသည်။	၀	၁	၂	၃
၁၈	ကျွန်ုပ်တို့သည် စိတ်ဆတ်လွယ်သည်ဟု ခံစားခဲ့ရသည်။	၀	၁	၂	၃
၁၉	ကျွန်ုပ်တို့သည် ကိုယ်လက်လှုပ်ရှားမှုမရှိဘဲ နှလုံးခုန်မြန်ခြင်း၊ နှလုံးခုန်မမှန်ခြင်းများကို သတိပြုမိခဲ့သည်။	၀	၁	၂	၃
၂၀	ကျွန်ုပ်တို့သည် အကြောင်းပြချက် ကောင်းကောင်းမရှိဘဲ ထိတ်လန့်နေတတ်ခဲ့သည်။	၀	၁	၂	၃
၂၁	ဘဝသည် အဓိပ္ပါယ် မရှိဟု ကျွန်ုပ်တို့ခံစားခဲ့ရသည်။	၀	၁	၂	၃

အပိုင်း ၅- လူမှုပုံစံအကျိုးဖြစ်ထွန်းမှု မေးခွန်းများ။

အောက်ပါဖော်ပြချက်များနှင့်ပတ်သက်၍ သင်မည်ကဲ့သို့ခံစားရသည်ကို ကျွန်ုပ်တို့စိတ်ဝင်စားပါသည်။

စာတစ်ကြောင်းချင်းစီကို သေချာဖတ်ပါ။ ဖော်ပြချက်တစ်ခုစီအတွက် သင်မည်ကဲ့သို့ခံစားရကြောင်း ဖော်ပြပါ။

မေးခွန်းတစ်ခုစီအတွက် သင်သဘောတူသော နံပါတ် ၁၊ ၂၊ ၃၊ ၄၊ ၅ သို့မဟုတ် ၅ ကို ကျေးဇူးပြု၍ ဝိုင်းထားပါ။

စဉ်	အကြောင်းအရာ	ပြင်းပြင်း ထန်ထန် သဘောမ တူပါ	သဘော မတူပါ	ကြား နေ	သဘော တူသည်	အလေး အနက် သဘော တူသည်
၁	မိသားစုဝင်များထံမှ ကျွန်ုပ်တို့၏မိသားစုသည် လိုအပ်သည့်အခါ စိတ်ပိုင်းဆိုင်ရာ ပံ့ပိုးမှုပေးပါသည်။	၁	၂	၃	၄	၅
၂	မိသားစုနဲ့ ပြဿနာတွေကို ပြောရတာ အဆင်ပြေပါသည်။	၁	၂	၃	၄	၅
၃	ကျွန်ုပ်တို့၏မိသားစုသည် ကျွန်ုပ်တို့အား ဆုံးဖြတ်ချက်များချရာတွင် ကူညီပေးလိုစိတ်ရှိသည်။	၁	၂	၃	၄	၅
၄	မိသားစုဆီက ချစ်ခြင်းမေတ္တာတွေ ရပါသည်။	၁	၂	၃	၄	၅
၅	အိပ်ယာထမှာ နေမကောင်းတဲ့အခါ မိသားစုက ကူညီပါသည်။	၁	၂	၃	၄	၅
၆	သူငယ်ချင်း/သူငယ်ချင်းများထံမှ မိတ်ဖွဲ့ရန်နှင့် ပွဲလမ်းများတွင် ပါဝင်ရန် သူငယ်ချင်းများထံမှ ဖိတ်ကြားမှုကို ရရှိပါသည်။	၁	၂	၃	၄	၅



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၇	ကျွန်ုပ်တို့သည် ကျွန်ုပ်တို့၏ သူငယ်ချင်းများနှင့် ငွေကြေးနှင့် ကျန်းမာရေးဆိုင်ရာ ပြဿနာများအကြောင်း ဆွေးနွေးနိုင်ပြီး ၎င်းတို့သည် အသုံးဝင်သော အချက်အလက်များကို ပေးပါသည်။	၁	၂	၃	၄	၅
၈	ကျွန်ုပ်တို့မှာ ပျော်ရွှင်မှုတွေ ဝမ်းနည်းမှုတွေကို ဝေမျှဖို့ ယုံကြည်နိုင်တဲ့ သူငယ်ချင်း အနည်းဆုံးတစ်ယောက်ရှိပါသည်။	၁	၂	၃	၄	၅
၉	ကျွန်ုပ်တို့၏သူငယ်ချင်းများသည် ကျွန်ုပ်တို့၏နေ့စဉ်အလုပ်များ (ဥပမာ၊ ချက်ပြုတ်ခြင်း၊ အိမ်မှုကိစ္စများ၊ ကလေးထိန်း) များကို ကူညီကြသည်။	၁	၂	၃	၄	၅
၁၀	ကျွန်ုပ်တို့၏သူငယ်ချင်းများသည် ကျွန်ုပ်တို့ဖုန်းတွဲအခါ ဆရာဝန်ဆီ ခေါ်သွားပေးကြသည်။	၁	၂	၃	၄	၅
၁၁	လုပ်ဖော်ကိုင်ဖက်များထံမှ ကျွန်ုပ်တို့၏လုပ်ဖော်ကိုင်ဖက်များသည် အလုပ်နှင့်ပတ်သက်သော ကိစ္စများအတွက်အထောက်အကူဖြစ်စေသော အချက်အလက် သို့မဟုတ် အကြံဉာဏ်များ ပေးပါသည်။	၁	၂	၃	၄	၅
၁၂	ကျွန်ုပ်တို့၏လုပ်ဖော်ကိုင်ဖက်များသည် ကျွန်ုပ်တို့၏စိုးရိမ်မှုများကို နားထောင်ပြီး အထောက်အကူဖြစ်စေသော အကြံပြုချက်များကို ပေးပါသည်။	၁	၂	၃	၄	၅
၁၃	ကျွန်ုပ်တို့၏လုပ်ဖော်ကိုင်ဖက်များက ကျွန်ုပ်တို့၏အလုပ်ကို တိုးတက်အောင်ကူညီပေးသော အသုံးဝင်သောတုံ့ပြန်ချက်ပေးပါသည်။	၁	၂	၃	၄	၅
၁၄	ကျွန်ုပ်တို့၏လုပ်ဖော်ကိုင်ဖက်များသည် အလုပ်တွင်အကူအညီလိုသောအခါတွင် ကျွန်ုပ်တို့အား ကူညီကြသည်။	၁	၂	၃	၄	၅

အပိုင်း ၆- ခွဲခြားဆက်ဆံမှု အကဲဖြတ်ခြင်း မေးခွန်းများ။

ကျေးဇူးပြု၍ ဖော်ပြချက်တစ်ခုစီကို ဂရုတစိုက်ဖတ်ပြီး သင့်အား အကောင်းဆုံးထင်ဟပ်စေမည့် ၀၊ ၁၊ ၂၊ ၃၊ ၄ သို့မဟုတ် ၅ ကို ဝိုင်းထားပေးပါ။ သင့်နေ့စဉ်ဘဝတွင် အောက်ပါအရာများ မည်မျှကြုံတွေ့ရသနည်း။ အမှတ်စဉ် “၀” “၁” “၂” “၃” “၄” သို့မဟုတ် “၅” ၏သတ်မှတ်ချက်မှာ အောက်ပါအတိုင်းဖြစ်သည်။

- “၀” ၊ ဘယ်တော့မှ မဖြစ်ပွားပါ။
- “၁” ၊ တစ်နှစ်မှာ တစ်ကြိမ်ထက်မနည်း ဖြစ်ပွားပါသည်။
- “၂” ၊ တစ်နှစ်လျှင် အကြိမ်အနည်းငယ် ဖြစ်ပွားပါသည်။
- “၃” ၊ တစ်လကို အကြိမ်အနည်းငယ် ဖြစ်ပွားပါသည်။
- “၄” ၊ အနည်းဆုံး တစ်ပတ်တစ်ကြိမ် ဖြစ်ပွားပါသည်။
- “၅” ၊ နေ့တိုင်းနီးပါး ဖြစ်ပွားပါသည်။



စဉ်	အကြောင်းအရာ	အဖြေ					
၁	သင်သည် အခြားသူများထက် ယဉ်ကျေးမှုနည်းသော သဘောထားဖြင့် ဆက်ဆံခံရသည်။	၀	၁	၂	၃	၄	၅
၂	သင့်အား အခြားသူများထက် လေးစားမှုနည်းသော သဘောထားဖြင့် ဆက်ဆံခံရသည်။	၀	၁	၂	၃	၄	၅
၃	သင်သည် စားသောက်ဆိုင် သို့မဟုတ် စတိုးဆိုင်များတွင် အခြားသူများထက် ဝန်ဆောင်မှုပိုညံ့စွာ ဆက်ဆံခံရသည်။	၀	၁	၂	၃	၄	၅

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၄	လူများသည် သင့်ကို ဉာဏ်မကောင်းသကဲ့သို့ ပြုမူဆက်ဆံကြသည်။	၀	၁	၂	၃	၄	၅
၅	လူများသည် သင့်ကိုကြောက်စရာကောင်းသကဲ့သို့ ပြုမူဆက်ဆံကြသည်။	၀	၁	၂	၃	၄	၅
၆	လူများသည် သင့်ကို မရိုးသားသကဲ့သို့ ပြုမူဆက်ဆံကြသည်။	၀	၁	၂	၃	၄	၅
၇	လူများသည် သူတို့က သင့်ထက် ပိုသာလွန်သလို ပြုမူဆက်ဆံကြသည်။	၀	၁	၂	၃	၄	၅
၈	သင်သည် ကိုယ်မဟုတ်သည့်နာမည်များအခေါ်ခံရခြင်း သို့မဟုတ် ဆိုးရွားသည့်စကားများဖြင့် စော်ကားခြင်းခံရသည်။	၀	၁	၂	၃	၄	၅
၉	သင်သည် မြိမ်းခြောက်ခံရခြင်း သို့မဟုတ် စော်ကားနှောက်ယှက်ခြင်းခံရသည်။	၀	၁	၂	၃	၄	၅

အပိုင်း ၇- အလုပ်ကျွေးခန့်မှန်းမှုကို အကဲဖြတ်ခြင်း မေးခွန်းများ။
ထုတ်ပြန်ချက်တစ်ခုစီအတွက်၊ ကျေးဇူးပြု၍ သင်၏သဘောတူညီချက်အဆင့်ကိုညွှန်ပြရန် နံပါတ် ၁၊ ၂၊ ၃၊ ၄ သို့မဟုတ် ၅ ကို ဂရုတစိုက်ဖတ်ပြီး ဝိုင်းပေးပါ။

စဉ်	အကြောင်းအရာ	ပြင်းပြင်း ထန်ထန် သဘော မတူပါ	သဘော မတူပါ	မသိပါ	သဘော တူသည်	အလေး အနက် သဘော တူသည်
၁	ကျွန်ုပ်သည် အလုပ်ကောင်းကောင်းလုပ်လို့ အသိအမှတ်ပြုခံရသည်။	၁	၂	၃	၄	၅
၂	ကျွန်ုပ်သည် အလုပ်မှာ လူတွေနဲ့ ရင်းနှီးတယ်လို့ ခံစားရသည်။	၁	၂	၃	၄	၅
၃	ယခုအလုပ်မှာ အလုပ်လုပ်ရတာ စိတ်ချမ်းသာရသည်။	၁	၂	၃	၄	၅
၄	ကျွန်ုပ်၏အလုပ်အတွက် လုံခြုံတယ်လို့ ခံစားရသည်။	၁	၂	၃	၄	၅
၅	အလုပ်၏စိတ်ဝင်စားမှုသည် ကျွန်ုပ်အတွက် အလေးထားသည်ဟု ကျွန်ုပ်ယုံကြည်ပါသည်။	၁	၂	၃	၄	၅
၆	မြိုင်ပြောရလျှင် အလုပ်သည် ကျွန်ုပ်၏ခန္ဓာကိုယ်ကျန်းမာရေးအတွက် ကောင်းတယ်လို့ ကျွန်ုပ်တော်ယုံကြည်သည်။	၁	၂	၃	၄	၅
၇	ကျွန်ုပ်၏လုပ်အားခက ကောင်းသည်။	၁	၂	၃	၄	၅
၈	ကျွန်ုပ်၏ အရည်အချင်းများနှင့် ကျွမ်းကျင်မှုများအားလုံးကို အလုပ်တွင် အသုံးပြုပါသည်။	၁	၂	၃	၄	၅
၉	ကျွန်ုပ်သည် ကျွန်ုပ်၏ ကြိုးကြပ်ရေးများနှင့် ပေါင်းသင်းဆက်ဆံရေးကောင်းပါသည်။	၁	၂	၃	၄	၅
၁၀	ကျွန်ုပ်၏အလုပ်အကိုင်အပေါ် သာယာကြည်နူးမှုရှိပါသည်။	၁	၂	၃	၄	၅

သင်၏ဘဝအရည်အသွေးနဲ့ ပတ်သက်ပြီး သင်ဘယ်လိုထင်မြင်ပါသလဲ။

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ယခုကဲ့သို့ ဖြေကြားပေးခြင်းအတွက် အထူးကျေးဇူးတင်ရှိပါသည်။



APPENDIX H

SUBTYPES OF SOCIAL SUPPORT AND ACCESS TO HEALTHCARE: UNIVARIABLE ANALYSIS

Table H1 Subtypes of Social Support and Access to Healthcare: Univariable Analysis

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor n (%)	Moderate /Good n (%)			
Family support					
Low/Moderate	60 (42.3)	82 (57.7)	7.41	4.36-12.57	<0.001*
High	25 (9.0)	253 (91.0)	1.00		
Friend support					
Low/Moderate	82 (26.6)	226 (73.4)	13.18	4.07-42.67	<0.001*
High	3 (2.7)	109 (97.3)	1.00		
Coworker support					
Low/Moderate	70 (35.9)	125 (64.1)	7.84	4.30-14.29	<0.001*
High	15 (6.7)	210 (93.3)	1.00		
Accessibility					
Not accessible	28 (43.8)	36 (56.2)	4.08	2.31-7.21	<0.001*
Accessible	57 (16.0)	299 (84.0)	1.00		
Acceptance					
Not acceptable	54 (54.5)	45 (45.5)	11.23	6.53-19.30	<0.001*
Acceptable	31 (9.7)	290 (90.3)	1.00		
Availability					
Not available	77 (35.3)	141 (64.7)	13.24	6.19-28.31	<0.001*
Available	8 (4.0)	194 (96.0)	1.00		
Affordability					
Not affordable	83 (34.2)	160 (65.8)	45.39	10.98-187.56	<0.001*
Affordable	2 (1.1)	175 (98.9)	1.00		

Table H1 (continued)

Characteristics	Quality of Life		cOR	95% CI	p-value
	Poor	Moderate			
	n (%)	/Good n (%)			
Appropriateness					
Not appropriate	71 (44.4)	89 (55.6)	14.02	7.52-26.12	<0.001*
Appropriate	14 (5.4)	246 (94.6)	1.00		

Note *Statistically significant level at p-value < 0.05.



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