

**THE EXPERIENCE OF BURMESE MIGRANTS WITH
TUBERCULOSIS IN TRANSNATIONALISM CONTEXT**

SUPA VITTAPORN

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S. Vittaporn

.....
Miss Supa Vittaporn
Candidate

Pimpawun Boonmongkon

.....
Assoc. Prof. Pimpawun Boonmongkon,
Ph.D
Major advisor

S. Thaweessit

.....
Asst. Prof. Suchada Thaweessit, Ph.D
Co-advisor

Kanokwan Tharawan

.....
Asst. Prof. Kanokwan Tharawan, Ph.D
Co-advisor

B. Mahai

.....
Prof. Banchong Mahaisavariya,
M.D., Dip Thai Board of Orthopedics
Dean
Faculty of Graduate Studies
Mahidol University

Pimpawun Boonmongkon

.....
Assoc. Prof. Pimpawun Boonmongkon,
Ph.D
Program Director
Doctor of Philosophy Program in
Medical and Health Social Science
Faculty of Social Sciences and Humanities,
Mahidol University

Thesis
entitled

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on
August 2, 2013

S. Vittaporn

.....
Miss Supa Vittaporn
Candidate

Siriwan Grisurapong

.....
Assoc. Prof. Siriwan Grisurapong, Ph.D
Chair

Pimpawun Boonmongkon

.....
Assoc. Prof. Pimpawun Boonmongkon, Ph.D
Member

S. Thaweessit

.....
Asst. Prof. Suchada Thaweessit, Ph.D
Member

Panitee Suksomboon

.....
Assoc. Prof. Panitee Suksomboon, Ph.D
Member

Kanokwan Tharawan

.....
Asst. Prof. Kanokwan Tharawan, Ph.D
Member

B. Mahachon

.....
Prof. Banchong Mahaisavariya,
M.D., Dip Thai Board of Orthopedics
Dean
Faculty of Graduate Studies,
Mahidol University

Wiriya Chinwanno

.....
Assoc. Prof. Wiriya Chinwanno, Ph.D
Dean
Faculty of Social Sciences and Humanities,
Mahidol University

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Supa Vittaporn

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TRANSNATIONALISM CONTEXT**

SUPA VITTAPORN 5036905 SHMS/D

Ph.D. (MEDICAL & HEALTH SOCIAL SCIENCES)

**THESIS ADVISORY COMMITTEE: PIMPAWUN BOONMONGKON, Ph.D.,
SUCHADA THAWESIT, Ph.D, KANOKWAN THARAWAN, Ph.D.**

ABSTRACT

The objectives of this research were to study 1) the context of Burmese migrant tuberculosis patients' lives; 2) operations of Thai state tuberculosis control as a form of governmentality; 3) the tuberculosis illness experiences of Burmese migrants that constitute acceptance, resistance or negotiation with the tuberculosis control and care system of the Thai state in the context of their migrant lives.

Ethnographic research was used in studying communities of Burmese labor migrants who had tuberculosis and received care at one state hospital in Thailand. The data were analyzed using the concepts of transnationalism, neoliberalism, governmentality and illness experience.

The findings can be summarized as follows. Burmese labor migrants in Thailand endure harsh living and work conditions that make them vulnerable to tuberculosis. The Thai state's tuberculosis control and care system, as a form of governmentality and "health securitization", involves mandatory health checkups on cross-border labor migrants, which turns them into a security threat to the Thai state and population in the public imagination, and objects of the gaze of the state. Public health personnel, as representatives of the state, surveillance and monitor their health and illness to contain security threats posed to Thai people by the possible spread of severe communicable illnesses.

The illness experiences of Burmese cross-border labor migrants demonstrate that tuberculosis patients in this group fully accept the tuberculosis care system. However, this acceptance does not constitute submission to state policies. Rather, they take the opportunity provided by the Thai state to recover their health so that they can once more work to exchange their body capital into cash that they can then send to their families in Burma.

**KEY WORDS: MIGRANT LABOUR/TUBERCULOSIS/ ILLNESS EXPERIENCE/
NEOLIBERALISM/TRANSNATIONALISM**

139 pages

ประสบการณ์ของแรงงานพม่าที่ป่วยเป็นวัณโรคในบริบทการย้ายถิ่นข้ามชาติ

THE EXPERIENCE OF BURMESE MIGRANTS WITH TUBERCULOSIS IN TRANSNATIONALISM CONTEXT

สุภา วิตดาภรณ์ 5036905 SHMS/D

ปร.ด. (สังคมศาสตร์การแพทย์และสาธารณสุข)

คณะกรรมการที่ปรึกษาวิทยานิพนธ์: พิมพัลย์ บุญมงคล, Ph.D., สุชาดา ทวีสิทธิ์, Ph.D.,
กนกวรรณ ธารวรรณ, Ph.D.

บทคัดย่อ

การศึกษานี้มีวัตถุประสงค์เพื่อศึกษา 1) บริบทชีวิตของผู้ป่วยวัณโรคชาวพม่าที่ดำรงอยู่ในพื้นที่ข้ามพรมแดน 2) เพื่อศึกษาปฏิบัติการของระบบการจัดบริการและควบคุมวัณโรคของรัฐไทยในฐานะการปกครองแบบชีวญาณ 3) เพื่อศึกษาประสบการณ์การเจ็บป่วยของแรงงานพม่าที่ป่วยด้วยวัณโรคที่ดำรงอยู่ในรูปแบบของการยอมรับ ต่อต้าน ต่อรอง ต่อระบบการจัดบริการควบคุมและรักษาวัณโรคของรัฐไทยและภายใต้บริบทชีวิตข้ามพรมแดนระเบียบวิธีวิทยาที่ใช้ได้แก่การวิจัยเชิงชาติพันธุ์วรรณนาในชุมชนของกลุ่มแรงงานข้ามชาติที่ป่วยเป็นวัณโรคและมารับบริการที่โรงพยาบาลรัฐแห่งหนึ่งของประเทศไทย การวิเคราะห์ข้อมูลภายใต้กรอบแนวคิดการข้ามพรมแดน เสรีนิยมใหม่ การปกครองชีวญาณ และประสบการณ์ความเจ็บป่วย

ผลการศึกษาสรุปได้ว่าแรงงานข้ามชาติที่เข้ามาทำงานในประเทศไทยต้องทนอยู่ในสภาพแวดล้อมที่เลวร้าย ทั้งที่อยู่อาศัยและการทำงานที่เอื้อต่อการเจ็บป่วยเป็นวัณโรคสำหรับปฏิบัติการของระบบการจัดบริการและควบคุมวัณโรคของรัฐไทยในฐานะการปกครองแบบชีวญาณ ได้แก่การที่รัฐบาลได้ใช้นโยบายตรวจสุขภาพกับแรงงานข้ามชาติทำให้อัตลักษณ์ของแรงงานข้ามชาติ กลายเป็นปัญหาความมั่นคงทางด้านสุขภาพของรัฐไทยและประชากรไทย กระบวนการทำให้เกิดความมั่นคงทางด้านสุขภาพของรัฐไทยโดยใช้นโยบายตรวจสุขภาพกับแรงงานข้ามชาติเป็นการลดทอนชีวิตของแรงงานข้ามชาติให้กลายเป็นเพียงวัตถุของการจับจ้องจากรัฐ บุคลากรสาธารณสุขในฐานะที่เป็นตัวแทนของรัฐในการสอดส่อง เฝ้าระวัง และติดตามแรงงานข้ามชาติในด้านสุขภาพและการเจ็บป่วยที่อาจนำโรคติดต่อร้ายแรงมาแพร่ อันกระทบต่อความมั่นคงทางด้านสุขภาพของคนในประเทศไทย

สำหรับประสบการณ์การเจ็บป่วยของแรงงานพม่าที่ป่วยด้วยวัณโรคที่ดำรงอยู่พบว่าแรงงานข้ามชาติที่ป่วยวัณโรคยอมรับระบบการจัดบริการรักษาวัณโรคเป็นอย่างดี แต่รูปแบบดังกล่าว มิใช่การสขบยอมต่อนโยบายของรัฐ แต่เป็นการใช้โอกาสที่รัฐไทยเอื้อให้ตนเองได้ฟื้นฟูร่างกายเพื่อกลับคืนสู่ร่างของผู้ที่มีสุขภาพดีอีกครั้ง เพราะพวกเขามีเป้าหมายร่วมกันคือ “การทำงาน” เปลี่ยนร่างกายที่เป็นทุนของตนเองให้กลายเป็น “เงินตรา” เพื่อส่งกลับไปยังครอบครัวในประเทศพม่า

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CHAPTER I

INTRODUCTION

1.1 Background and rationale

1.1.1 Why study tuberculosis?

The report of the Bureau of Tuberculosis, Department of Disease Control, Ministry of Public Health, about the number of migrant workers with tuberculosis in Thailand has been increasing, especially in the border of Thailand - Burma and other provinces in industrial areas. There are migrants with TB infection; especially workers who are not registered, and so lack of medicines. Treatment is not continuous and the resistant tuberculosis develops. From a study on drug resistance surveillance, MDR-TB was found in patients who live in the provinces of the Thailand – Burmar border and was as high as 5.3 percent, which can be spread to others: both the workers and the general population in Thailand. That impacts on the overall situation of the tuberculosis in the country (Bureau of Tuberculosis, Department of Disease Control, Ministry of Public Health, 2011). The treatment registration of migrant workers in the year 2008 was 1,531 patients and the successful treatment in the year 2009 was 72.19 percent, which was lower than the target of 85 percent in 2009. There was a mortality rate of 6.2 percent and 14.4 percent lacked medicines (Bureau of Tuberculosis, Department of Disease Control, Ministry of Public Health, 2011). So, it can be seen that the migrant workers from neighboring countries along the border, or the people who are laborers in the city, are at risk of being TB patients and they need treatment that is continuous and effective. This suggests that migration affects the social relationship in many areas, such as the economy, politics and environment including increased disease outbreaks. Currently, tuberculosis has been classified as a social disease and disease of poverty (Darbyshire, 1996 cited in Barrett, et al., 1998; Godfrey-Faussett & Ayks cited in Allotey & Guapong, 2008) because 95 percent of tuberculosis patients that died were in developing countries (Reviglione at al., 1995

cited in Barrett, et al., 1998). In these countries it is known that people live in famine conditions, the sanitation is poor, there are crowded shelters, disadvantages in education and lack of health services. Environmental and social factors that result in people living and working in crowded and unhygienic areas are the factors that make poor people exposed to infectious diseases more easily. These include massacres, stress and overloaded working. They cannot access health services, which makes the patient delay treatment. All of which are involved with the political, economic and social conditions of the patients. Diseases of poverty have dynamic relationships with poverty and bad health (World Health Organization, 2004). Tuberculosis and poverty are like the double-sided coin (Enarson, ElSony, Chen-Yuan & Rusen, 2009). Due to the poor people living in slum areas, air does not circulate. The patients that live in these communities do not access medical treatment due to their poverty (Amara Soonthorndhada, 2007) which means the poor are infected with TB more than the people with better economic status. In Bangladesh it was found that 70 percent of TB patients that were treated were in poverty. In Brazil, the prevalence and mortality of TB patients has reflected the economic and social factors as well as the lack of fundamental factors in the community that were a catalyst for the ill to die of tuberculosis (Ministry of Health and Family Welfare, 2002 cited in Amara Soonthorndhada, 2007).

In addition, tuberculosis that causes TB in patients limits their human rights and dignity. TB patients are discriminated against through social exclusion, which is directly related to the illness and changes in health. TB is very common in the population that is the most vulnerable group as the marginalized people who were already excluded and segregated: the people were discriminated against by society or who are living with poverty. The incidences of tuberculosis in countries with economic levels that are moderate to high are usually among migrants from poor countries (Godfrey - Faussett & Ayks cited in Allotey & Guapong 2008). In the United States, tuberculosis is also referred to as blackamoor and the poor and those living in slums or the bad environment have "the Lung Block" (Ott, 1996). In Thailand, female tuberculosis patients were seen in a negative way due to their TB infection because of inappropriate behavior or the risk living like men (Soonthorndhada, 2003, cited in Amara Soonthorndhada, 2550). Therefore, TB has

social, economic and political dimensions that overlap greatly so requires a Social Science perspective to analyze the problem of tuberculosis.

1.1.2 Why study tuberculosis in migrants?

Migration across borders causes the circulation of transnational culture. Migrants not only take their culture, but each person has different health conditions. Some patients have tuberculosis because of the social conditions, the economic problems in their country and the destination country. At the present, the return of tuberculosis in developed countries is becoming a health problem as well. In the United States, one third of new tuberculosis patients were foreign patients (McKenna, McCray and Onorato, 1995 cited in Smith-Nonini, 2009). Migration is affecting the health of people in both the countries of origin and destination (Boyle, 2004 cited in Jatrana, Grahamand, & Boyle, 2005). Research has found that migrants are healthier than the people in their country (Anson 2004; Rosenwaike 1990 cited in Jatrana, et al., 2005), but the illegal immigrant workers have worse health status because they are faced with poverty and conflicts with government officials. Especially during the journey, it is more difficult to access health care systems (Taran 2002 cited in Jatrana, et al., 2005). When they were living within the population of the destination country, they faced the loss of economic and social aspects: no social network, discrimination, language barriers, socio-cultural barriers to assimilation and lack of knowledge about health services (Newbold 2005 cited in Jatrana & Chan, 2005; Asis, 2005; Pracha Vasuprasath, ILO / Japan Regional Program of the International Labor Organization's management of migrant workers in South-East Asia, and the International Labor Office, Asia and the Pacific, 2010). Social, cultural and political contexts have affected both points, the direct and indirect health of migrants, through the lack of treatment in hospitals and clinics, the lack of work and exclusion. So the status of migrant workers becomes marginalized. Also, the government has classified their health status directly with an annual health check that has an impact directly on their access to health services. In addition to the work environment, their home is very crowded, they work long hours so have less relaxation (Pracha Vasuprasath, et al., 2010) and the context of the lives of these workers are at risk of being tuberculosis patients. What makes the migrant workers into TB patents are complex under a

circulation of the transnational culture, including the context living of migrant workers who are controlled by the autonomous control program and TB treatment and services are provided to migrants by the government (Foucault, 1991).

1.1.3 Why study the lives and experiences of migrants?

Migrants smuggle across the border into the state. In many areas, the migrants live together until they become the transnational community. Then because their relatives or acquaintances settled early, they become an important social network that makes the migrants come to work in Thailand, for example, introducing workplace and finding the place to live. The researcher has lived into this area since the year 2005, at that time the author was working for a NGO in migrant health. Also, the researcher has worked with the various organizations in Sinsamut province, which is the center of the key industry sectors such as the fishing industry, plastic and electronics so in this province demand the labor from Burma is intensive, due to competition in the globalized economy. The author observed that in Sinsamut province there is the recruitment of workers in both languages; Thai and Burmese are at the bus stop, shops, such as the cellular phone stores, the copy stores and the photo shops. They invite the customer with Burmese ads to service in the shop.

If you look at the migrants in the circulation of culture in the ethnoscape, they always embraced their cultural dimensions. Whether, the technology, money, media and ideology it can be said that the circulation of cultural dimensions of the ethnoscape would have the other side of the circulation of culture under the current globalization. Lifestyle and culture of migrants occur when migration or the migrants' journeys were across state borders. Migrants would stay and live in the society and a new culture for at least a period of time before they can adapt to the social, cultural and political context of a "new home". They are faced with alienation and problems caused by differences racial stratification, legal and language between the native people and newcomers. These cause a problem to adapt to the new culture.

The face of alienation and adaptation continue endlessly, and in 2011 a group of countries in Southeast Asia established the ASEAN Economic Community. This will affect the way the culture of the people in this region adapts. It causes a free market in this region. The collaboration between the state and capital created

economic stability for the country. The state has a waiver policy to allow workers to escape across the border of the state if they are entering to seek better opportunities in their life. Those workers are able to work temporarily in Thailand. There are measures in reconnaissance and surveillance; especially for tuberculosis that is considered as one of the health problems of migrant workers from Burma.

By mutual agreement at both international and national levels, such as the "Amsterdam Declaration to Stop TB" that was the main significant deal to prevent the tuberculosis problem. By speeding up the policy and action plan that focuses on the importance of the participation of personnel in all sectors, such as the Government agencies, NGOs, social development groups, international organizations, industry entrepreneurs and public (Public Health Watch, 2006) Millennium Development Goals (MDGs) that seek to control and stop infectious diseases prevalent in poor countries away, including AIDS, malaria and tuberculosis, can be achieved.

Thailand's government has adopted a strategy to treat patients with tuberculosis by having a directed observation treatment or DOT¹. The World Health Organization proposed that various countries around the world use this system in the treatment and control of tuberculosis, which contains a covenant of the political parties as focus on the tuberculosis problem, the laboratory standard. The nurse supervises taking the medicine and the management of drugs for the tuberculosis patients, and that the Tuberculosis Register is complete and accurate.

At present, the goal of the World Health Organization has not been achieved due to the treatment outcomes that show the sputum was found TB in new patients by more than 85 percent (Ministry of Health, 2005) and migration was seen as the problem to control this disease. TB has become a major problem in migrant workers that must be stopped. However, for migrant health services it is necessary to understand both ways: the physical and psychological symptoms in the context of cultural differences between the service providers and service recipients. Therefore, care should be taken with cross-cultural understanding in the context of providing

¹ Stands for "Direct Observation Treatment" as a part of the major strategic of the National Tuberculosis Control Plan, for the hospitals that have the tuberculosis patients by the nurse/mentor is directed to taking the medicine to ensure the effectiveness of TB control.

basic health care (Waitzkin, 2009). To transcend the barriers of language, culture and beliefs are different because in the interaction between doctors and patients they are not aware of the different cultures that may lead to misunderstanding when communicating the symptoms (Willging, Waitzkin, & Nicdao, 2008 cited in Waitzkin, 2009).

The author points to the major issues that should be studied such as the life context of the TB patients who live in areas of the migrant culture and the life experiences of migrants who were ill with tuberculosis already. This is opposed to permitting, against and at odds with the service and control system and the treatment of tuberculosis of Burmese migrants who are TB patients under the life context of the migrant workers.

The study of the context and life experience of the migrant workers with TB reflects an understanding of the process. The definition of the interaction at the individual level of individuality and life experiences such as the experience of illness and health care that consider the interaction of the TB patients to the illness in each conditions and the tuberculosis is an indicator of social inequality as well. This will look at the world of illness and the choice of treatment that depends on their social and cultural factors such as the behavior, belief and value systems. All of which is to understand the phenomenon of health as a social phenomenon and the studies can lead to solve the problems. However, it cannot be denied that the policies that have defined the way of life of individuals and the autoregressive individuals are organized. The policies are classified, formatted and organized for the individual and the state, the role of the citizen, the experts, the ethnic group, the criminals and the unusual persons that misses awareness and control through consciousness by the model that Foucault called governmentality (Shore & Wright, 1997).

Medical treatment for tuberculosis, according to the World Health Organization, is supported by the DOT strategy. It is believed that it has the ability to treat patients and prevent resistant TB as the DOT medical culture is focused on the scientific knowledge to deal with tuberculosis. The Thai government has also adopted the DOT as a tool to work with TB patients since 1996. The DOT policy is a medical discourse to control the population and uses surveillance and control of the citizen through invigilation and gaze so the TB patients are docile and has discipline for the

medicine as a control. When a person is faced with an illness problem, they chose to filch any discourse of health that was used to solve the problem; it is still under power relations in the social context of health knowledge with scientific knowledge as the main discourse. The discursive practice and knowledge have been affected to the other discourses such as the traditional health care model that is capable of self-care. It has been ousted and classified in a state of poor and marginalized by pressing the power structures and social institutions such as the law, the state policy or the public health agencies, which provided the valuable knowledge to science as legitimate and a valid knowledge unconditionally. In the midst of social change with the migration of workers it has been carried out by their traditional health beliefs as set with oneself. Thus, the new explanation resulted or the combination with the other knowledge. It happens in all areas and times in the context of migrant workers. Any knowledge is static in only a form of knowledge in all conditions.

Due to the discourse of modern medicine being the product of scientific knowledge, the medical discourse has ignored social issues, culture and politics when looking at the disease, and the cause of disease in the health profession. So it does not regard the illness as an experience of the individual patients that have the symptoms that occur in people with heart and soul, they have wills and dignity. Each culture has a meaning of the nature of illness and a system of their health care. Medical anthropologists have studied the relationship of social and cultural processes linked to illness and health care. When he/she is ill, what is the affect on the lives, families and society of the patients? The relationship between the patient and the healer is what? What is the patient, family and community's perspective of the cause of the disease? The disease and treatment are known in diverse cultures and the classification of a disease or the importance of the illness is different in each society. Patient's treatment with any doctor depends on the recognition of the symptoms and disease. To find the cause of a disease that causes a change in the physical environment, natural theology, the emotional changes or something supernatural because of the causes of diseases are not separated from the social and cultural context. Describing the causes of diseases is describing the experiences from the patient and the views of members of the same society. Anthropologists will form an understanding in the context or situation, the patients choose services, the faith, the diagnosis and the treatment are appropriate and

lead to more efficient treatment. These things are the experience of illness that important for understanding to organize and control tuberculosis in migrant workers. A study on the illness experience of migrant workers who are tuberculosis patients in Thailand reflected the existence of their own and in the context of transnational migration, which were treated as "the others" from the social and health services of the Thai state. Before seeking treatment, patients interpreted their symptoms and consulted with others about how they should live or how to help themselves (Punamaki, 1995).

The responses of them will lead to changes in health care systems with the power relations between service providers and clients without discrimination because of ethnic discrimination. The hybrid identities that migrants create are not caused by the formulation of the institutions. However, those are the cultural adaptations of migrants to challenge the authority of the nation state. The migrant workers filch identities as determined by the conditions and circumstances.

Thus, identity has a wide range, flows and does not stop. Meaning is created in the world of the migrant workers in Thailand that are under the socio-cultural context in Thailand. It is unlike the original country of the migrant workers. Those are the clash and coordinate between the old traditional culture and the new culture of the country that is the new residence. There will inevitably be differences between people in Thailand, included the service, the preservation process and preventing the disease. Especially the patient cared for with the observation system by the mentor who warns them to take the medicine by DOT watcher, which is the main strategy of the treatment of tuberculosis in the community and health service place that the migrants face under the health policies of the Thai state.

1.2 Research question

What are the illness experiences of Burmese migrant workers with the tuberculosis disease that exist among the service operation system to control and treat tuberculosis and the life context in a cross-border area?

1.3 Research objectives

1. To study the lives of Burmese with TB who living in transnational context.
2. To study the operating service system and the TB control by Thai government.
3. To study the illness experience of the Burmese with TB that exists by the adoption, resistance and negotiation with the service operation system to control and treat the tuberculosis by the Thai government that is under transnational context.

1.4 Scope of research

This study is qualitative research to study the illness experiences of migrants from Myanmar who have tuberculosis in the Health Service of the Thai state with data collection techniques such as: 1) deep interviews with the migrants with TB disease and related service providers. 2) Observed involvement. 3) Conduct interviews in the area of daily activities in the community that the patients stay. 4) Record the daily conversations within the health services area.

In this study, the researcher used Sinsamut hospital (alias) as the initial source of data that expanded to the community that the TB patients live in, in a town from Sinsamut Province (alias). The research period was March - May 2012.

1.5 Expected benefits

1. Using research to solve the health problems in the group of migrants with TB disease in the treatment, prevention and control of the disease, which are most often the focus on a paradigm in the health care providers, and who ignoring the information that is the viewpoint of the illness experience by the migrants who have the social and culture backgrounds that are different from Thai society.

2. To use the research information, especially in the dimension of the meaning of tuberculosis in the oriented-symbolic language that is used in the communication process between doctors, medical personnel and patients.

3. The approach in policy development to treat, prevent and control of TB with the migrant workers, with regard to the honor and human dignity.

4. The guidelines for research and study on the migrant workers with TB disease have more diverse perspectives.

1.6 Term of references

1. "Migrants" means laborers working in cities and townships but having country domicile. Therefore, they bear two statuses, from Burma and work in Thailand, both the legally permitted workers and illegal labor.

2. "Tuberculosis patients" means the migrant labors from Burma who have been diagnosed by a doctor that they are TB patients including those who are under treatment, stopping the treatment by oneself and those cured of the disease.

3. The "health services system" means the prevention, control and treatment to the migrants with TB disease at Sinsamut hospital.

4. The "illness experience" is the meaning of a disease, the beliefs about the morbidity, the disease classification, treating the disease and finding the treatment methods. The relationship dimension is related to the emotions of the patient and the economic and social relations in which the patient lives.

5. The "life in transnational context" means the adaptation, the daily lives of the migrants from Burma in Thailand and how they preserve the relationship between the people of Burma and Thailand.

CHAPTER II

RELATED LITURATURE

Within the framework of this study, the daily life of laborers who migrated from Burma and are living in a community of migrants is investigated as well as migrants who are suffering from tuberculosis and were treated in Thailand; thereby, being exposed to the Thai medical system. Of interest for this investigation are the features of transnationalism, neoliberalism, mentality of governmental authorities and the experience of patients.

2.1 Transnationalism

Social Anthropology involves the study of social and cultural diversity across the world. In the past, Social Anthropology was interested only in the issue of man living in the society and social changes did not matter much. Later, beginning in the 1930s, anthropologists at the Manchester School of Anthropology started researching migration dynamics and its impacts in central Africa. Since the 1970s, the discipline has developed a growing interest in the ethnicity of post-migration communities, after the colonial period. Since the 1990s, migrant transnationalism has become one of the most studied research topics. There are still lots of blank spots surrounding the issue of migration, not least with regard to the public debates around multiculturalism (Vertovec, 2007). The migrants have been termed as ‘diasporas’, a term that relates to people who have been relocated or removed from their homeland (Vertovec, 2009).

According to Appadurai (1990), polarization models such as producers/consumers or center/periphery can no longer be used to explain the global cultural economy. Global cultural flows occur in and through the growing disjuncture between various areas as outlined below:

1. Ethnoscapes are landscapes of persons who constitute the shifting world in which we live: tourists, immigrants, refugees, exiles, guest workers and other moving groups and persons who constitute an essential feature of the world and appear to affect the politics of and between nations to a hitherto unprecedented degree.

2. Technoscapes refer to the global configuration of technology, and the fact that technology (high and low or mechanical and informational) now moves at high speeds across various kinds of previously impervious boundaries. Appadurai adds that there is a relationship between technoscapes and ethnoscapes because the movement of technology and the movement of the actors capable of manipulating this technology are closely linked.

3. Finanscapes relate to the flows in currency markets, national stock exchanges and commodity speculations.

4. Mediascapes pass on both the distribution of electronic capabilities to produce and disseminate information (newspapers, magazines, television stations and film production studios), which is now available to a growing number of individuals in private and in public throughout the world. The images tend to be centered on narrative-based accounts of strips of reality.

5. Ideoscapes are also images linked together and are often directly related to political issues and frequently have to do with the ideologies of states and counter-ideologies of movements explicitly oriented to capturing state powers or a part of them.

The transnational framework is especially useful in hinting towards the importance of linkages between home and host countries. Many migrants are now trans-migrants, whose daily lives depend on multiple and constant interconnections across international borders and whose public identities are linked to more than one nationality (Glick Schiller et al.1992a; Basch et al. 1994 cited in Schiller, 2004). Migration proves to be an important transnational process that reflects and contributes to the current political configuration of the emerging global economy. There are three reasons, related to the forces of the current global economy, which lead present day immigrants to settle in countries that are centers of global capitalism, but they have to live transnational lives: (1) a global restructuring of capital based on changing forms of capital accumulation that leads to the deterioration of social and economic

conditions in both labor sending and labor receiving countries with no secure land of settlement. (2) Racism in both the origin country and country of settlement contributes to the economic and political insecurity of the newcomers and their descendants. (3) The nation building project of both home and host society build political loyalties among immigrants to each nation-state in which they maintain social ties (Schiller, 1995). Trans-migration also involves cultural flows; the concurrent movement of peoples, activities, network and the relationship among migrants (Schiller, 2004) The research which reported by Marjorie Faulstich Orellana (2001 cited in Vertovec, 2009) that Mexican, Korean and Yemeni parents expressed frustration that their children in the USA did not appreciate things children back home would never have, and they thought about sending their own kids back to give them another perspective on life. Using the term 'back home' as a reference point for values and behavior, 'transnational disciplining' serves as an important strategy for some parents to control children's behavior. However, as Guarnizo (1997 cited in Vertivecm 2009) points out, this strategy often backfires because of diminishing family support, a migrant's most valuable asset in the country of origin, and the occasional unwillingness of mothers to take care of forcibly repatriated children.

The culture flow together with the migration from the original homeland to the host country, remains with the migrants and is sometimes diversified according to the environment and the culture of the place or state where they live. For example, the Indian culture about food, entertainment, goods and services in the homeland and the present country of residence of the migrants are diversified (Appadurai and Breckenridge, 1988 cited in Schiller, 2004)

The concept of creolization is one that is currently used to refer to this process of cultural interpenetration. The anthropologist Ulf Hannerz (1989 cited in Schiller, 2004) said that globalization need not be a matter of far reaching or complete homogenization; so the increasing interconnectedness of the world will result in some cultural gain. The people on the receiving end of globalization do have a choice of what to accept and very often they choose bits and pieces which they mix with their own forms and expressions. Creolization can be considered as a global village, since it is simultaneously a spatially bounded, hence territorial village whose geographical boundaries serve as the source of community identity and a completely unbounded

non-territorial community whose socially determined space encompasses the whole globe.

However, it needs more specific concepts to explain immigrants and migrant activities. In this regard we define 'transnationalism' as the processes by which immigrants build social fields that link together their country of origin and their country of settlement. Immigrants who build such social fields are designated 'trans-migrants'. Trans-migrants develop and maintain multiple relations such as familial, economic, social, organizational, religious and political connections that span borders. Trans-migrants take actions, make decisions, feel concerns and develop identities within social networks that connect them to two or more societies simultaneously (Schiller, 2004).

Transnationalism is often associated with a mixture of styles, social institutions and everyday practices that might fully resemble neither the styles of their home country nor the styles of their present residence. These are often described in terms of syncretism, creolization, cultural translation, cosmopolitanism and hybridism. In case the so called globalization intensifies, the migrant might have to build social relationships among those who live in the city, rural areas and industrial real estate that link together their societies (Vertovec, 2007). The social workers of the settlement country focus only on the overall administrative issue but not on the activities of individual migrants, which might affect the everyday practice of the young generation (Vertovec, 2004).

Transnationalism is a globalization phenomenon based on deliberation: people go beyond the country borders. Together with them, vast sums of money travel around the globe. Money is spent in different currency in individual countries; formerly the exchange rate was fixed by the government of those countries. However, in 1973, the governments of various countries agreed that exchange rates should be floating and not fixed by the government any more. The result was that trading companies all over the world charged the prices of goods and services according to the floating exchange rate. The consequence was the transformation of financial and cultural matters as well as means of communication and technology across national borders. Nationalism is now confused with racial matters and state authorities attempt to control a confused nationalism concept (Teerayut Bunmee, 2004). Transnationalism

also involves financial matters and this is one of the perils of economic globalization, since there are cross-border movements of loans, equities, direct and indirect investments, and currencies that influence the power of nations (Appadurai, 2006). The economic aspect of migrant transnationalism involves multiple economic activities, and has financial multiplier effects that are generated by migrants' relations with their various homelands. Globalization and transnational migrants become visible in many states/countries, so that people from far away come to live in the same area, building their communities and social networks. Therefore, we should understand the mode of transnational migrants, the diversity of migrants' relationships with their place of settlement and the activities of the migrants as well as their communities and networks. The issue is linked to ethnical and financial matters, to technology, media and ideology aspects (Vertovec, 2003).

It can be said that transnational migration is one form of globalization that emphasizes expanding material relations and connecting societies across national borders; social relations should not only be limited with villages, cities or nations but beyond these geographical areas (Pries, 1999; Cohen1997 cited in Thirawuth Senakhum, 2006). The new imagination of social movements that tries to connect local territories, nations and continents, has an impact on reality and affects the daily life concerns of people (Cohen1997 cited in Thirawuth Senakhum, 2006). Many cases of transnational migration have been due to civil wars or unfair treatment caused by conflicts between national authorities and population groups. Transnational migration processes are a dimension of globalization that expands beyond the borders of particular states, but are at the same time shaped by the policies and institutional practices of states and their governments (Ong, 1999).

The term "diaspora" was used by Steven Vertovec to identify people who are not living in their homeland. Home in the context of migrants does not only mean a place to live, but it is a place they spend a considerable or very important time of their life and is well regarded in their memory. The new home in contrast is the place where they exercise social activities, experience cultural diversity and are exposed to a number of categories of a new environments (Vertovec, 2009).

Within the term globalization, a number of entities are connected, such as migration, commerce, communication technology, finance and tourism. The term also

contains the bipolar imagery of space and time of the modern worldview, which is also expressed in modern anthropological theories. It could be considered as a progressive bipolar issue within history beginning at the recognition of history in ancient times and it might go on up to the end of mankind, when history will end. Within the context of globalization, metropolitan centers and peripheral sites come together due to the immense development of communication. The term also implies hierarchical systems of classification and administration. Nations are deeply influenced by the activities and decisions made by other nations and by this are forced into a global network with after effects on the populations all over the world. Globalization refers to the idea that nations no longer act as separate units but as a part of a whole: actions at the local level are influenced and effected by the rest of the world. Anthropologists refer to the social, economic, cultural and demographic processes that take place, but also look at the local processes, identities and units of analysis that are incompletely understood by the locals (Kearney, 1995). Globalization and transnational migration have lead to cultural hybridism, a mixed culture that might weaken the nation-state and decline patriotism. The transnational migration results in a demographic globalization, caused by people migrating from various countries, and different geographical areas with different backgrounds. While living in the host country, the diasporas use long-distant calls to communicate with their relatives at home, and by this might be able to also influence the politic in their home country in some form. Examples are the Jewish, Palestinian and Irish living in the USA, Kurds living in Germany and Tibetans living in India (Anderson, 1992 cited in Pieterse, 2009). The diasporas have adopted the culture of the host country and mixed it with their own original perception and have created a hybrid culture, and by this develop a new identity that fits into the host country. At the same time, the old identity still remains. Hybrid identities or hyphenated identities are terms that imply a dual identity, an ethno cultural one and in between identities (Virankabutra, 2009).

The diasporas, as an example of transnational communities, must also navigate between the present tension, where they are living and simultaneously remembering the places they left, which remain in the distant past. The diasporas assumed a new life and a new identity in the host country. Diaspora communities are strong ethnic groups, whose consciousness is sustained over a long time and based on

a sense of distinctiveness, a common history and the belief in a common fate. Diaspora communities are engaged and connected with the homeland on a cultural, political, economic and social level (Tirawuti Senakum, 2006). Diaspora communities are composed of migrants who feel (maintain, revive, invent) a connection with a prior home. This “homing” desire or narrative is not necessarily the same as wanting to return to a physical homeland. Instead, it is more of an understanding that regardless of where the persons relocates, their conception of home is always with them and that it will remain a central part of their identities. Robin Cohen defined a diaspora community as the members of such a community who have a strong bond with each other based on their shared belief in having a unique and distinct cultural and national identity as well as a belief that they have a common and connected future because of this identity. Diasporas consisting of different ethnicities have complicated relationships with each other, as well as with the host country and the country of origin (Kasame Penpinunt, 2009). Nina Glick Schiller stated that in the period of colonialism and imperialism, the social and cultural background of people in their countries was diversified, and their identities were modified according to the socio-cultural diversity. People in the post-colonial time resorted to transnational migration and transnational social movement from the original place to a new place of destination. Communities were formed as a result of everyday experiences, stories told and communication and interaction with others from the common homeland. They create and sustain multiple social relations that link them together with their societies of origin and residence. The social fields connect migrants and non-migrants across borders. Their social connections are divided between two countries and they travel back and forth (Thirawuth Senakhum, 2006).

Transnational migration creates communities in the land of destination; their social networking, cultural- and religious activities influence other social sectors, organizations and institutions, such as political authorizes, political parties and nongovernmental organizations. Although the trans-migrants or diasporas live outside the territory of their homeland they keep strong ties with their land of origin. Here they might also be engaged in the politics of their homeland in some form. They are encouraged by state authorities or politicians of their land of origin, that wherever they live, they remain the people of their homeland. This might result in politicians of the

country of origin dominating diasporas beyond its geographical borders (Kearney, 1995). Former studies only investigated the aspects of power and the control the authorities and politicians had on the migrants within the country of destination, but this turns out not to be the appropriate approach for research. Since globalization took place, social, economic, cultural and demographic process inevitably play an important role in this aspect (Thirawuth Senakhum, 2006). Under the present situation, nations extend their policy of power to control the foreign people who live in other countries as citizens (Suchada Thaweessit, 2011).

The borders of Thailand were fixed in the colonial era. Southeast Asian countries such as Lao and Burma were colonized by France and Great Britain respectively. The present borders of those countries are the result of colonial actions, in which some provinces or territories that formerly belonged to Thailand were occupied. People now living in these territories recognize that they are actually staying in a new state, such as Lao and Burma. They cross the border for trading and visiting relatives, and some of them migrate to settle in the territory of Thailand. In 1972 the Thai government announced a policy that does not allow Laotian and Burmese migrants to live in Thailand (Yos Santasombut, 2008). It was an autocratic and administrative means to control and organize Thailand within its borders. Starting in 1975 there was a revolution in Laos, and the communist party ruled the country by setting up the Lao People Democratic Republic (Lao, PDR). Thailand enforced more surveillance and strict regulations on border crossing of Laotians executed with the help and cooperation of the immigration bureau, customs department, department of livestock development and border police patrol. After the fighting in Laos ended, the foreign policies of Thailand and Lao focused more on economic issues, and in 1986 the Lao and Thai governments resumed trading across the border. This made it easier for people to come into Thailand and leave. This also created a step related to globalization and the exchange of money, information, culture, ideology and mixture of ethnicities (Appadurai, 1996). International organizations for migration were established as the International Human Rights Organization, and some of its declarations interfere with the internal affairs of the member country, and reduce the authority of the states (Teerayut Bunmee, 2004). With advanced technology, people can communicate with others far away through many kinds of media. The importance

of nations, languages and cultural identities decrease. Presently there is an intensification of world-wide social relations that link distant localities in such a way that local happenings are shaped by events occurring many miles away and vice versa (Kearney, 1995).

This study investigated transnational migrants suffering from tuberculosis and the stigma they experienced from the migrant labors of the same nation. They migrated from Burma, live in Thailand and work there in industrial factories. The daily life of their community relates to social networking and the exchange of experiences related to the working life in the factory. They had to adapt to the new social environment, society and culture in their new home. Their daily life takes place between two cultures related to food consumption and utensils used in the family for instance.

Commercial activities are theoretical aimed at wealth acquisition without limit. Concerned with money and the exchange of goods, commerce also involves the improper use of things. Commerce is a craft that produces excess needs for gratification and involves malpractice towards labors, for instance when working in industrial factories with a working schedule as a shift job, long working periods without a break, working overtime but not getting paid adequately and the authorities do not pay attention to the unfair working conditions.

2.2. Governmentality

Governmentality is a concept first developed by the French philosopher Michel Foucault. The notion derives from the French word *gouvernementalite* meaning “concerning government”, and was a word linking governing (“gouverne, govern”) and reflection (“mentalite, mentality”). The term mentality or thinking refers to a collective activity, that is, the sum of knowledge, beliefs and opinions of the people in the society (Burchell, Gordon, & Miller, 1991). Governmentality involves various technologies of power such as bio-power or bio-politics. Bio-political techniques are aimed at the collective or a social body as members of a biological species. Foucault began using the concept ‘bio-politics’ in the early 1970s, especially in his work on the history of social medicine and medicine in a

bio-political strategy. The demography of a population is determined by the birth rate, the death rate, age distribution, age pyramid, degree of morbidity and state of health. A population may perish or may, on the contrary, expand. The vital characteristics of human beings are that they are living creatures who are born, mature and inhabit a body that can be trained and augmented. The vital characteristic of a collective or population is that it is composed of living beings. The bio-politic is used as a strategy to solve the problems of collective human vitality, morbidity and mortality; over the means of knowledge, regimes of authority and practices of intervention that are desirable, legitimate and efficacious. The state governs the population through the technologies of self, as techniques that allow individuals to effect their own means to a certain number of operations on their own bodies, minds, souls and lifestyle. The bio-politic is related to social relation, and can be understood as an art of government (Dean, 2010). Following Foucault (1991), places such as army base, school and factory are the physical places that control human beings using social discipline and regulatory control, which are efficient systems, and can be used for punishment.

In the 18th century, the concept of governmentality was developed in the West. Foucault defined governmentality as a concept represented by institutions, but also procedures, analyses, reflections and tactics that allow the exercise of specific, albeit, complex forms of power with the target of a population. The techniques are used to provide a society with the feeling of economical, political and cultural well-being. Political economy is exercised at the level of the entire state, which means exercising towards its inhabitants and influences the wealth and behavior of each and all. To maintain a well ordered political economy, an essential technical use of the security apparatus gives people the illusion that they live happily in a society (Burchell, Gordon & Miller, 1991). Governmentality is an art of government that consists of various technologies and strategies, institutional procedures and knowledge, and might be altered according to the social relations between rulers and the population. In the 16th century, power played a major role in governmentality. Foucault identified three forms of government:

1. The juridical state and sovereignty: medieval states were based on customary law, written law and litigations, and were concerned with control over land and wealth. In the Middle Ages, the sovereign power was the right of a ruler to seize

things, time, bodies and ultimately the life of subjects, and was in the hands of religious organizations and/or the king.

2. The administrative state is the result of the processes of the juridical state, and is based on the disciplinary regulations of individual bodies in different institutional contexts. The underlying philosophy of the state is considered as an art or a technique whose powers are based on rational knowledge, wisdom and prudence rather than violence and threat. However, the state aims to use governmental technology associated with education, health, division of labor, administration and communication to influence the quality of life of the population. In general, government governs people as a collective body or social body and does not consider them as individuals.

3. The government of a state or governmentalized state, throughout the above describes developments that have gradually become governmentalized. The evolution was from a Medieval state, with the main objective to maintain its territory and keep an orderly society within this territory by simply imposing its laws upon its subjects, to the early renaissance era, which became more concerned with disposing of things arranged in a convenient way, and began to employ strategies and tactics to maintain a content and thus stable society, or in other words to render a society governable. The population is seen as depending on the environment constituted by the physical and economical elements of the state, which itself, in turn, depends upon the population. The state essentially has to take care of the population, employ various forms of governmental technologies such as governmentality and thus engage in techniques or ways of intervening in the common activities of individuals such as work, production, exchange of goods and accommodation. This is done to foster citizens' lives, understood as improved living, in such a way that their development also fosters the state's strength. Thus, in relation to these activities, the health and physical well-being of populations became a political objective, which the policy of the social body must ensure along economic regulations and the need for order. Statistics are one of the governmentality strategies that collect data on a population's birth rate, mortality and morbidity rate, illness, wealth and poverty, together with gender, age and race as well as health conditions and health behavior, and the flow of populations into certain regions or activities.

Foucault defines government more precisely, as “the conduct of conduct” and thus as a term which ranges from “governing itself” to “governing others”. To govern involves attempts to deliberate on and direct human conduct. To govern also signifies problems of self-control, guidance for the family and for children, management of the household and directing the soul, etc. Governmentality is a tactic of the government, to dynamic form and historically stabilizes societal power relations and the level of exercising political power (Burchell, Gordon, & Miller, 1991).

Governmentality is a term not only discussed in a political context but also in philosophical, religious, medical and academic texts. Governmental does not mean only the structures of political institutions or state structures, but denotes an ideology that presents the government as the origin of social relations. Governments employ governmentality techniques to manage and administrate aspects concerning communities, families, sick persons and the relationship between physicians and patients (Burchell, Gordon, & Miller, 1991). The formulation of policies and political action are supposed to be useful in order to meet the population’s needs in using the technologies of knowledge about health, political, economical and social relations.

Power and knowledge are insidiously related, because the exercise of powers is essentially based on knowledge, and the government employs power through governmentality methods and strategies. This involves political and social knowledge, and is based on narrative knowledge passed from one generation to the next. The populations engage in various political forms, such as anatomo-politics, which is the bio-power that concentrates on the human body, seeking to maximize its forces and integrate it into efficient systems, as an invisible power. The bio politics of the population, focusing on the species body, the body imbued with the mechanisms of life: birth, morbidity, mortality, longevity. The state exercises its power through communication routes, broadcasts to control individuals and social bodies on a micro level, and define the national policy on a macro level. Psychological and cultural aspects are employed as invisible power tools to control the social body.

Governmentality is the technique, art and theory that governments use to shape the population’s behavior according to a particular set of norms. Government involves efforts to deliberate on and direct human conduct using power and disciplinary actions. Governments exercise power through technologies of power that

imbued aspirations for the shaping of conduct in the hope of producing certain desired effects and averting certain undesired ones. Methods for this involve disciplinary actions, legislation and ethical norms. The daily activities of populations observe social discipline that defines norms of behavior and deviance. The individuals are made to behave in certain ways. Governments exercise their power using a variety of techniques; one of them allows individuals a certain number of actions and variations related to their bodies, minds, souls and lifestyle. This is thought to attain a certain state of happiness and good quality of life. Discipline produces docile bodies seen as something to be manipulated, shaped, trained and made to obey. It involves the micro-physics of power. The individual is subjected to a certain understanding and knowledge, and through this political technology the power to be creates the concept of psyche, personality and consciousness in order to enhance the physical efficiency. Discipline relies heavily on the means of correct training, including the techniques of hierarchical observation. The individuals are clearly visible to permit detailed control and to transform them. For example, the English philosopher Jeremy Bentham, is one of the foremost initiators in the reform of corrections and rehabilitation of prisoners. He designed the famous “panopticon” style prison: where the prisoner would have constant surveillance and their activities are continuously viewed by an inspector. The method of disciplinary power, as exercised by the administrative systems and social services consisting of surveillance and assessment no longer requires force or violence, as people, prisoners learned to discipline themselves and behave in the expected ways. In the 19th century, the most important benefit of Bentham's design was that his panopticon concept could be integrated into many social functions, including hospitals, schools, industrial factories and military barracks. The activities of individual inmates in these buildings were observed, and those observed made decisions to act according to what they believed to be good and suitable for them under the social disciplinary ideology.

Modern Western states integrated in their new political shape the old power technique that originated from Christian indoctrination. This technique to execute power can be called the pastoral power. It refers to the metaphor of the shepherd guiding his flock of sheep and it is applicable to the activities of a deity, king or leader. It also relates to the individualized kindness of the shepherd for whom each

and every one of the flock is the object of care and sustenance. The shepherd analogy used here, in order to describe the pastoral power, is exercised over a certain flock like the modern government that exercises power over the population rather than the territory. It is the shepherd, who cares about each member's thirst and hunger and keeps watch when his people are sleeping. This is comparable to the modern government that cares about health, security, welfare and efficiency of its population. The pastoral power should be understood as a conduct of conduct. The state's power is both an individualizing and a totalizing form of power, and that is one of the reasons for its strength. This form of power cannot be exercised without knowing the inside of people's minds, without exploring their souls and without making them reveal their innermost secrets (Foucault, 1982). The pastoral power as governmentality tactic governs the population with an individualizing and totalizing form of power. The individualizing form seemed to encourage the population to live and be concerned about their lives such as the reciprocal deeds. This totalizing form of government is likely to convince the population to think more about others and develop a conscience that affects the other's lives and safety within a social body (Anan Karnjanapan, 2009). Modern state makes use of governmentality techniques and discipline that is an important apparatus of micro power to control the population and their everyday life activities (Foucault, 1991). The modern state exercises the power using governmentality self-disciplined technology such as self-surveillance or care of the self, a sense of personal responsibility, in order to control the behavior of the population (Fox, 1993). Power is generally everywhere and comes from everywhere and the government has power to govern the population by using the various technologies of power as described above. Governmentality is concerned with analyzing opinion and the ways in which opinion operates through regimes of practices to produce truth. The government exercises medical power to produce truth about health and activity related to health in people's daily life in the macro social level through the relevant institutions such as health institutions that provide health education, Directly Observed Treatment (DOT) can help to treat tuberculosis early and effectively. It is the political power that finds its base within a medical form. People should follow the recommendations of the physician because if they do not they might have health

problems (Gastaldo, 1997). Foucault claims that to maintain power is to exercise the power and where there is power there is resistance against the power.

2.3. Neoliberalism

Neoliberalism became quite widespread around 1980 in some political and academic debates. Several authors have even suggested that neoliberalism is the dominant ideology shaping our world today and that we live in an age of neoliberalism (Thorsen & Lie, 2006). Neoliberalism is in the first instance a theory of political economic practices that proposes human well-being can best be advanced by liberating individual entrepreneurial freedoms and skills within an institutional framework characterized by strong private property rights, free markets and free trade. The role of the state is to create and preserve an institutional framework appropriate to such practices. The state has to guarantee, for example, the quality and integrity of money. It must also set up military defense, police, legal structures and functions required to secure private property rights and to guarantee, by force if needed, the proper functioning of markets. Furthermore, if markets do not readily exist in areas such as land, water, education, health care, social security or environmental pollution then they must be created, by state actions if necessary. Beyond these tasks the state should not venture. State interventions in markets once created must be kept to a bare minimum because, according to the theory, the state cannot possibly possess enough information to second-guess market signals prices and because powerful interest groups will inevitably distort and bias state interventions particularly in democracies for their own benefit (Harvey, 2005). The claim that neo-liberal ideas are enshrined in global rules and circulated by a set of global regulatory agencies such as the WTO, IMF and World Bank, which discipline states around the World, is sustained through an entrenched vocabulary of discourse and material practices (Harvey, 2005). The neoliberalism notion applies to the economic and political fields. Within this concept, more cooperation with international companies and business groups is desirable so that the power of neoliberalism, and by this wealth will increase (Thorsen & Lie, 2006).

Neoliberalism has been used to refer to a whole range of issues, outcomes and processes. To Ward and England (2007), there were four ways to approach this concept:

1. Neo-liberalism is recognized as an ideological and hegemonic project. This understanding refers to the political and cultural dominance that is exercised through the formation of class-based alliances-elite actors, institutions and other representatives of capital at a variety of spatial scales, who produce and circulate a coherent program of ideas and images about the world, its problems and how these are best solved. This is not to say that this view of the world is something imposed on the subordinate, but it is through the willing consent that these core constructs permeate common sense. For example, the rise and acceptance of the entrepreneurial city, at the forefront of rendering this space tautly business-like and competitive, is the expectation of the citizen to behave entrepreneurially and to identify themselves as responsible for their own successes but also failures.

2. Neoliberalism as a policy and program also refers to the transferring of power/responsibilities/regulations from the public to the private sector, with the concomitant redefinition of these categories. The policies and programs that illustrate this understanding are the ones related to deregulation, privatization, decentralization and liberalization. Again, the underpinning logic of these policies is that government is inefficient to regulate the economy and society; therefore, all the responsibilities should be transferred to the market.

3. Neoliberalism refers to a governmental form that could restructure the quantitatively and qualitatively nations or states, and is redrawing the boundaries between the civil society, the market and the state. Conceived from way, neoliberalism is “rolling back” on a market’s logics to accomplish the destruction of an entrenched welfare state as envisaged by Keynesian and his follower economic theories of John Maynard Keynes (1936). Keynesianism, as it is called, and the subsequent “roll out” of new policies and institutions and features workforce programs and penal systems to partnership-based modes of urban governance and community regeneration (Peck and Tickell, 2002 cited in Ward & England, 2007). Neoliberalism facilitates something important: a more stable sociopolitical infrastructure for neoliberal strategies of capital accumulation (Fourcade-Gourinchas & Babb, 2002 cited in Ward & England, 2007).

4. Neoliberalism can be seen as another form of governmentality in which relations among people are assembled and translated, to the effect of political management at a distance (Larner & Le Heron, 2002 cited in Ward & England, 2007). Both the economy and the state are involved in the construction of essential matters to a society of autonomous and 'responsibilized' "neo-liberal subjects" (Rose, 1996 cited in Ward & England, 2007). Through privatization and personalization, neo-liberal governmentality aims to transform recipients of welfare and social insurance into entrepreneurial subjects, who should be encouraged to become responsible for themselves. Such a project of transformation may be based either on a social model of helping, training and empowering, or on a police model of governing every aspect of life (Ren, 2005 cited in Ward & England, 2007).

Neoliberalism as a social phenomenon has been mainly developed through the reframing of Marxist concepts of class ideology and structural change, and the main issue appears to be identifying the scale of neoliberal progression and the appropriate scale of analysis (Ong, 2007; Ward & England, 2007). Neoliberalism as a creative tool has obviously entailed much destruction, not only of prior institutional frameworks and powers such as the supposed prior state sovereignty over political economic affairs but also of divisions of labor, social relations, welfare provisions, technological mixes, ways of life, attachments to the land, habits of the heart and ways of thought among others. So far, neo-liberalism values are marketed as an ethical value in itself, capable of acting as a guide to all human action, and substituting for all previously held ethical beliefs. It emphasizes the significance of contractual relations in the marketplace. It holds that the social good will be maximized by maximizing the reach and frequency of market transactions, and it seeks to bring all human action into the domain of the market. This requires technologies of information creation and capacities to accumulate, store, transfer, analyze and use massive databases to guide decisions in the global marketplace. Hence neoliberalism intense interest in and pursuit of information technologies; leading some to proclaim the emergence of a new kind of information society (Harvey, 2005). Neoliberal economic theories are based on efficient allocation of resources; the most important purpose of an economic system and the most efficient way to allocate resources goes through market mechanisms. Acts of intervention in the economy from government agencies are therefore almost

always undesirable, because intervention can undermine the logic of the marketplace, and thus reduce economic efficiency. The possibility of a self-regulating market is a core assumption in classical liberalism, and an important presumption among neoliberals as well (Munck, 2005 cited in Thorsen & Lie, 2006). In the period around the end of the 1960s, global capitalism was declining and the neo-liberalism emerged. Neoliberalism is an epoch-marking order that relies to the quasi-legal restructuring of relationships between nations and states and transnational agencies. Neoliberalism is a global set of rules and is accompanied by a hegemonic notion of inevitable progress and social hierarchy associated with market civilization (Gill, 1996; Comaroff and Comaroff, 2000 cited in Ong, 2007).

Neoliberalism has been viewed as capitalist machinery that is structuring a new planetary geography. However, the newness of the neo-liberalism word does not disguise the classic method of relying on old macro political distinctions. By now, we are familiar with the image of neo-liberalism as an economic tsunami that is gathering force across the planet, pummeling each country in its path and sweeping away old structures of power. This approach proceeds on the assumption that neo-liberalism is an ensemble of coordinates that will produce the same political results and social transformation everywhere (Ong, 2007). Neo-liberalism is involved in migration related to political, economic and special economic zones such as Golden Boten City (GBC) as a land concession across the Chinese border in northern Laos. The zone is near the Thai end of Route 3, the new road that links Thailand to China. The Golden Triangle Special Economic Zone, Luang Namtha and Huai Xai in northern Laos were in fact a trade route, connecting trading activities in the south of China with those in the northern part of Thailand. These are the Special Economic Zones (SEZs) and the special zones of the borderlands, in which investors have all the rights to invest (Lyttleton, 2011). However, neo-liberalism give people free will to chose and make a decision, but some people use their liberty in a negative way. An example is the attack of 9/11 in New York. Before the attacks, the relationship of the USA with countries in Central and East Asia was formerly concentrated on mainly economic aspects but since the 9/11 event, the foreign policy of the USA with Russia and countries in Central and East Asia has been focused more on the security issue. There has been new regulatory governance, defining disciplinary neo-liberalism and concentrating on

military power in order to win the war on terrorism (Jayasuriya, 2006). Through the immigration department, regulations and rules were enhanced and executed for security reasons. People who want to enter the USA are now being strictly checked.

The International Confederation of Temporary Work Businesses (CIETT) draws attention to the situation in the labor market in the 21st century by hinting towards the fact that temporary employment increased as well as the amount of migrant labor. Employers use flexible staffing arrangements to employ regularly part-time workers, short-term hires and on-call workers (Ward, 2007). More recently, Hardt and Negri had a closer look at the neoliberal North–embattled South model by updating structural Marxism through an infusion of Foucauldian-inflected notions of planetary regulations. They made the epochal claim that we are in a transition to systems of control spread by the deterritorialized flows of global markets (Hardt & Negri, 2000 cited in Ong, 2007). There is an emerging empire of globalized uniformity in labor regimes, creating laboring populations who are finally decontextualized as a placeless multitude. The very information and communicative tools that have been used to regulate them become weapons for the multitude as a counter-empire, arming them to demand global citizenship in capitalism’s empire (Ong, 2007). In addition to neoliberalism being a technology of governing free subjects that co-exists with other political rationalities. Neo-liberalism is viewed as a dominant structural condition that projects totalizing social change across a nation. As a determining set of economic relationships, Neoliberal transformations in all domains and produces an all encompassing condition are under the hegemony of unfettered markets. In Great Britain and other advanced liberal nations, neoliberalism has been defined as a mode of governing through freedom that requires people to be free and self-managing in different spheres of everyday life: health, education, bureaucracy and the professions, etc (Ross, 1999 cited in Ong, 2007). If globalization involves the international expansion of markets and market relations and the global pursuit of economic liberalism, a central factor in these processes has been the commoditization of human labor. It has been argued that globalization assembles an increasing proportion of the World’s population directly into capitalist labor markets and fastens national and regional labor markets into transnational labor regimes. The arsenals of changes, administrative, institutional, political and economic that underwrite this process have

been variously termed as the “neoliberal turn”. Neo-liberal global interventions mark a shift in the management of populations and the administration of spaces in that they appear as nonpolitical and non-ideological problem-solving projects, driven purely by market calculations. Yet, new alignments of sovereign rule, market rationality and regimes of citizenship have emerged as a result of these processes in the last 25 years that have had a profound impact on social life.

The above developments might be understood and discussed as the new conditions of international migration. In particular, conditions focus on contemporary welfare and labor regimes, claims on citizenship rights, immigration rules, public debates, interethnic and racial experiences and controlling individuals bodies, subjectivities, social life, health and labor. Anthropologists also focus on the institutions, practices and ideologies that immigrants themselves employ to organize their lives before and after migration. A variety of ethnographic research is done, with the aim to provide a more grounded theoretical and empirical perspective on the contemporary conditions within which human mobility occurs. Topics discussed include, but are not limited to, transnationalism, the recuperation of overseas populations into a cultural nationalist framework, the questions of borderlands and movement across borders, undocumented migration, refugees, global reproductive labor and human trafficking. We aim to work out an approach to migration, informed by humanity and rights of the poor. Previous studies investigated political, economic and changes in the law in Zimbabwe. The mobility of people in and out of Zimbabwe predates artificial colonial borders imposed by the colonialists such that even after the establishment of these borders people tended to ignore them as they continued to visit their relatives in other areas. Therefore, the mobility of people across borders whether for political, economic or social reasons is as old as the borders themselves. Zimbabwean migration to South Africa became popular in the colonial era when Zimbabweans migrated to South African mines, plantations and farms. The motivation for migration tended to be socio-economical and political. These Zimbabwean migrants were not included into the South African community and they remained non-South Africans in isolated communities. In the post colonial era, Zimbabwean migration continued due to a number of political reasons such as the purging of the Ndebele between 1980 and 1986, social reasons such as economic pressures caused by

inflation and unemployment. Again, there were no formal ways of including these non-South Africans into the labor market, especially not the undocumented migrants, who tended to be the majority. The response by the South African State to such migration tended to be to arrests and deporting the migrants. A change in the South African policy towards Zimbabwean migration came partly as a result of the increase in Zimbabwean migration and the futility of its practice of deportations. Zimbabwean migration has had great social implications and caused congestion in institutions of health, housing and employment. Most Zimbabweans traveled to South Africa as illegal undocumented migrants. Employers take advantage of the illegality of Zimbabwean migrants and other foreign nationals by paying them lower wages as these workers cannot negotiate for better working conditions and remunerations for fear of being deported by the authorities. In terms of housing and other social amenities, Zimbabweans face harsh conditions of overcrowding, lack of privacy and living in shacks in informal settlements that are dirty, without water and electricity. The poor Zimbabweans face social exclusion in two main ways: marginalisation (through unemployment) and segregation (in terms of their residential areas where, without formal documents, one cannot have access to formal housing). Zimbabweans also face inequality and discrimination in health and educational institutions (Rutherford, 2011).

The topic of this study relates to the health of people in communities and their access to health care providers. The health provider might be home care nurses or Community Care Access Centers (CCACs) such as in the Canadian province of Ontario. The CCAC as a governance structure was first implemented in 1996 as part of a new system for administering and delivering home care in the province. The CCACs are now implemented in 43 regional organizations and govern the delivery of home care services and admissions to long-term care facilities. The restructuring of home care was introduced as part of a wider set of neo-liberal-oriented social policy changes in the mid-1990s by the then recently elected conservative provincial government. These CCACs were organized around the market-oriented logic of managed competition, a popular transnational health policy reform (Larner, 2000; Peck & Tickell, 2002 cited in England, Eakin, Gastaldo, & McKeever, 2007). According to Ong (2007), neo-liberalism is conceptualized not as a fixed set of

attributes with predetermined outcomes, but as the logic of governing that migrates and is selectively taken up in diverse political contexts.

The aim of this study is to investigate the Burmese labor migrants who are ill with tuberculosis, and their working and daily life before and after migration. The Thai medical health system must relate to a migrant's health, to the culture and beliefs of the migrants in the new environment.

2.4. Illness experiences

It is accepted that there is a difference in the understanding of health and disease between professionals and lay people; however, an ethnographic approach focused on lay people with health problems serves to shift the attention from the healthcare provider's perspective to the sufferers who, after all, experience their illness. Kleinman (1980) promoted the separation of lay and professional models related to the perception of illness and disease. Illness represents the subjective, lived experience of the sufferer while disease is the understanding of the expert that is biomedically oriented and depicts a technical malfunction of the body's processes. The term sickness is associated with the people and macro social structures such as economic, politic and institutions (Kleinman, 1986).

Everyday ways of thinking about health and illness are dynamic, construed from personal experience, the attitudes of members of the family and social networks, formal education, history, popular discourse and so on: they are culturally informed. Attitudes to health potentially trigger decisions to seek help towards a timely diagnosis, affect interactions with health providers and adherence to treatment regimens as well as satisfaction with the medical management of sickness episodes. The individual perspectives of illness often come from, or are influenced by local cultural systems (Kleinman, 1988).

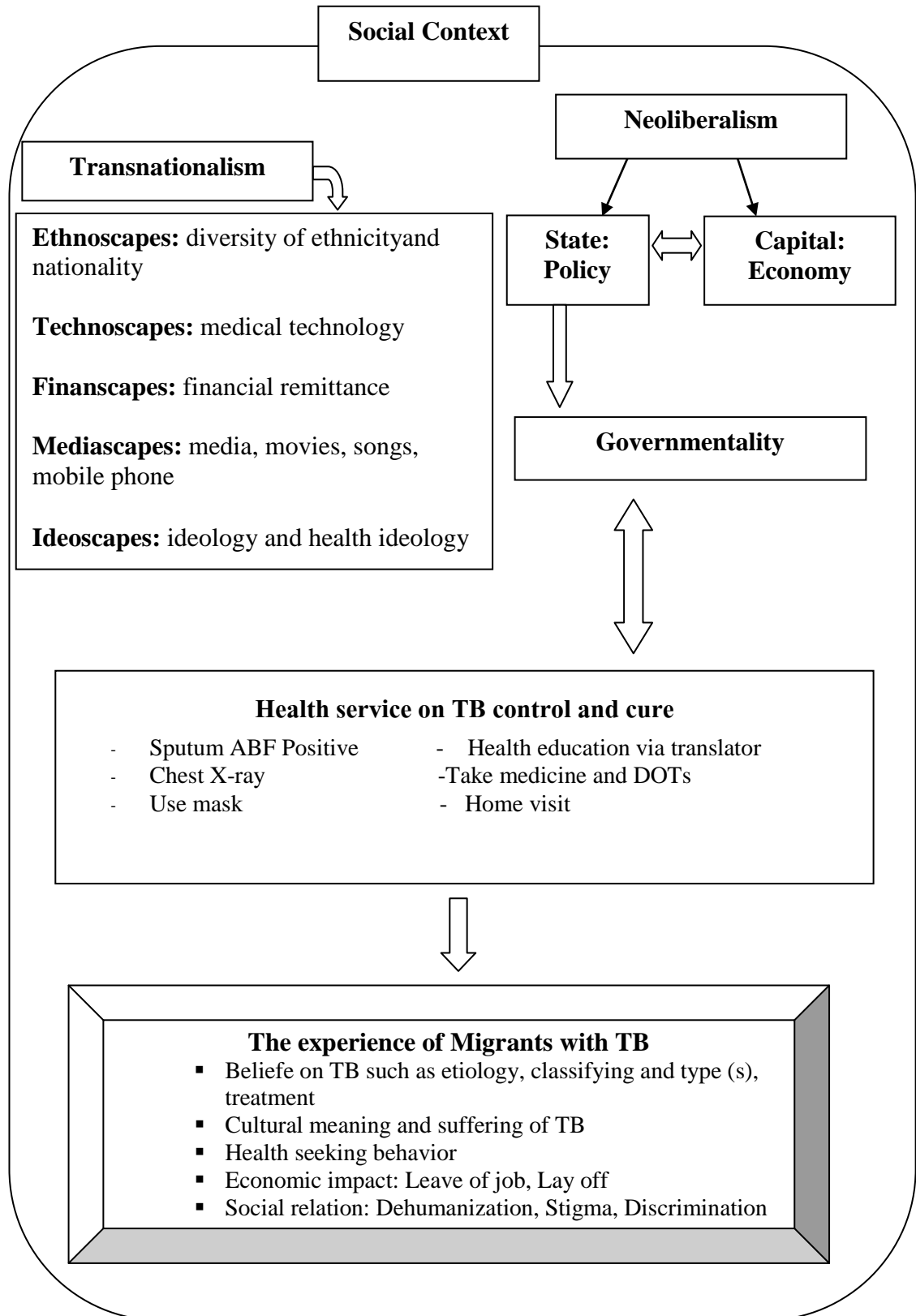
The illness narrative discloses that a lay person's (sick person) lived experience with suffering is associated with physical illness and daily life activities; besides that, the cultural form and social structure dominate the stance of people in the community in an everyday way towards the individual sick person (Apinya Fuengfusakul, 2003). Various studies focus on illness and healing of sick persons as

the cultural event. The patient reveals his/her expression concerning the suffering of being sick through the illness narrative. The cultural resources, symbols and modes of experience also influence the way in which stories are told. Lived experience and narrative also have a close relationship, the very nature, or art, of a good story is “its capacity of dramatically transform lived experience”. Through narrative, images of self these stories are conveyed and negotiated with others. Narratives are created intersubjectively and express shared meaning between the narrator and the interlocutor. Narrative is a fundamental human way of giving meaning to experience and constructing the reality (Garro & Mattingly, 2000).

The type of illness, either acute or chronic, involves the length of suffering, the impact on one’s life, and the extent to which the illness necessitates significant life changes. The illness narrative disclosed within subjective stories is that some patients remain silent when suffering. Serious chronic illness presents an intriguing case for social scientists to study disclosures within subjective stories, and their absence. Such silences often reflect the meaning that by having a chronic illness the patient feels that he or she is somehow removed as a full member from society (Charmaz, 2009). Stories of and silences about sickness hold promise for exploring narrative meaning, temporal duration and sequence and reconstruction of self after overcoming the disease. Illness is associated with suffering and pain. There is a need to explain to ill people and their families the nature of the illness and the treatment process. It is also necessary that the physician is aware about the perception of lay people toward their illness. Kleinman developed the concept of the “explanatory models”, the notions about an episode of sickness and its treatment. The “explanatory models” should be employed by all those involved in the clinical process of caring for patients. Explanatory models are linked with mental illnesses, which is due to the efforts of cross-cultural psychiatrists and anthropologists. The framework of the explanatory model emerged from anthropological fieldwork in China and Taiwan, and identified differences in the conceptualization of mental illness between eastern and western cultures. The understanding of professionals and laymen about the illness were rarely matched. Health professionals need to explore how their patients understand the nature of their illness so that the professionals are effective in providing care. Clinicians could gain much insight into lay peoples’ perceptions of the

pathophysiology of a disease, time and mode of onset of the symptoms, the course of the sickness, its etiology and treatment by exploring their clients' explanatory model (Kleinman, 1980). There is considerable evidence from medical anthropology suggesting that illness explanatory frameworks differ profoundly both within and across cultures.

2.5 Conceptual Framework



CHAPTER III

RESEARCH METHODOLOGY

This research is qualitative research including the four concepts of transnationalism, governmentality, neoliberalism and illness experience. It aims to answer the research's question about how Burma migrant workers who suffer from tuberculosis cope with the cross-border context that operates under the control and management of tuberculosis treatment. The research question is divided into the following sub-questions:

1. When they suffer from tuberculosis, how do they encounter the illness, how to explain the illness, how to search for treatment, how they live across the border with the illness.
2. How the Thai government performs the management and control of tuberculosis treatment and how the performance affects the illness and treatment of Burma workers.
3. How Burma migrant workers who suffer from tuberculosis negotiate with management and the control system of the Thai government under the cross-border context.

3.1 Methodology

This research uses ethnography, which is at the heart of the study of anthropology. Ethnography means the recording of the stories of people in which the people create meaning of things and the researcher includes the interpretation of the participant (Goldbart & Hustler, 2005). Cultural differences between the researcher and participants might cause the researcher not to access the world of the participants seamlessly. The researcher should choose to use the ethnography research method with the rear modern idea that a "true" or stories that portray things "created" comes from when the researcher and participants cooperate. It empowers the participants who are

“migrants” by writing the report, the researcher comes up with their own message; therefore, the role of describing is the role of the researcher and not the participants (Suchada Taweessit, 2006).

This research uses ethnography in the Sinsamut area and migrant tuberculosis patients who are empowered to manage the biomedical control in their lives. The researcher has studied tuberculosis as a contagious disease and the health service as a part of the medical culture in order to reflect the experience of the patients in their daily activities (Atkinson, 1988), including medical acceptance, bargain and resistance against the culture under the complex and unfair social structure in Thailand. The researcher used postmodern ethnography for study and data analysis, and used qualitative methods to study the anthropology as the key tool by the researcher observing and making detailed notes to understand the conditions and context of migrant workers living in the study area. The researcher observed and interview in both formal and informal settings through various activities such as at the tuberculosis clinic area, patient home visiting and DOT, then selected participants such as migrant tuberculosis patients, providers in the tuberculosis clinic, migrant health volunteers and the tuberculosis patients’ families in order to conduct in-depth interviews.

The researcher performed data collection through:

1. In depth interviews
2. Participant observation
3. Talking about daily activities in the community where the patients live
4. Interviews with key informants
5. Recording fieldwork.

The researcher spent many hours conducting fieldwork during March-May 2012 starting from Sinsamut Hospital using the observation method without participating in the tuberculosis clinic, which is the hospital’s regular program during Thursday afternoons. The researcher discussed and became familiar with the migrant workers who were suffers of tuberculosis and requested to visit the patient’s home. When the researcher entered the community of the tuberculosis patient interviews were conducted not only with the patient but also caregivers and neighbors in the vicinity to confirm the validity of information obtained from different sources. The

participants recruited in this study were both legal and illegal migrants. The diagnosis of tuberculosis included 2 parts.

Part 1) Study in one tuberculosis clinic to gather information by using in-depth interviews with migrant workers who come to the tuberculosis clinic. Both men and women were included in the interviews with service providers, doctors, nurses, pharmacists, clinicians and foreign health workers.

Part 2) Study of migrant tuberculosis patient communities including residential and office (when still working) by interviewing family members, neighbors, colleagues of the tuberculosis patient, employer and DOT watcher.

3.2 Fieldwork Study

This study used a health facility or hospital as the major area for research. The researcher selected Sinsamut Hospital, which has a clinic for providing tuberculosis treatment every Thursday afternoon and activities during a meeting of a group of migrant tuberculosis patients on the same day in the morning.

The researcher selected Tambol Mahachai as the study area by selecting tuberculosis patients who live or work in one Tambol in Amphur Sinsamut in order to reflect the interaction between the service provider at the hospital, the tuberculosis patient and citizens in that area. This area is an area with a lot of ethnic diversity. The community developed with fishing as the main source of employment more than one hundred years ago with the migration of people from many nations, who spoke many languages. In the earlier era, Chinese had settled since the reign of King Rama V and also evacuation of Mon from Ratchaburi. In addition, this field became an industrial area with a lot of workers from the Northeastern area. However, at present, there are many migrants from Burma and this area has started to overlap with varieties of semi-rural, semi-urban areas and diverse cultural, language, religion and ethnicity as well as areas that are appropriate in the context of a cross cultural border (Transnationalism). The study of the flow of culture across a country has five dimensions according to the concept of Appadurai, which are ethnoscapes, mediascapes, technoscapes, finanscapes and ideascapes that show there are no clear boundaries for the area of cultural flow and were contracted to come up with the influence of globalization. Including the

study of adaptation and creating a new identity hybrid with conflict between migrant rebels against the government and private sector including tuberculosis patients in order to follow the power and knowledge to the public and private sector.

There were Global Found Round 8 and Round 10 activities in the Sinsamut area between migrant tuberculosis patients that were enforced by the government and private sector which show the intensity of the treatment by insisting in DOT and providing transportation expense to both patients and volunteers who make DOT to patients in the community.

3.3 Entry into the fieldwork

Due to the researcher having worked with Sinsamut Hospital since 2005 promoting AIDS Prevention Among Migrant Workers in Thailand, the researcher is familiar with the leader of the PCU and the department responsible for the health of migrant workers directly. Entering into the field of research should be introduced and allowed by the gatekeeper (Burgess, 1991; Lofland & Lofland, 1995 cited in Shaffir, 1998). The head of the PCU is the gatekeeper in this study. At present, there is a group of tuberculosis patients under the project 'strengthening tuberculosis quality among disadvantaged population groups and community empowerment to tuberculosis' operated by the NGO foundation. The main reason for choosing Sinsamut Hospital was that the researcher was familiar with the staff and volunteers in the project. It enabled the researcher to build a relationship quickly and gain trust from participants.

3.4 Participants

This research studied the issue of tuberculosis illness experiences of migrant workers from Burma, their daily lives, management of patients and opposition to negotiate with the health care system in the treatment of tuberculosis patients. The researcher chose specific participants who were migrants from Burma, suffered from tuberculosis and obtained service at the Sinsamut hospital. The researcher selected 13 participants (10 women and 3 men) as follows:

1. Suffer of tuberculosis illness

2. Treated in Sinsamut hospital and came from Burma
3. Treated for a period of at least two months
4. Living in Thailand for more than 2 years
5. May or may not be eligible for workers' health insurance, researcher

will study the data of both groups.

6. Patients should be able to communicate in Thai language because the study of a vulnerable population may be faced with limitations in language (Fisher & Ragsdale, 2006).

The researcher conducted formal and informal interviews as well as participant observation. The concepts and theories have already been defined. The issue in this study is a sensitive issue and may have an impact with the participant; therefore, it is necessary to maintain the confidentiality of the participants. At first when the researcher met the participant at the tuberculosis clinic of Sinsamut hospital, the researcher introduced themselves as a PhD student from the Faculty of Social Sciences and Humanities at Mahidol University. Then the researcher described the purpose, study method and other details of the study to the participants. After consent, the researcher may then visit the participant's home at the participant's convenience in order to get to know the place where the participant lives, family members and the community. Then, there should be another appointment with the participant depending on the availability and convenience of participants. The researcher builds a relationship by participating in various activities in the daily lives of the participants, including regular visits to the tuberculosis clinic in order to observe the treatment of the migrant tuberculosis patient. Understanding the issues also required data from the people who were involved with taking care of the 13 tuberculosis patients. This was done by conducting interviews with 4 clinic providers, 2 drug observations, 2 family members who take care of the patient, 3 community members and 2 colleagues.

3.5 Validity

Validity is important in qualitative research because the sample number is low.

3.5.1 Rapport and trust

After the researcher creates an intimate familiarity with the migrants who come to the tuberculosis clinic by asking about the symptoms, talks to them friendly and facilitate the use of hospital services such as helping them to make payment, coordinating with NGOs for refunding the expense about sputum and transportation, etc.

In this step, the researcher shall selected participants who have a lot of information, then introduce themselves as a student doing a thesis, explaining the objectives and expected benefits of the research. Then request an appointment for in-depth interviews at the convenience of the participants, including emphasis on the issue of confidentiality. Whether the participant rejects or accepts the research, there will be no impact in terms of service at the hospital.

3.5.2 Triangulation

- Investigator triangulation of migrants, hospital staff, volunteer workers and neighbors.
- Data triangulation is from the file of patient data.
- Methodological triangulation is in-depth interviews, observation both with participation and without participation.

Reflexivity is a feeling, emotion and personal opinion of the researcher that occur during the fieldwork, which may affect the interpretation of the data in that period of time.

In this study, the researcher recorded the field thoroughly included physical environment, facial expression of participants, reaction of people associated with the participants and researcher as well as the opinions of the researcher at that moment of time during the fieldwork (Pollner& Emerson, 2007). To review the data and may lead to modification to access the information more easily (Chai Bodhisita, 2004) and the researcher may use this data as a reference or to recheck at any time.

3.6 Unit of analysis

The main unit of analysis education is at the individual level or the migrant worker who suffers from tuberculosis, but that analysis is closely linked to the structural level analysis. This is whether the relationship between participants and providers of health services as well as national and international health policies affect the lives of migrants including a cultural context, social context, family, friends, relative or the community that the tuberculosis migrant is living in.

3.7 Analysis and data presentation

The researcher analyzed the data during data collection in the field by estimating that the information was complete enough to answer the problem of the research or not, to prevent spending time during the fieldwork collecting incomplete data and then trying to understand it preliminary through analysis of the data.

The researcher used data obtained from the field such as participant observation, in-depth interviews and informal discussions with participants. All the collected data was input into a data management system to process the data.

The researcher analyzed the data to characterize the main questions and sub-question, and then interpreted the data by the definitions from existing data about how to answer the questions based on the context of community life and transnational migration. This was done to understand the behavior of different communities and explain the reason by linking the relationships between information in a logical manner to understand events and behaviors that occurred. This research analyzes the experiences of migrants who were tuberculosis suffers by using theoretical perspectives including illness experience, governmentality and neoliberalism under the context of cross-border and cross-border circulation of five dimensions that are ethnoscapes, mediascapes, technoscapes, finanscapes and ideascapes.

3.8 Ethical consideration

Before proceeding with the research, the researcher's proposed protocol had to be certified and approved by the Committee for Research Ethics, Social Sciences, Mahidol University (MU-SSIRB). In addition, the researcher had already obtained the training in human research ethics arranged by Mahidol University.

The researcher conducted extensive research to ensure compliance and to protect against damage that can occur as a primary key of participants by explaining the objectives, research methods and the benefits that will result from this research. Then, keeping the data of the participants confidential and not using identifying information that can be used to trace the participants by using pseudonyms.

When the participants accepted the interview, the researchers requested that the participants sign a consent form. During the discussion, the researcher must be careful with sensitive issues or to implicate other parties. The researcher has to talk in a private area and be careful in small communities with confidentiality and tracking information (Fisher & Ragsdale, 2006). The researcher realized that the stories associated with this research are subject to privacy and sensitivity, which may have affected the performance, family relationships and community. Therefore, the confidentiality of participants is extremely important. For the above reason, the researcher conducted interviews with people who already knew the participant's illness.

In addition, to understand the emotions, thoughts, beliefs of the participants, acceptance and to respect cultural norms of the participants is important (Mohatt & Thomas, 2006). Therefore, the researcher should not blame or judge the behavior of the participants but be open minded to listen and learn with the participants. During this study, the researchers focused on participants who are like teachers of the researcher who was a PhD student, Faculty of Medical Social Sciences, Mahidol University that had to learn their everyday life and explain the purpose and benefits expected to be derived from the research. Upon completion of the study, the researcher used the data to write a thesis that is part of a doctoral degree. During this, the information was kept confidential so as not to impact the family and community of the participants by using a pseudonym. After processing, analysis and report writing has been completed, all documents will be destroyed.

CHAPTER IV

LIFE CONTEXT OF MIGRANT WORKERS

This chapter describes the unstable territories and cultural fluidity in various dimensions, including the ideological belief of the new and old house, in which the migrant labors have created the "Transnational space" (social relations in our globalizing world are increasingly stretched out across the borders of two or more nation-states). This has been done through cultural fluidity in five dimensions: ethnoscape, finanscape, mediascape, technoscape and ideoscape. The researcher interviewed 13 Burmese migrant workers (10 female and 3 male) who were tuberculosis (TB) sufferers, the age group of the participants was 22-55 years old. There were eight "Mon" people (the Mon are an ethnic group from Burma), their names are Zin, Kyaw, Phyu, Sheuc, Myo, SanDar, Aye, Htabe and Than, two Karen people called Bo and Moc, one Shan/Tai called Tun and one Burmese called Khaing. Their duration of residence in Thailand was between 2- 30 years. They were employed in large industrial plants, such as alumina and sea processing plants producing fish & chips, fish balls, sweet fish and frozen food. Some worked in small plants making shoes and petrol tanks, for example. Others labor are at shrimp and fisheries. One person in this group is a laborer and another person does not work due to visiting her son. Out of the 13 migrant labors only five people have passport, six labors were smuggling illegally and two labors have the illegal migrant registration card (form Tor Ro 38/1). Therefore, seven labors have the right to healthcare and five labors (who do not have a passport and illegal migrant registration card) have no health insurance rights, but they will have help from the special project founded by the Global Fund. There is only one person who has to pay for the medical treatment by themselves.

4.1 Ethnoscapes

4.1.1 Entry of migrants: Political refugees and those want a better chance in life

Migration from Burma to Thailand has been happening for a long time. Burmese migrant labors come to work in Thailand with the hope of seeking better opportunities in their lives; for both economic and political reasons that caused some people to be refugees from war in their country. Some come to earn money to send back to their hometown, where they used their saved money, the money from the sale of their assets or loans to come to work at Sinsamut city, although this journey to work is quite expensive, the cost is a starting investment.

“Phyu” has imaged Thailand since childhood from her mother and Thai series, so she is committed to working and making money in Thailand. Her mother did not allow her to work in Thailand because she is a woman, fear of harm and no one protects her. Most women tend to travel with their family or relatives. Then after "Phyu" married, she persuaded her husband to go to work in Thailand together.

The journey of migrants is largely illegal immigration, there people have been contacted by the Labor agency in Thailand and they travel together as a group. A couple might be contacted by their relatives in the country beforehand. Some people take several days to travel because they live in rural areas, some walk over the border into Thailand and some work in the border provinces of Thailand. Then they move into Sinsamut city, mostly for people from Burma their destination is Sinsamut city.

Everyone must pay for the transport to take them to Thailand. Some sold their cattle. Such cattle paid for the travelling cost that was about 15,000 to 20,000 Baht per person. Some people borrow money from a neighbor who had come to work. Then in the case of Kyaw who arrived with his wife to work in a sweet fish factory in Thailand, the travelling cost was 30,000 Baht. They have been paying this cost in installments to the labor agency for almost two years, the contingent liabilities arising from this travel is a long time payment that means some labors must work hard to earn money but do not use his money because they need to send money home to pay for the travel expenses. Some migrants say that they can use their own money to pay a debt and they must wait to clear these debts.

Many of the migrants were forced to come because of warfare between the Burma government and the ethnic minorities. Some people came to Thailand when they were a child because they lived in Burma on the border and they had to flee to save their lives. Nowadays, some people who became migrant labors live as statelessness people because they do not have any evidence. Some people are lucky as they can read and write the languages of Thailand and Burma. They have learned the news from other Burma migrants and have been proven and accepted to have Burma citizenship. “Win” from the Mon people, is a minority who has been exploited in many difference aspects, his father was killed by soldiers and his sister was lost in the war while Win escaped from the war and the genocide and fled into Thailand 30 years ago.

Other migrants have the same bad experiences, such as being forced to work and having money extorted. They were punished if they fled from the arrested to be slave labor. SanDar told that for men from an ethnic group, it is difficult living in Burma. Sometimes their money and property was taken by soldiers, some were captured to do hard work such as digging roads or railroad in the strong sunlight. There are some people who decided to run away. It is only with luck they can escape. Unfortunately, if the soldiers captured them they would be severely punished. The men of the various ethnicities cannot stay in their home and they fled to work in Thailand.

During their trip they found hardship and things cost more when travelling. Some people have the relative that works in Thailand or some people come to Thailand through the labor agency.

It is not easy when coming into the other country because they must hide from Thai authorities at the border areas, due to the stringent control of the trans-boundary movement by the authorities.

4.1.2 Living conditions in their new house: Housing and slums

In their new area and the living conditions, they met Thai and Burmese, who came into Thailand the same as they did, but they are diverse ethnic groups, such as Mon, Dawei, Tai, Karen and Burmese. The migrant labors live with their ethnic group.

The migrants have relatives or acquaintances who have come to work or they are working in Thailand. These individuals are the vital lifelines linking the labors from Burma into Thailand. Khaing was invited to work in Thailand by his brother who worked in a factory at the Wat Ket area. Khaing met his wife, works and lives at a temple.

He did not stay in the community with the other labors as the pastor permitted him to live in the temple and his house is a two storey buildings, but the downstairs cannot be lived in due to it being decayed. So the labors live as one family per a room. Some rooms have a large chalkboard mounted on the wall indicating that this place used to be a school before. Khaing lives with five families of migrant labors at this temple, while most migrant labors are in a community that is massive and close to the workplaces because it is easy to go to work.

The shrimp market is not safe because there are a lot of illegal labors. This is the warning from the authorities. There are a lot of illegal labors, there could be a problem for the safety of the researcher, however, this community has been chosen to be studied by the researcher because it has many migrant labors that work and live together. This community is adjacent to a highway through the Southern of Thailand. The front of the site is a shrimp and seafood market for the middlemen; this place has been divided into many blocks, each block has a sign at the front. Some shops also have their phone number and the truck drives off most of the time. A man is putting some ice into a basket that has shrimps almost full, he does not wear gloves and is pale because of the cold. Some labors drive a pickup truck to collect the large trays with the frozen shrimp into 6-wheel trucks, also male and female labors sit together on the cement floor peeling the shrimp energetically.

Next to the block store in front of the shrimp market there is a commercial building, four rows of three Soi for a small road in and out for the trucks to buy the seafood at this market. Downstairs is a grocery store, Burmese food store, shop carte, Blog for selling the seafood and the inventory lock for the front of the seafood market. On the 2nd to 4th floors are rooms for the labors; at the rear is a supermarket that sells goods from Burma. The area behind the building becomes a cockpit on Sundays.

There is also a community with many migrant labors at "Wat Tuek" that is a community that needs to cross the railway or ferry to Sinsamut city. When arriving at one corner it is called Wat Tuek.

The researcher and research assistants go to a house is a small grocery store near the temple in the alley. I met a woman; her face was painted with a thin pale yellow powder. We walked into the alley behind the house, there is a grocery at this area and it is covered with low and high cement, not always the same. There are four rows of single rented rooms, in front of the room there is a channel and faucets. Some rooms have a water jar and sink to contain some water, At the end of these rented rooms are six bathrooms.

Five bathrooms are locked with keys. The middle one the researcher opens to view the condition of the toilet, which is stained dark brown fully. Next to the bathroom is a large rectangular cement pond with some muddy brown water in half of pond, a young woman wearing a sarong is washing her hair beside the pond. One side of these rented rooms has a small rectangle cement pond that is very low but the water is almost full and it is used for bathing as well. Some people put water in a jar in front of the room for convince. The condition of this rented room is known as "a public bathroom" because they use the bathroom and water pond together. Each room is about 3 X 4 meters, which is often staying with friends or family. Opening the door there is a kitchen area with stove, pans and cookware, and nearby an area for sleeping. Some rooms have a cupboard or shelf in the middle of the room to divide this area into two sections for a private area. The charge is around 1,000 Baht per month – the averaged cost of the amount of power used is 500-1,000 Baht per month.

For a rented room with a bathroom, but without furniture, that is not too small, about 4 x 5 meters, a bathroom in the corner, the opening to the back room has a sewer and wastewater and the window glass is louvers without the mosquito wire screen, the rented room price is 1,500 Baht per month excluding cost of utilities.

Some labors live together in a large house, for example, SanDar's rented house. It has two floors, downstairs the floor is cement, upstairs is a wooden and with a galvanized iron roof. There are 9 people living here and they share the rent and cost of utilities, the women live together at one side of the upstairs in an area where the size is 3x3 meters. One side is a residence for one family, SanDar lives in the rest of the

area about 1x2 meters with the women. This area does not have a window but it is not hot in the night and she is pleased here as she can turn on the fan and relax when it is a holiday. In the middle of the house there is a television, the other room has four women. Downstairs is the laundry, cooking and living place of two men. In their house they have two refrigerators, which contain food bought from the market during the holidays, near the refrigerator there is a 1x1 meter wooden table with five rice cookers, one for each family.

A Burmese woman holds a blue 5-Tier Tiffin plastic food carrier with a spoon packed at the side of the Tiffin carrier. She holds the hands of a boy and girl, and is painting her face with the thin yellow powder using one hand. The children wear a uniform, like for Thai school. They wait for a pickup to take them to school. The driver looks nice and kind with the kids, he rushes to get the bag and sets the seats in his car for the children. Their mother pays 300 Baht per month per person for the shuttle cost.

4.1.3 Daily life: Work uniform and schedule time

In the area for the four women (room size 3 X 3 m) I am lying alone (in the niche between the passages, width less than 1 meter). It has no window (it is bad to have no windows, it is not airy) but is cool and comfortable (the house is roofed with corrugated iron and is very hot at noon). They sleep well lying in the dark (at night) it is not hot.

Many refrigerated trucks pass this way, the labors wear a blue or white uniform with hats and boots, they sit together as a group at the appointed place to wait for a shuttle to pick them up, some plants have free shuttle. Some plants have a charge every two weeks of about 300-500 baht by deducting it from the compensation.

From 4 to 6 a.m, the labors start to go to work, some labors dress in the factory uniform: shirt, pants and a hat in one hand. They also hold the Tiffin food or plastic bags for personal use in one hand. Some factories force the labors to wear white pants with plain shirts and they must arrive at the plant at least 30 minutes before working time for changing their dress to wear the factory uniform all day.

Most labors have to wake up early to prepare breakfast and lunch for themselves and the family members, but some people do not eat breakfast due to

drinking coffee at the factory shop before lunch in work. Then they dispersed to their own departments, known as "line". These migrant labors need to adapt themselves to work in a shift system.

Although labor law protection sets working hours at 8 per day, included rest time, and labors in an industrial factory should not work over 48 hours per a week, in reality, most labors work 12 hours per day that is split to night and day shifts and have one holiday per week. They get a wage per day and overtime pay by law. In some of the smaller factories the labors get a lower wage. Some large plants provide funds for labors who work during the night shift called "the sleepy cost" of 20 Baht per night. A long work time had to switch to two parts of each shift. Coffee is favored by some migrant labors for refreshment and waking up during work. Some labors drink four coffee packs per day, coffee replaces the "betel nut" snack that is favored for migrant labors, both men and woman, who come from Burma. Eating "Maak" in Thailand was seen as backward and dirty, so eating "Maak" is prohibited in the working area and it is against the factory's rules. The relationship between the migrant labors with Thai labor or boss is to sometimes exploit the Burmese labor. The Burmese labors are ordered by the leader to work more than Thai labors who finish their work at the clock out time and they do not work overtime, or the Thai labors are elevated to the supervisor or the clerk, but the Burmese labors have less chance.

There is also another group of labors who have uncertain working time, such as the labor at the jetty who work at the stake trap or place for the shelled shrimp/fish, which starts as soon as the boat arrives at the jetty. They spent 3-5 days to transport the fish in each boat, sometimes he has to work until two a.m. and work again in the morning. They work for several hours to unload the fish from the boat or to transport the fish to the truck, some months have 3-4 boats, the labors use drugs such as amphetamines and alcohol for they are still working round the clock. The labors at the place for the shelled shrimp/fish or small plants that are family affairs often have uncertain work, some people do not have a holiday. When these labors are absent from work they will rest or eat betel that is very easy to find at the jetty.

Migrant labors are always hired to do the 3 D that is "work hard, dirty and dangerous" as the male labors are hired to do mostly, such as Win who is working in a melting scrap aluminum factory. He has worked here for 4 years. There is no Thai

labor at this factory because the labor must work at the high temperatures all the time, in the past the factory had three burners but now the factory has two burners that are open 24 hours. They use a gas head with a size that is equal two fan headers to melt aluminum and use a ton of gas to melt it each day. Male labor is in front of the burner at the melting temperatures of up to 700 to 800 degrees Fahrenheit. They wear the high temperature protective suit and glasses mask but it is not standard equipment, it is a plastic mask, when exposed to heat from the furnace it is already shrinking deforming. When working, they need to venting of the liquid nitrogen into the furnace, if aluminum splashes out his clothes and skin are burned, all labors have these experiences. He showed large scars on his stomach, arm and forehead. During the rainy season he was scared due to the blow up of aluminum in the furnace that could be heard in his camp that is around 500 meters from the plant.

Although Burma employees are aware of the dangers to themselves and their colleagues from the aluminum blow up, they are patients when working in front of the tube furnace that has a very high temperature. They ask for safety equipment for their work, but are ignored on this issue. In the case of Win, he has called for a safety suit at work from the factory 3-4 times but never received it. The difficulties for the migrant labors from Burma, which many people face at the work place, whether working hard and unfair compensation, the risk to health and life that Thai labors do not need to face. Male labors in many industries have to work hard and it is more dangerous than for the women, and the company is not responsible for any losses incurred with these labors.

Family members who are at working age will work to help collect money, the role in the house of making food within the family is necessary because it saves a lot of money whether men or women need to help cooking. Due to the clock out time of some families, such as Khaing who is in construction labor at Wat Khet, and his wife who works at the plant, they go to work early and come home late every day; therefore, he is responsible for cooking for the family, both morning and evening. In the morning, he always cooks food for his wife and children to put in the Tiffin. After the clock out time from the construction work in the evening, he comes back to cook and waits for his wife to eat together. For BO who became unemployed for several

months, he did the housework and everything to lighten the burden on his wife such as cooking, washing, cleaning and delivering his wife to work by bicycle.

At about 8 o'clock a pickup truck picks up many labors who stand on the pickup for night shift labor at their house. Three girls who wear a white uniform returned to the house from work and were very tired. A Burma song is heard when they open the door and the audible voice was completely silent after they close the door. A small Burmese child is shoving a fish trolley with her friends in front of the room; she is a little white skinned girl who does not go to school the same as the other children.

The daily time of migrant labors who come to work in Thailand is largely devoted to work. They spend at least 12 hours a day in the workplace; this does not include the traveling time, preparation before and after work. The holiday must be at least one day per week. Migrants are often regarded as diligent, easily tractable and exploitable without demanding anything. Some factories avoid the law by extending working hours on Saturday, OT hours are long. Some labors can punch the clock out of work on Sunday morning. The most intensive production system in large and small industries are causing the deterioration of the labor health because they had little leisure or less recreational activities that is in the afternoon on Sunday only.

4.2 Finanscape

4.2.1 Burmese living in Thailand: Activity, network, relationships and identities of the migrants

The migrants barely had a chance to choose to live anywhere else. The workplace forces their living because they need to be resident in the area of the factory or to rent a room nearby the workplace for ease of travel and to prevent encounters with the police. Some labors went to work by foot or cycling to work. For people who are far away from the factory, they must rely on the transfer of labors from factories or public minibus. Thus, the communities they live in are filled by a variety of ethnic people from Burma and those from Thailand who lived in that area before. This results in a relationship that is both supportive of one another and sometimes conflicting. The

plants almost always have a wide variety of ethnic migrants as work colleagues, but in some areas, residential neighborhoods have some ethnic minorities as the majority of the community. The Dawei people live around Wat Hong and the "Mon" people live around the KlongSue channel. Migrant people live with the same ethnic group in a rented room and living together, living with their family, friends or relatives saves money. The coexistence of the same ethnic group occurs on the bias against other ethnic people. The ethnic "Mon" people often believe that Burma people are rebellious and Dawei people are heartless.

They wear different clothes according to circumstance, such as the work uniform is worn at the work place, while the ethnic clothes that are beautifully decorated are wore in the religious ceremony in communities and the temple. During the holidays, some people wear their traditional clothing as well as in Burma, the men and women wear sarongs and wear a T-shirt. Some people wear in trend the same as Thai people and apply yellow powder (Tanaka) on their face, such as Phyu, she came to Thailand seven years ago and has never been back to her birthplace. She is a young woman who dresses fashionably modern. The researcher always found her with a new image, is always changing her nails and hair color along with her costume jewelry. One thing the researcher noticed is that she always wears a Garuda locket, which is not an amulet because it is not any faith. She looped a pendant Garuda because she saw that Thailand's symbol is the Garuda, also she believes that Garuda represents Thai people as she had seen it on documents of Thai government or an insignia of Sinsamut city municipality. She told the researcher that she wants to be a Thai person. Her fashion stylish with a Garuda locket is to harmonize with Thai people that depict some culture as she choose and interpreted that is Thai people.

Except for dressing that is indicative of their own identities in different situations, also consumption of various goods shows their identity as migrant labor from Burma. This can be seen from the stores in the communities; in the stores are sold the goods that are imported from Burma. Most of the stores are small rental rooms that serve at the ground floor or front of the community. Some labors who have more money invested to buy dozens and they sell them by themselves in their rental room. Most consumer goods are products such as rice, fish sauce, MSG, cigarettes and alcohol, mostly the store owners come from Burma, some people are married to a

husband or wife who is Thai and doing a business with the migrant labors. Some of the store owners also give credit to regular customers who pay by installments. Most factories pay every two weeks and they are called "Veek" (biweekly or wages payment every 2 weeks in a month).

In addition, the markets near the communities that have many migrant labors have stores that often sell products that are interesting for Burmese. Some stores sell fresh and dry goods, clothing, appliances and necessary things that are imported from Burma, such as brooms, candles, incense, herbs and snacks. Some shops only sell books, maps and images of the Buddha from Burma. Some shops sell clothing that includes all fabrics such as silk, sarong and clothing of various ethnic groups, such as the Karen, Mon and Burmese who are the migrant labors from Burma. They have the option of shopping for the various things easily; both the market and grocery store only sold the goods from Burma.

The most popular products from Burma are betel. A betel and cigarette shop is a very popular stop for the labors from Burma. It always has a small table and some red lime for eating with a betel leaf in a small jar near the table. In old stores that have sold for many years, the jar of lime mortar is usually white, crystals perched on the side. Some stores have more crystals until a full jar and they will not clean or remove the lime crystals because it is a symbol of good sales and lucrative. Traders would wrap a betel leaf to a piece and put it in a transparent plastic bag with 4-6 pieces per bag, at 20 Baht. The betel for men is a stronger taste than for women because it is a mixture of some black powder. Women would not eat a piece of black powder because they will feel intoxicated. Maak is very easy to buy: it is sold in every community because most factories do not allow labors to eat Maak in the workplace. They will eat it when they do not stay at the workplace. Maak is a tonic; one of the research assistants ate a piece of betel at lunch and he refused to eat lunch. Therefore, it is not surprising that the rest of the tract migrants often have signs of water shortage stains. After work, male labors or middle-aged women tend to buy betel to eat regularly.

In some communities there are coin-operated games that some labors come to play and cheer the player after work every day, some grocery stores in some communities also have a table for them to sit and talk together. Some men use this

opportunity to drink. For the days that the Thai government announces a ban on alcohol selling, they will not be allowed to sit and eat at the store but a shopkeeper is willing to sell alcohol to those labors by wrapping a bottle of alcohol with paper bags in order to shun the police or other stores observing.

Most plants have one holiday each week, usually Sunday, and some labors spend this day for full relaxation, cooking together and sleep. Some people will spend this time to meet their relatives who work and live in other areas. Such as "Myo", after receiving her wages she will bring money to collect with her older brother at his house in the countryside in order to send it to their mother in Burma. Some people do recreational activities that are arranged regularly: the shrimp market has cockfighting every Sunday. Some communities have free space to be used for playing sports, some men like to play sports such as football and rattan ball, while some people watch TV, movies in CD or listen to Burma song that can be purchased at the Burmese market fair.

4.2.2 Compensation/Welfare

Burmese workers must work hard each day, for example, Win works at the aluminum smelting plant and 20.00 is the time for clocking out and he is very tired, his body needs to relax. He works in front of the furnace smelting aluminum at high temperatures for almost 12 hours a day for a daily wage of 195 to 320 Baht and overtime hours at 5-42 Baht. Most employers pay less than the wage rate by the labor laws.

Large plants will have an annual bonus and the incentive is to create discipline in the functioning of the labors. Most plants have 7-10 days holiday in a year and there are bonuses to employees of 5,000 to 15,000 baht each year as considered individually. If you have a day off during the year you will not receive a bonus while some small plants are not very stringent and have no the punch out system, but they check by themselves that the labors come to work or not. Many small factories provide accommodation for the labors where the rental costs are different rates; too cheap or free, in some places the workers are responsible for their own utilities and some places give free rice for workers. The labors are satisfied when an employer pays attention to them although the compensation is not high as the large

plants. There are some workers who have worked in the factory without any benefits, although they negotiate and ask for overtime payment but the employers ignore them and threaten to lay them off if they do it again.

About the 10th or 25th of every month, they will receive compensation for both daily wages and overtime wages. Most plants pay wages two times a month and call working time half a month is a "Week" (biweekly or wages payment every 2 weeks in a month). In front of new markets in the evening the labors come out to eat and buy consumer products. On the other side of the market the labors are queuing to withdraw from an ATM with the language options of English, Burma and Thai. They pay the cost of rental and utilities, as well as debts such as cost of transport from Burma and commission fee.

4.2.3 Sending money back to home country

They do the work to get the compensation that the company gives to them. For some it may be enough for daily life and some can send 1,000-5,000 Baht every month to their home, but some can collect more money and returns several tens of thousands of Baht.

Workers send money back to their home country often through a broker rather than the banking system. Although the commission agency will determine the exchange rate of the Baht to Kyat by themselves such as one hundred thousand Kyat exchanged from 3,200 to 3,875 Baht, which is the rate for currency with the U.S. Dollar. If workers need to send money to the home country he will call their broker and inform their address, when a recruiter contacts with representatives of the Burmese community to bring money to anyone by the amount of Kyat, when parents or relatives have been completed. The representative in Burma for the exchange money is called to inform the commission money in Thailand to collect money from workers and confirm by the phone. Parents or relatives have been funded. Workers pay at the rate of Baht the exchange broker established. Sometimes the broker will call their parents or relatives to talk to workers directly. The migrant workers from Burma mostly chose this channel for sending money because of the trust and the person or family that is more convenient to travel to Burma to bank transactions manually.

Currency is connecting people in their home country and the destination country. The aim is to build the economy and the likelihood of their lives together.

4.3 Mediascapes: Connecting the remote areas closely

4.3.1 Mobile Phone

Mobile phones have become an important factor for foreign workers to communicate with relatives, friends and brokers both in Thailand and Burma. Zin traveled to Thailand and has lived in Thailand for seven years; she returned home four years ago to visited her parents at home at a few times before returning to the family permanently to Burma. Yi Hong uses a mobile phone band "iMobile" and her phone is a smartphone with a new touch-screen system. She often uses this phone to contact relatives or acquaintances who live in Thailand. Sometimes she will contact her parents once a month by calling the neighbors telephone number. The call rate per minute is from 22 to 26 Baht and migrants are most often in contact with their parents or relatives in the country of origin regularly by phone to 1-2 times per month, but some migrants use phone calls less with one time during 2-3 months.

Kyaw uses a cell phone band "SAMSUNG" smartphone as well. On the screen of his cell phone is saved his son in the home country. He uses his cell phone contact with the commission who led him work to deferred commission payments only. While he must pay an installment of 1000 Baht every month to a broker for this phone he bought a phone card at the convenience stores. Sometimes he uses the phone to take photos and video clips to contact with his parents in Burma and his parents can contact him by broker phone or public phone of Burma and the public phone service fee is 10 Baht per minute.

4.3.2 CD, music and movies

The media that is popular with a lot of migrant workers is CD, a technology that presents both audio and animation, such as music and Burmese, Thai and Western films and CDs of audio prayers in Burmese. One morning in Wat Khet, at about eight a.m. Burmese songs were chanted from the door of the next room and a

male Burma voice sang this song to feel good. Next to the second room is "Htabe's" room and her son opens a DVD of a Western movie as a copy. The movie sound is in Thai. Beside the TV a table has a small square basket that is full of CDs from several countries: Western, Thai and Burma while the CD is a media that can be purchased easily at the market where the migrant workers go shopping.

4.3.3 Satellite TV

The apartment buildings have many rooms for rent and they are installed a satellite that can receive TV signals from Burma, from which the researcher watched the Burmese TV at channel MRTV that had game shows and Burmese songs at "Phyu's" room. Burmese migrant labors also often watch programs on Thai TV, especially Thai series to learn and absorb the Thai language automatically, such as "Sheuc" who traveled to Thailand when she was 11 years-old, so she did not attend school. She does not have any recollection about her homeland and she can speak English fluently from the TV that has passed the culture to the Burmese ethnic and tribal and Thai.

4.4 Ideoscapes

Ideology is the belief that is prevalent with the migrant labors from Burma that they can be used by these cultures into a new area. The identity or identities have been expression in the context of transnational migration that were presented to four subjects are Buddhist, democratic, remedies and healthy including eating and healing as they adjust their context for a new society in Thailand.

4.4.1 Buddhists

During the merit traditions associated with important days such as Makha Bucha Day and Buddhist tradition, the merit tradition is organized by themselves, such as the annual ceremony of the community. The migrant workers from Burma wear the colorful ethnic dress and they do not wear modern clothes or working uniform. Men wear a sarong or Longjee. Male Mon wear a bright red sarong and women wear sarongs and shawl cloths. The shawl is not only a beautiful dress but it is used for

receiving the respecting and laying on the floor to receive a priest on foot. Mon people from Burma youth are a community as a group, they made a white shirt with a swan design or Mon wording on the shirt for wearing in this traditions. Young people are encouraged to participate in traditional activities to organize them smoothly. At the merit traditions, they will invite the monks from Burma or monks in Thailand who can give a sermon and preach in Burmese or Mon.

Activities during Songkran festival will be organized at the temple such as the sand pile, to pour water on a Buddha image, bathing adults, bathing Bo tree and using a large bamboo or wooden pole to prop the Po tree, as well as herbal baths to cleanse the bad things out of themselves. Some people use herbal water to wash their face and hair like shampoo. In the evening, the monks from Burma will arrive and preach, also have shows and music in the Burmese language. Moreover, it has merit to dedicate merit to the dead people or make a virtue for the next life is important for migrant labors from Burma. So no matter how much they get for their wage they will save some money for philanthropy.

Migration does not affect their traditions. On important Buddhist days have made space to express them, despite Thai government announcements to prohibit the festival in sometimes. There is harmony and oneness with Thailand that is Buddhist. The migrant labors from Burma are the main people who nourish and maintain the religious activities to existence. The traditions and culture that they practice link their minds together. Even though they come from the same country they are different races and sometimes they feel conflict. The merit at the temple is the center of their minds together and it links their minds with Thai people. The rite of their religion is a valuable and meaningful spiritual identity as a part of their social space. In addition, some migrants from Burma are iconic and have faith in Buddhism and they practice Buddhist precepts such as charity, providing and pray every day. In the migrant labors' rooms, when they are Buddhist they will have a Buddhist altar to put Buddhist images. In the early morning, they will have the merit, pray and bring some food to dedicate to the Buddha. In the vases they will change the flowers every three days, to receive the precepts before going to bed every day about three in four of the female migrant labors from Burma do like this and a spouse will support their

wife. When his wife makes a merit the husband will make together then some men practice the moral principle of Buddhism strictly as well.

In holidays related to or not related to religion and public holidays such as Visakha Bucha Day, Lent Memorial Day, New Year's Day, Labor Day and Songkran Day, some migrant labors take this opportunity to make the merit at the temple. Philanthropy is not just donating money or goods to a child. Some migrant labors make a positive contribution, such as cutting and cleaning the grass, pick up the waste and fixing the damaged faucet, some migrants labors say that it is done by their power, and the meaning of "power" is the capital to accumulate merit.

4.4.2 Gratitude to ascendants

The researcher often visited KlongSue community. The migrant labors living in this area are well acquainted. One day the research went to visit Phyu as normal, Yo is a neighbor who worked in a shoe factory. He recently returned from Burma only two to three days ago, he came to greet Phyu's friend who was chatting with the researcher. So the researcher questioned him about why he returned to Burma? He point to his hand to show that he went to be a monk in the priesthood, then Phyu explain that a son should to be ordained for the mother because his mother cannot be ordained. That men are ordained into the priesthood in Buddhism is considered gratitude to the mother from his son. On the other side, "Maw" is Phyu's friend, a close friend of her told her that Mon's friend was stealing hair as long as waist length, then her friends were laughing from her mate by comedy. The researcher knew why woman have long hair: the answer is she keeps it for her mother when it falls, the daughter had to cut their own to make a bun; as a matter of gratitude from the daughter. Phyu loves and relates to Thailand, but she plans to go back to Burma one day to take care of her mother. She must go back to the mother until the end. It is the duty of women. Then she will return to Thailand again, Thailand is a land of dreams. She and several friends of migrants who came voluntarily are settling in Thailand because the living conditions are good. Money is easy to find and there is more freedom.

Migrants work hard to collect money and send it or goods to their parents or relatives who live in Burma. In families that have many children, only one son or

daughter may be responsible for the parents in Burma. The other brothers travel to work abroad, including Thailand. Thus, some workers who come to work in Thailand still maintain the relationship among siblings in the family and obligations are often to come to visit or contact by phone regularly. Most of the migrant labors who are not married have a family and would gather in groups of siblings for a big return to their parents in Burma next deal, as the assets purchased in the migrant workers who are not married, they may send money to their parents in a smaller amount because of the increased payment costs. So they send money and goods from Thailand to the parents or relatives who live in Burma as the gratitude of the migrant workers. Some migrant labors have not sent money to their parents but their parents wanted them to collect money and take care of them.

4.4.2 Democracy

Countries in the world are in the stream of liberalism and democratic ideals. Even Burma has recently endured a coup and was ruled by the military. Even General Aung San died since in 1977 until the year 1988 had the protest movement of the students in Burma. Then Miss Aung San Suu Kyi, his daughter, became a symbol of the fight for democracy and founded the National League for Democracy party. Although she did not win the election, there is the freedom from the dictatorship era.

In a trip to Thailand by Miss Aung San Suu Kyi, she created hope in the migrants from Burma working in Sinsamut greatly on May 31, 2012 at the office of the Burma Embassy. Several hundred workers stood and held the banners as well as the images of Miss Aung San Suu Kyi and General Aung San to welcome Miss Aung San Suu Kyi with the symbols of democracy. Some people waved flags of many colors and some people took flowers to give to her. Police had to protect her with steel panels, to control the crowd that gathered in the sitting space only. Moreover, it also had a fleet of Aew Sou Yo the prank show that is displayed at the carnival and the tower festival yearly (Thai people call the merit temple), the showers are male. Indicator, one man dresses as a woman and holds an umbrella. The courtship dance has shown with the rhythm of the drum, percussion and bamboo. Migrants labors from Burma believe that Thailand has more freedom and democratic than Burma, such as the freedom of expression for political support of Miss Aung San Suu Kyi today.

4.4.3 Beliefs about health, healing and food

Burmese migrant workers who come to work in Thailand bring beliefs about health, self- healing in order to have confidence when living in a new area. Each ethnic group will have a different belief and faith. Most Burmese people from Yangon are remained of the ancestral animist call "U Ya Nut" is the spirit of the ancestors of both the male and female, most grandparents are relatives who are dead and that nomenclature varies by ethnicity. Affinities with the ancestral spirits briefly by Mon people call "Ku" and the Burmese ancestral spirits called "Nut", they mean the same thing. If there is a malfunction within the family they do not know the unusually events, they also add to the prophet to predict the unpredictable to disturb the soul that does it with help or want to do anything. Then they follow the prophet as recommended by ancestors with offerings of food or fruits such as coconut and banana, etc.

The animist ancestors of both parties are more important than marriage. If they do not respect their ancestors, the living may be faced with a bad story or the illness of a family member. The trade deficit for the relatively poor labors when pains have been healed by a ceremony to pay respect to the ghost this is a way to heal their pain.

Sometimes the migrant labors do not go to the doctor at the hospital. The migrant workers from Burma have a culture of health that refers to the methods of modern medicine as fluid replacement therapy; most of them are going to heal at a clinic or health center. Some people are going to heal with the quack while some workers alleviate their illnesses with the energy drinks mixed with a painkiller.

In addition to cooking, turmeric is integral and MSG has a component with another. They favor MSG made in Thailand because it is white and cleaner than MSG made in Burma, but fresh and processed food, such as the pickled santol, marian plum, red onions and dried fish as ingredients in Burma food, are produced and sent from Burma to be sold to Burmese labors. Burma dishes that can be easily consumed in a market or markets that are connected to all ethnic Burmese migrant labors in Thailand and their hometown and compensation for their emotion recognition or longing for their homeland too. Some people have adapted well to eating habits in Thailand.

4.5 Technoscapes: Medicine in Burma and Thailand

Technology makes the world more fashionable; migration is adapting their life into the changing environments. This study is focused on medical technology, and it is discussed in both Burma and Thailand in connection with the care of tuberculosis patients.

4.5.1 Medical in Burma

In Burma, the hospitals and various health facilities, also the modern technology, is often clustered and existed in big cities only. People who live in rural areas do not receive the medical service while the people who are rich, have access to medical care more than those who live in rural areas. The rich people use medical services both in Yangon and other countries.

TB treatment model in Thailand is like Burma, it is to take the TB drug at six months. The Burmese believe in the modern medical knowledge and technology to protect the body against disease and the treatment of infection with antibiotics. Patients merely bring a prescription from the doctor to buy drugs from the pharmacy because the hospital has only a doctor, nurse and patients, but no TB drugs.

Although the Burmese people know that TB can be treatment with the drug that is received continuously for at least six months, but their awareness about how to access drug-resistant tuberculosis is different, since it costs a lot of money to get treatment. So the knowledge about TB and the experience of TB treatment with healing medicine of the labors from Burma affects their behavior for TB treatment when they come to live in Thailand.

4.5.2 Medical in Thailand

The Thai government has organized the structure of both the control and treatment according to the guidelines of the implementation of the National TB Control (National Tuberculosis Program: NTP) in the treatment and care of patients. Sinsamut hospital has been working according to the principles set out by the type of patient benefits of the National Health Security Office, including searching for vulnerable groups and touch screening with campaign activities at home. It provides a one stop service for medical monitoring and evaluation of treatment, operating at the

district level and the district is managed and directed by Sinsamut hospital. In addition, Sinsamut hospital has a policy of serving migrant labors without discrimination, especially for the treatment of tuberculosis that is free to everyone.

However, the hospital has a policy of providing to discriminate against patients by the right. Therefore, the disparity in the benefit of treatment and the different medicines such as for TB/HIV patients who are Thai are only entitled to receive the antiviral drug PCL. The migrant labors are treated as the "other" for social and health care systems. Sometimes the health providers are not aware of their rights, such as treatment of TB is provided drug-free, but sometimes the drug provider gives the wrong types of item, so the patients must pay more for these drugs.

Migrant labors who come to work in Thailand, are from several ethnic groups and are both legal and illegal migrants. Therefore, the population of each group is entitled to different treatments and the migrant patients with TB, have difference rights as well, but TB is a disease that is easily spread to other people so there is an attempt to provide the tuberculosis patients with drugs for free.

Migrants from Burma into Thailand are entered into the social security or health insurance. They have the right to medical treatment by the hospital, some people will exercise their right to medical treatment in public hospitals, but most people choose to go to the clinics because even though they lose money they save their work and end of year bonuses. Most migrants do not have the health card for medical treatment know the Foundation Center Drop in Center that is located in the Burmese community in the shrimp market and use it to get medical treatment here instead.

Migrant labors who migrated to work in Sinsamut city have adapted to survive in the circulation of the five dimensions of the ethnoscape; where old and new people come to live together. Next, the dimension of the finanscape in which the migrant labors send back their money to their birthplace. Thirdly, the dimension of the mediascape is limitless communication that connects people and fulfills the emotions of their ethnicity. Fourth, the dimension of ideoscape is the fusion of the identity or identities of Burmese ethnic groups in each area of Burma to express their identity in the public area. Lastly, the dimension of technoscape is an understanding of the medical technology in the country of origin and country of destination. The cultural fluidity in the five dimensions are reflected in identity, also the creative identity as

migrant labors from Burma in Thailand, which exists in the context of Thai society. Either the costumes are changed as the context of each area, such as working uniform, the ethnic costumes or the plain dress that are worn for the same dressing in each occasion as the meaning that they are the same group. This also maintains the relationship between the labors that come from Burma as well. Labor is the same ethnicity and the relationship between Thai and Burmese that reinforces the origin of culture through the ethnic costumes and the religious rituals. Donation is blended with the old traditional culture and absorbed Thai culture into their life, such as wearing the shoes into the temple, which shows that he has no respect for the worship place. Therefore, when the migrant labors learned and had the experience through a merit at the temple along with Thai people, so they have been absorbing this culture of wearing shoes inside the temple as well. Wearing the same working uniform for each plant; the dress does not reflect the performance of the plant modernization rather, it represents a compromise by the rules of society for both the Thai and migrant labors who are working in the factory. On the other hand, these regulations are exploited such that the labors must buy the most expensive working uniform because it is being monopolized by a group of employers and supervisors in the factory.

CHAPTER V

POLICIES AND PRACTICES AS GOVERNMENTALITY: A PROCESS OF ESTABLISHING THE SECURITY IN HEALTH

5.1 Management policy of illegal immigrant workers

Immigrant workers have been branded a threat to national security by the Thai government. The idea behind it is based on nation state and ethnicity and the fear that immigrant workers would do harm to the people and the nation. Meanwhile, there are illegal immigrant workers from neighboring countries continuing to smuggle to work continuously in the country because of the need of low-wage labor by the private sector, both in agriculture and industry in Thailand. Immigrant workers have had their role in improving the country's growing economy because their labor is cheaper making Thai capitalists richer. However, they are seen as having brought diseases into the country, especially in cases of tuberculosis viewed as a serious disease. It is necessary for the screening for diseases as the following statement by one of the hospital staff.

“In a positive way, immigrant workers in Thailand are beneficial in economic terms. If we were to ask if all of them are legal, I would say, not all of them are. Many of them also tend to spread some kinds of diseases”

Phakamas, a Communicable Disease Control officer

In epidemiological terms, those, with a high risk of tuberculosis means they are having low immunity living in a crowded community. Immigrant workers are seen at risk because they come from poverty-stricken countries where hygiene is at a low standard stereotyping and stigmatizing that immigrant workers were responsible for bring diseases to Thailand since 2004. The government, therefore, had solved this problem by taking measures by allowing workers from Burma, Laos P.D.R and

Cambodia into the official management of immigrant workers with Immigrant Labor Management Commission (ILMC) serving as a representative of the state responsible for a process of security among immigrant workers. Meanwhile, the government would do surveillance on immigrant workers as a new group of citizens. At the beginning, the government would have taken a measure of "counting the population" by allowing illegal immigrant workers to report to related government agencies and issuing the Tor Ro. 38/1 document to declare them a "temporary population" in Thailand. Their jobs would be limited to 2 professions including the housewife and the construction laborer. The main purpose of the document is to do a "population control" discouraging illegal immigrants from smuggling into the country. The current government of Thailand has taken a measure to negotiate with other countries in a state-to-state negotiation so that the states of immigrant workers' origin could issue a certificate for their citizens and the passport instead of using the Tor Ro. 38/1. This is why the nationality of the immigrant workers is to be proved as a "temporary population" in Thailand.

A process of establishing the security of health is a one seen as beneficial for investment to prevent and control the spread of tuberculosis among immigrant workers, which may affect the health of the Thai people as well. The Immigrant Labor Management Commission (ILMC) had assigned the Ministry of Health a mission is to conduct health check-up and health insurance for immigrant workers. These immigrant workers were branded "disease carriers" into the countries. The hospitals in locality, therefore, had to service an annual health check-up, medical treatments and other services involving health promotion and prevention along with the surveillance of diseases in an intensive manner all the time from immigration to what the employer had been expected to realize the importance of screening for diseases, especially in the case of tuberculosis, which is not financially expensive and effectively controlled among various groups of population.

The Ministries of Health and Labor had been in collaboration in establishing a process of health security for Thai citizens by physical checking up and controlling standard of health check-up for immigrant workers, who applied for work permits, including tuberculosis detection and the x-ray on the lung for everyone. If the examinations confirmed TB infection, the suspected patient would be tested further on

his/ her sputum. If the result turned positive, the person would be classified as "having a forbidden disease not being allowed to work" The hospital in charge would never issue a medical certificate to the migrant worker who were in contact with tuberculosis. Meanwhile, the Department of Employment would also refuse to issue a work permit until it was confirmed that the person were fully recovered from the disease. However, in this issue, the employer did not see as being important to them. In effect, it did not affect the employment of immigrant workers because what the employer was concerned the most is labor not health issue.

The government has applied a policy in health check-up, making the identity of immigrant workers a threat to national security and to the Thai people. Meanwhile, in a process of securitization, immigrant workers would be reduced into the object of state surveillance. Medical personnel as a representative of the state would be responsible for monitoring, detecting and following immigrant workers in issues concerning health because the workers might be carrying a serious disease and spreading it out, causing a threat to the national security in health among the Thai people.

5.2 Screening in immigrant workers

When the cabinet announced a registration or extension of certificate for immigrant workers, Sinsamut Hospital, as an agency of state health provider in the area, allocated a special ad-hoc space behind the hospital, conventionally used as a parking lot for the ambulance as a health check-up station for immigrant workers. In other words, this was a "special point for gazing" being separated from other service areas. There were minibuses carrying workers gradually filled up the car park. Workers would come as a large group with their brokers or personnel officers of the company. Sometimes an appointment had to be made with the hospital prior to the process that there would be workers coming to receive medical services during the day. When migrants arrived, they would be told to complete documentation by filling out some given documents. After that, workers had to stand in line to get the DEC, a kind of medicine against elephantiasis and then took the pill in front of the staff. This is perceived as a way to deal with the body of immigrant workers constructing an

assumption that inside their bodies have been filled with germs. In this case, they all had the elephantiasis parasite in the body therefore they were to be forced to take medicine. Such a way of taking drug before the medical personnel made them an objects to be “gazed”. Within this area, they were forced to follow the rules strictly. The author had an opportunity to talk to a broker serving as an intermediary on behalf of a business operator during the registration and renewal of work permit. He recalled that he used to take girls under 15 years of age to be registered by lying that they were 18 years old. After taking the DEC drug, the fateful girls went intoxicated, falling asleep for hours.

After taking drugs, immigrant workers would have to pay at the counter inside the hospital and then came to be called in a process of medical "surveillance". The staff would collect their blood and urine for testing whether there were any transmitted diseases in the body of illegal immigrant workers. The workers were unselectively branded as disease carriers harmful to the Thai people. They, therefore, were placed in group exclusively at a corner. The space where they were told to sit together as a group makes it easier to control and monitor their behavior. One of the hospital personnel served to make the name calling call so that each individual worker could see the doctor. Then each of them had been taken to have an x-ray on the parked radiography mobile car nearby. The x-ray is a technology that monitors the health of immigrant workers with physicians in mission were authorized to classify if the x-ray photos exhibited irregular lungs. The workers, who were already suspected of being infected with pulmonary tuberculosis will be observed in a new pattern; having a test of sputum for three times repeatedly. If it turned out that the sputum became positive, that means there would be pulmonary tuberculosis in the lungs classified as a disease being prohibited from working. The hospital will provide a foundation to track workers found TB to work and accommodation. The hospital would send their medical personnel to monitor the infected workers at home and at their workplace and to give them container to put the sputum in the morning. The workers had a mission to submit their own containers to the hospital or if it was impossible to do that by themselves, the medical personnel would do it on their behalf. In case of the workers failed to submit the container, the hospital would send its personnel or assign a healthcare station officer to follow them. In addition, the foundation officer also played a mutual

role with the hospital in "classifying" patients from normal people by screening for tuberculosis exposure among the patient's family at home.

"Interpreters had submitted their collected cases based on their own screening. In some cases, being those, who share household".

Pakamas a communicable disease control officer

Measures of health checking among workers are part of the state policy in prevention of the spread of dangerous diseases. People with tuberculosis have to be under treatment until they are in full recovery by taking medicine for 6 to 8 months with the sputum being tested negative. After that the hospital will issue a medical certificate to prove the status of TB infection returning to be cured. For immigrant workers, passing a regular checkup, they will be given a medical certificate to be eligible for work permit.

Tuberculosis is a disease, possibly occurring within all of the organs in the body but can be transmitted to others through coughing or sneezing. So there is "surveillance" exclusively on patients with pulmonary tuberculosis under the treatment system because it can spread to others. When Sinsamut Hospital found a TB patient, it would provide measures by "screening" those who might contact with the patient meaning those who are physically close to him/her. The assumption is that the exposed individual might have been infected with tuberculosis as well. The hospital had worked with the foundation to do "surveillance" by making a home visit and collecting the sputum given from individuals likely to be in contact with the infected at the hospital.

"In case of the infected being undergone the screening, they would be searched into their data by the hospital's registration section to know their personal information; who is his father and who is his child. With this, we would know who the person is; whether he/ she is classified in a TB infected group. Then the name of a child will be told here with his/ her mother's name. Now that we know that the

person is infected, separated by cases to which the Foundation had visited and ones with a complete collection of sputum by the officers.”

Phakamas, a communicable disease control officer

The hospital also has an approach program in educating workers about health, including issues concerning tuberculosis. This is considered a series of knowledge-turned truth produced by the medical institution to generate power for the medical personnel to monitor "surveillance" and "classification" among TB immigrant patients in factory to the treatment system. A set of medical knowledge on tuberculosis would make TB patients agree to take drug. However, some TB patients, who remained strong with unclear symptom, were likely not to accept that they were infected and would not refuse medication. Health education in business sites served as a way to let immigrant workers absorb the truth in a perspective of a doctor so that workers would do "self- monitoring" and, for the medical personnel part, "isolating" new cases of tuberculosis TB patients new to the treatment process as soon as possible to prevent infection to the Thai people and their colleagues. This is a process of establishing a health security for the Thai people by controlling the lifestyle of patients leading to a process of disciplines in regular medicine intake to ensure the health personnel that tuberculosis in the body is controlled and contained, not spreading to those who are close.

“I am responsible for TB-related issues, searching for the infected with positive sputum in test. If we found such a patient, we would follow him/ her symptoms and assign a care taker to monitor how he/ she would take medicine.”

Dhi, the Foundation's fieldwork officer

The knowledge of epidemiology has contributed to the stigma of immigrant workers bringing diseases into the country getting even more intense. The state had taken measures to control and deal with migrant workers by doing surveillance and classifying the workers along with isolating the TB-infected ones.

When a new case of TB patient was discovered, the nursing staff, pharmacists and interpreters would communicate an understanding of the discipline of regular medicine intake as a restatement of knowledge in the patient's practice.

"We have to talk to them to make them aware of taking medicine. However, here the nurses have been working hard, taking to all of new cases individually about how to take medicine, what kind of side effect they might encounter. For the pharmacists, mainly they stimulate the patients' general intake along with following possible side effects."

Wichuda, a pharmacist

The medical personnel also visualize TB patients as an identity filled with disease and germs, subject to killing or controlling the spread of germs with a primary aim in the efficiency of the drug. The identity of the TB patient was more specially focused by the hospital than the treatment of other persons in general with a program providing knowledge and practice for the patients through the Burmese interpreters about a regular medicine intake'. Naing talked about a communication between the doctor and the patient about what the symptom is and how it is to be treated.

"The doctor always asks what symptom he/ she has or what tuberculosis (TB) is. In Burma, TB is a kind of lung disease. The doctor talks about it this way. He doesn't say it is TB. If a patient had a chronic coughing for more than 2 weeks, didn't lose weight, with the loss of appetite and a low fever. Why is the infected patient forced to take TB medicine? The disease is not yet in a spreading stage."

Naing, the hospital's interpreter

Measures of the screening for tuberculosis were done among illegal immigrant workers, who were branded as a bioterrorist by providing some special space for screening in separation of a normal service area of the hospital which will be

discussed in more detail later. After finding that an immigrant worker was infected with tuberculosis, his sputum would be brought for the re-checking. The infected immigrants would be tracked to his workplace and residence to be given health education and to do the screening for tuberculosis exposure. The screening process had to lead to a treatment process as soon as possible. This is how to build confidence among the health personnel that immigrant workers could not spread the germs to the Thai people and their neighboring labor. This process includes the establishment of health security to the Thai people.

5.3 Management of space in services to TB infected immigrant workers: The interpreter as a medical medium

On a Thursday morning, the author arrived at the hospital and rushed to see Sirirat, the head of Immigrant Worker Health Unit of the hospital. The author was told that to enter the door at the back of the hospital by turning right and walking past a fruit shop down to the Bodhi tree square and a four-story building. That was where the Primary Care Unit located.

The author saw a sign indicating that the building was for the health checking of immigrant workers. The first floor was used as mobile primary cares unit where medical and relevant apparatus were stored, including green bicycles for a home visit, medical cabinet and other printed documents about immigrant workers. There were two table placed alongside where the medical personnel in the unit came to use in exchange regularly. Sometimes, Aunt Jan, the maid, would use these tables as a place to count the vermicide tablets and put them into the plastic bottle, each containing two of the tablets. Some days Naing, the Burmese interpreter Burmese of the hospital, would use the table to copy the list of the Burmese patients to prepare for a home visit and prepared the files containing the patient information, who would come for a health check during the afternoon. Everyday at noon these tables would become dining tables of the Burmese interpreters of all departments of the hospital to come together. The author also used them in a meeting with the Burmese interpreter and in following the news regularly.

This room was quite filled with equipment belong to the immigrant health unit of the hospital; be they knowledge exhibition boards, the bicycles for home visit, the medicine cabinets and pamphlets scattering all over the place. In late hours of every Thursday, this room would be transformed into a "health club" for training in health education for immigrant workers who were diagnosed by a physician as having tuberculosis. Health club was run by the Foundation (Non Government Organization), which were financially supported by the Global Fund.

At about nine o'clock Dhi, the field staff of the foundation, was assigned to place ten chair for arranged in resembling of a classroom. He arrived about 30 minutes earlier before Chan did. About 10 A.M., there was an immigrant male with a dark complexion entering the room. He was reluctant about what he would do. This room was unusual to him. Dhi spoke Mon with the male patient to wait for others first. After that, a middle-aged women and a teenage girl came together. Chan spoke to them and the female teen submitted the sputum bottle to him. It belonged to the middle-aged woman, who was her mother. Chan filled in the form and then sent the bottle and the form to the health personnel.

Sometimes the desk was used as a place for a speaker. Sometimes the speaker would drag his chair to sit inside with the desk serving as a block separating the highly educated speaker and the patient. This sort of position makes the speaker staying in a higher power than the patient although similarly they were Burmese workers.

Almost 11 o'clock in the morning, eight patients gradually came in to this room. Dhi distribute an evaluation form prior to giving them knowledge in both Thai and Burmese. After all of the patients had finished the form Chan, the field staff of the foundation, came to sit at the table on the front end and began to describe the knowledge about tuberculosis beginning with its cause, treatment and self- care. Most patients did not pay attention to the talk but sitting in this room with an uncomfortable feeling. There were no questions from the patients. Dhi, the foundation field staff, stood on the outside of the gate. Until it was close to afternoon, Dhi went back into the room with instant food in Styrofoam boxes and water for the patients and the staff of the foundation.

Chan told the author that he wanted the TB patients to gather at the health clubs. He wanted the Burmese people to have knowledge about tuberculosis and exchange ideas about it and giving their peers encouragement. But the most of them did not have the spare time. The author noticed that some of them had joined the club just a couple of times although the foundation had an adjusted activity schedule to be before noon in relation to the time when the patients came to receive services at the clinic. But the TB patients were still focused on visiting the doctor and bringing the TB drugs home.

During her appointment to see the doctor, Phyu had to take a leave the whole day. She was not keen to join the health club. Instead, in late afternoon, she went shopping for new clothes and earrings at a shopping center in the city of Sinsamut.

"Going to Nampoo department store, I went with friends. That's why I didn't go to the club. I had no reason to go. I didn't want to go. But this time, I came to bring a medical certificate to the factory. I am happy to have smaller tablets of medicine."

Phyu, female, 22 years old

The TB patients were treated at the hospital for full recovery and could be back to work normally. They focused on visiting the doctor to get medicine and submitted a request for a medical certificate to verify a sick leave from the company without being charged extra money or benefits that they might be given at the end of the year. The establishment of the health club did not respond to their very essence of life in terms of income. This is why they did not care to participate in the club's activities continuously.

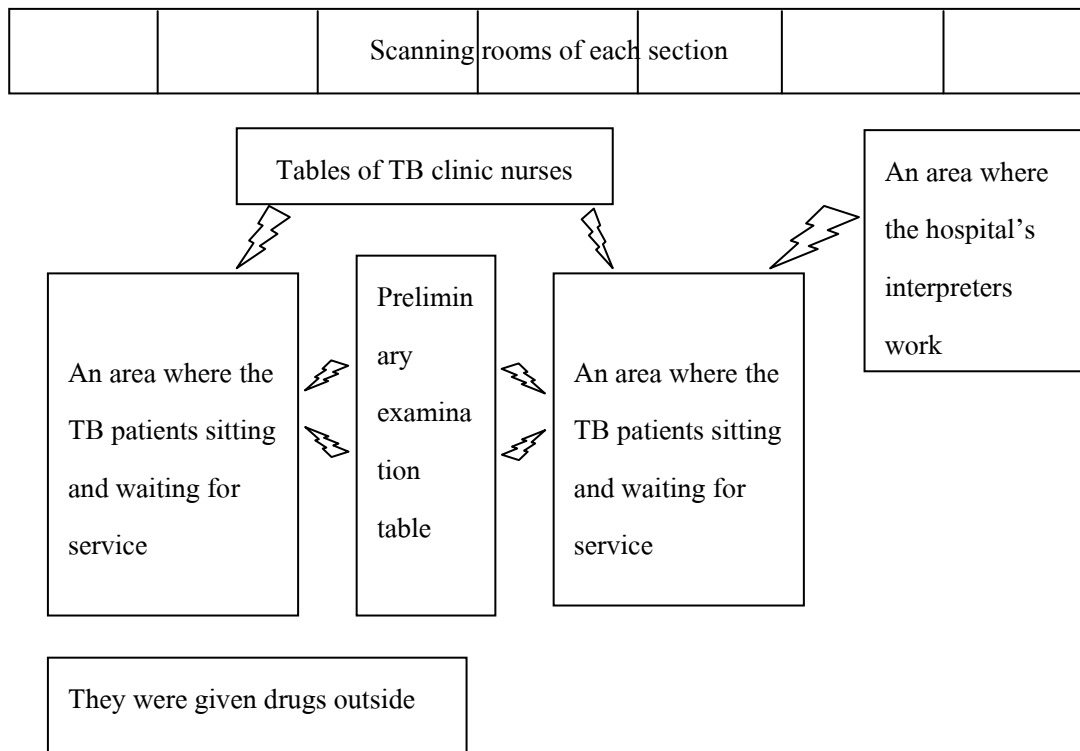
On Thursday afternoon, the front of the examination room of the in-patient building was used as a tuberculosis clinic of Sinsamut Hospital. It was located on the lower floor with a large wide hall with six blue chairs lined up. The Clinical was not a space in separation from other medical units. Other patients came for service in the neighboring unit. The hospital personnel still walked passing the clinic. What was special for the clinic was that the patients and healthcare providers in this clinic wore a

clinical mask. The pharmaceutical unit had set up a special desk for distributing the TB drug at the gate of the clinic close to the stairs. And that's important. All of the pharmacy staff wore thick masks and dressed as safely as possible. This reflects a domination of the medical truth that they could protect themselves against TB germs, mixing with the feeling of alienation and fear of tuberculosis and migrant workers.

About half past twelve, the TB patients, Thai and foreign, gradually came to wait. The people who came earlier sat in the front row seats. The second row seats were filled with patients awaiting, almost all of whom wearing a clinical mask. Some of them wore a mask covering only the mouth, leaving an area around the nose open because of the uncomfortable breathing. Chan, field staff of the foundation, who used the eyes as a radar to monitor the patients who refused to wear a mask. When he saw one, he would bring a mask to be worn immediately with the explanation that it was dangerous for the person and it was risk spreading germs to others. He emphasized that even he was not infected; he had to the mask as well. Most of the patients in the clinic were displeased to wear the mask. On Thursday afternoon, the atmosphere of this area is packed with people, ranging from the health personnel, interpreters to patients. Some patients brought a mask out of pocket before walking into this area as if they entered an area where everyone had to wear the same thing; that is the mask. Some patients, after receiving the drugs, went just a few steps out of the hospital and took off the mask and kept it in their pocket before walking along with common people. Wearing masks is a norm in health clinics while wearing it in public might make others feeling paranoid and being branded.

The area between the blue chairs was left as an empty space. The folding tables were placed there so that the staff of the foundation could help migrants prepare documents and records their blood pressure and filling out the form before sending it to the nurse, who were standing in front of the examination room. The "preliminary examination table," performed by the officers of the foundation became a central point of control where the patients were closely observed. Those, who were in charge there, could observe all of the patients waiting for service and they could walk through between tables of the TB clinic nurse and the examination room to provide convenience to the interpreters. Therefore, the immigrant patients were obedient in wearing a clinical mask as if they were observed upon by the doctors, the nurses and

the medical interpreters and officers. And sometimes they probably had to get a cooperation or assistance from the foundation staff to communicate with the medical staff or financial officers in case they did not understand it. Therefore, wearing a clinical mask is indirectly meaning non-conformist cooperation reluctantly as shown below.



Thursday afternoon at a tuberculosis clinic, the name calling were aloud for TB-infected patient by an officer, who was wearing yellow "..... the Burmese ," she repeated the name several times. However, there were no patients leaving the chair in front of a blue check it. Eventually she asked Chan the field officer of the Foundation to act as a caller, instead. This is how Chan, as an immigrant worker himself, had the power over other immigrant workers because if he did not assist in the name calling mission, the patients in queue might be mistaken or fail to get a service at all that day. The officer might think that the patients might go home. When patients came to the table for checking the blood pressure and weighing their weight, they had to go to the front desk, where nurse was sitting before the examination room to be checked if the patient wore a mask properly or not before the patient went to see the doctor in the examination room. The nurse would tell the patients to wear a mask by squeezing the

top of it where a flexible wire is attached to its soft nose part. A nurse emerged out of the room. She shouted out loud; "I need an interpreter". Chan walked into the examination room behind the nurse immediately.

In providing services to immigrant workers at Sinsamut Hospital, there have been Burmese 16 interpreters in mission, exchanging service in various departments in the hospital. Generally interpreters serve as a bridge between persons who speak different languages. They are often trained in intensive health education before entering the actual work, such as the knowledge about communicable and non-communicable diseases. Naing as served as an interpreter for the TB clinic. He not only interpreted languages for doctors and nurses but he is also responsible for health education and for home visits for patients with tuberculosis. He had provided the knowledge of drugs harmful to health and of working or describing the nature of the disease, its cause and medicine and answering questions as explained by the interpreter below.

"I asked him what was wrong. He said he had been coughing. I asked him that after being given a prescription what the doctor had told him. What kind of disease he had caught. In his reply, he said it was tuberculosis. I had not heard of it before. I, therefore, asked him if he knew what it is and how it spreads. Some did not know. Then I explained to them what it is."

Naing, male, aged 36 years

In context of the hospital's services, where service providers are Thai and those who receive the service are foreigners. The interpreter serves as a spiritual medium of the doctor in providing truth about how to take care of oneself when that person is infected with tuberculosis, its prevention from spreading the disease to others, care taking, medicine intake and self-adjustment to the environment including possible danger as a result of inconsistent drug consumption as instructed by the doctor making infected immigrant workers following the instructions by themselves.

“If there is an interpreter, there is no problem. All of the problems we have is language. The misunderstanding in drug intake is all about language. If they understood our language, there would be no problem”.

Nanthiya, a family physician

The management of the hospital's service area reflects co-operation in containing and controlling the TB infected patients by providing the foundation some space to organize activities regarding healthcare for the patients in the morning. Meanwhile, in the afternoon during Thursdays, there would be a TB clinic opening for both Thai and immigrant patients. The separation of space out of a regular area even in the treatment building and the use of space in front of the examination room with a primary desk for health checking placed between two chairs in opposite side and the presence of the foundation officer are about giving power to the hospital's interpreters in doing surveillance and management of the patient's lives by telling the patients to wear a clinical mask including a provision of knowledge in discipline in self-caring not to spread the disease to others. This power and knowledge had previously passed on from the healthcare personnel.

5.4 The hospital's medical programs for taking care of TB patients

"Multiple resistant tuberculosis" is a point in which every health care organization are interested ranging from the World Health Organization (WHO) to local medical practitioners because multiple resistant tuberculosis costs a lot of money in treatment is an issue affecting health organizations in all levels because it costs a lot of money and is likely to be chronic. Sinsamut Hospital, therefore, has various healthcare programs to discipline the immigrant workers, who were successfully cured TB patients along with prevention programs to prevent multiple resistant tuberculosis by an emphasis on health education and home visits and the usual intake of medicine the care for neighboring Burmese labor in their area.

5.4.1 Training in health education

After the doctor's diagnosis that an immigrant workers were infected with tuberculosis, they would be taken into a treatment and discipline with the interpreters providing knowledge about the prevention of TB, its contact and advise on self-treatment and adjustment to the environment. The interpreters would talk to and convince TB patients to obediently believe that they could return to good health again by simply completing prescription drug and continuing doing it for at least 6 months. This is how the patients had absorbed medical knowledge that their bodies were clean, without diseases by taking medicine that is potential in eradicating diseases. And can make their own body by eating clean sterile drug deserted destroy pathogens. This includes examples of other successfully healed patients, who used to have more severe symptom than they did. When the patients came to believe in the efficacy of the drug, they would agree to modify their own behaviors and follow a new discipline by imagining themselves as the subject, who decided to choose whether to pick up a pill to swallow or not. He is the creator of discipline to lead their own life in a fight against the pathogen in the body. Therefore, when he had the discipline to have a regular intake of medicine, his opponent, which is tuberculosis, would finally be defeated. With the interpreters, advice would be given to patients to treat themselves to maintain their health along with an emphasis the drug intake without discontinuity.

"When we see the patients, we would remind them of their regular intake, doing it on time without missing it even once. They would also be told to care for themselves and protection against the disease. In particular, for the patients with positive sputum, they would be advised to stay away from others. Most of them followed this accordingly".

Dhi, male, 26 years old

One of the most important missions of the hospital is to provide knowledge to and follow the patients, who are in a stage of TB spreading in the first 2 weeks after diagnosis and drug prescription to prevent the spread of infection to surrounding people by separating daily items from those who live in the same

residence. A set of knowledge envisions that the body is like a germ being absorbed into the body of the patients. The body of the patient is to be treated as docile, subject to be separated from their loved ones. Their items should also be separated as a means of prevention or, otherwise, their beloved would be infected.

"[I] recommended patients with a large amount of positive sputum that in the first two weeks, they had to separate their items from those of others. After two weeks of drug intake, the disease may still not be cured not spreading to others. During the beginning period, all of the patient's items shouldn't be shared".

Pakamas, a disease control officer

"It is a good practice to cover the nose and the mouth before sneezing. At home, they should stay in an air-flowing area and take medicine for 6 months. If it is not yet cured, they have to take it for another two months before having their sputum tested. If it turned out that there is no infection found, the doctor would advise to reduce drug intake. It is considered the patients for not being cured yet. They had to be dependent on medication for full sputum five months. After that they are required to have their sputum tested again. Inconsistent medicine intake might result in the testing being positive, meaning still being infected. The patient needs to take drugs consistently. Failing to do so might cause drug resistance. If that happened, it meant they had to take drug for life. Well, I just exaggerated. In fact, it would never do that for real".

Naing, male, 36 years old

What the medical doctor has done to TB patients reflects how the immigrant workers treat themselves. It turns out that they follow the given instructions very well. Despite the fact that the TB patients agreed to abide by the implementation

of knowledge about tuberculosis strictly; such as taking drug on time, a manner in spitting the sputum and in covering their mouth and nose while coughing and sneezing, a regular bringing of their sleeping equipment to dry in sunlight. Infected immigrant workers cases would bring recommendations as they were a subject to fight against tuberculosis within their living areas. However, some instructions were difficult for migrant workers to follow; such as opening a window for ventilation. Some of them were afraid to do so for fear of being arrested by the police.

"What they can't do is to open the window. Most of them don't for fear that the police would arrest them. They are also afraid of any other possible harm as well even though their houses are safely closed. This year, many of them have had ID cards. Last year, they didn't. If they opened the window and the police came coincidentally, they would be in trouble. That's the way it is. When I went to see them, I saw them living in their house where there is only one door without any window. That is true. I had to tell them to stay outside while they used the electric fan as ventilation. If they have a mosquito net and a blanket, the majority of them would bring those sleeping equipment to dry in sunlight".

Naing, a hospital interpreter

Health education is considered a set of knowledge or truth to be taught to patients to care for their health. However, there is a hidden agenda intending to establish health security to the Thai people, preventing immigrant workers from spreading tuberculosis including the demand for labor as a production unit with no burden to the society. With public health officials having a lack of sensitivity and some specific demand of each individual patient, health education is therefore presented as a one-sided set of truth, making it a tool of demand to guide and control the workers' lives. Some officers even think that a patient infected with HIV and drug-resistant TB had no right to have children or the right to decide for themselves whether to become pregnant or have children or not.

“Speaking of him, he is an interpreter. Speaking of prevention, it is difficult to practice. There is a person who has a drug-resistant tuberculosis. She is infected, you know. She has to avoid having kids. She knows it well. But with a new husband, she is encouraged to have kids. This is why she deliberately stopped protection from pregnancy. Her husband needs a kid. She agreed. Is this considered problematic? It is. One, she gets infected. Even worse, it is a drug-resistant type. She got pregnant voluntarily even knowing this fact. Her kid is obviously infected by the same type of disease. The kid is also contacted with AIDS. Now we have another new AIDS infected person.”

Pakamas, a disease control officer

Paranoia and doubt about the identity of immigrant workers involves causing the spread of diseases. When there was detection that an immigrant worker was infected with tuberculosis. The hospital would health education program by an interpreter. Within the knowledge, it focused on regular medicine intake for at least six months to kill *Mycobacterium tuberculosis* in a patient. This further validates the identity of immigrants with tuberculosis that they were real disease carriers. They felt alienated from others. Meanwhile, they were also afraid that pathogens in their bodies would spread to other surrounding people. The TB patients would have to be in various health programs in order to be disciplined in medicine intake. Providing health education is a set of medical truth in control of the patient's physical and spiritual beings so that they would follow the disciplines including how to take medicine by fellow workers regarded as a way to deal with a relationship in their daily life such as the separation of belongings and of sleeping areas for patients.

5.4.2 Directly observed treatment (DOT)

This strategy is a form of organizing and controlling the life of the patients by someone who is not a close relative, serving as a care taker helping tuberculosis patients to take drugs on time, completely and regularly. This is not consistent with the

way of life of immigrant workers who live with their families and do not trust strangers. In some cases, it would be difficult to find a DOT watcher.

In a normal life, when a family member got sick, they would take care of each other. But the strategy is meant to intervene a normal living, based on the belief that TB medicines have side effects on the patient, especially in the early stages when the drug in the body would fight the infection. The TB patient might be fatigue, vomiting, and suffering jaundice. Discouraged, the patient might stop taking medicine or at best taking it inconsistently. Therefore, it is necessary to find an assistant to act as a care taker helping the patient taking the medicine besides relying solely on the medical personnel. In many cases, members in the patient's family served in the position because they were familiar with the patient.

The DOT is employed to manage a social relationship with the TB patient to be different from what it used to be. World Health Organization had also recommended that the taker should not be a relative or someone being in a close relationship with the patient. Such a measure would allow more people to intervene in the lives of the patient. In taking the medicine, there will be a taker to check and record the time. These people might be a close relative of the patients themselves or someone, who would not be familiar with the patient. The goal of the strategy is to discipline the patient by controlling their time for drug consumption on time consistently. Sinsamut Hospital, serving as an operating organization, would adapt the strategy from using those who are not a relative to the patient's family member to make it convenient and consistent.

5.4.3 A home visit

"We are infected (by tuberculosis) if not taking drug, we could die. Taking drug would be 1 to 1.5 years. Some refused to come. We can't follow others who did not come up for medication. They refuse to give us their address, where they work or even the information about how many people in their family. If I had their numbers, I would visit them. When I was free, I would see them home".

Naing, an interpreter of the hospital, would provide health education to the patients along with verbally threatening them that the hospital would have to be tracking every TB patient, who refused to continue medication in a harsh manner.

Typically, the hospital had organized a home visit on Tuesdays after Tuesdays, along with Mother and Child Health Care Section, emphasizing on patients with a serious amount of sputum. In the trip, there would be some health personnel to assess the taking of tablets, along with counting the left ones and suggesting how to manage a daily living.

The home visit by health authorities might be a way to get access to the patients, showing their care. But, in fact, the assessment would aim at controlling if the patient had followed the knowledge given or not. This is also a strategy in "gazing" the patient unconsciously to the gazed. Medical personnel would evaluate the medicine by examining the color of the urine. During home visit, the staff would ask patients the symptoms caused by the drug, requesting to see the record of medicine consumption and giving a transparent container to the patient to store their urine to check if the urine turned orange or not. The color of urine assesses the drug taking behavior for whether it is practiced regularly or not. This practice would be taken more serious than the record in the book. Besides, the aims of home visit would be to do the screening of a practitioner into a system of "investigating" separating the patient from the normal.

Drug treatment of tuberculosis would require a period of at least six months and must have sputum examination to confirm the results of therapy. While some immigrants tended to move to a new workplace frequently making the home visit a very difficult task. This might affect the drug consumption or the original period because of the nature or duration of a new work shift.

"Moving to Wat Gate Temple, or moving to a factory; moving to Wat Gampra to work as a shrimp plant worker. they don't move to a new accommodation because they usually come to pick them up. The change of residence means they aren't unable to take drug consistently. When do they have to visit relatives? When do they have to work? How do they go there on Sundays? Typically, they don't work on Sundays. Sometimes, my calls weren't answered. In some factories, using the phone is prohibited. I had to turn off mine."

Naing, male, aged 36 years .

In addition to surveillance, there was also a branding of patients. Some immigrants did not feel convenient to have the health personnel or strangers to visit their home or workplace for fear that there might be a negative impact on their work.

"I used to visit in Soi Mama. Then a lot of their friends surrounded us, making our talk difficult. Some refused to let us visit because they were afraid of dismissal".

Kwanchanok, a home visiting nurse

The management policy of controlling illegal immigrants in Thailand is a process of creating a health security to the Thai people through the use of "surveillance" and "gazing" the body of immigrants in order to separate healthy workers from infected ones. Meanwhile, it is aimed at forcing the infected workers into the treatment as quickly as possible to prevent the spread of TB to the Thai people and their peer immigrants. Strategies employed by the hospital to monitor and control the behavior of the workers under a healthcare program included a home visit and the testing of urine color simultaneously. This might prompted the patients to be active in taking drug because they felt that they were gazed. They had to behave themselves under the disciplines and to follow your doctor's instructions. However, the main goal is to use their body as a capital. When they felt sick, it would be good to follow the doctor's instructions to change the patient's body into a healthy workforce again.

CHAPTER VI

ILLNESS EXPERIENCE AMONG BURMESE MIGRANTS: CROSS CULTURAL CARE

6.1 Tuberculosis in a world view of Burmese migrants

The given meaning of tuberculosis in the opinion of the people is in relation to an original ideology upheld by them, an idea about illness, a disease and a new ideology of capitalism, where modern medicine is growing very fast in modern medicine , in a capitalist society, consumerism and the acceptance of conditions in the Thai state's healthcare service system.

6.1.1 An unknown disease to them.

The majority of TB immigrant patients often did not know what kind of disease they had suffered until being notified by a doctor at the hospital and was diagnosed with tuberculosis. Some of them were afraid of this disease.

"I had never knew the disease before. At the hospital, it was told what it is though I am not sure what caused it" .

SanDar, female, 28 years old

"I didn't know what kind of fever I had. The doctor diagnosed it. I became scared. I was scared of death. I was scared that I would suffer from it forever. Am I likely to be cured?"

Tun, female, 41 years old

Some of the immigrants denied that they did not catch the disease because they had no risky behavior leading to the infection of tuberculosis; such as smoking. To others, the cause of tuberculosis was heavy smoking.

"I do not have a chance to catch because I do not smoke ."

Kyaw, male, 30 years old

"I felt [chest] pain is because of heavy smoking. I usually smoke three packs of Krongthip Tobacco I don't smoke traditional tobacco. I smoke only the brand for 2 packs daily. When my child was alive, I smoked a little. But when he died, I did smoke heavily."

Bo, male, 34 years old

After his 5-year- old son died, Bo was in sorrow and turned to smoking to relieve distress until he had chest pain and went to the hospital for a health check. He was diagnosed with tuberculosis. Bo believed that smoking was the cause of tuberculosis. Altogether SanDar, Tun and Kyaw led their lives like any other immigrants who paid attention to collect money to build a future for themselves and their families. When they became infected with tuberculosis, they did not pay much attention to it. Some immigrants even thought that their illness was due to smoking like Bo did.

6.1.2 Tuberculosis as a result of black magic

Some Burmese immigrant workers still had a traditional belief that the diseases was caused by something supernatural doing to the body. Sheuc was a Burmese worker, who came with her family to Thailand since childhood. Her main work was the selection of shrimp in a cold storage plant in the Wat Ket area. She became ill without a cause. Eventually, she believed that it was "black magic". This forced her to make a trip back to her hometown Burma for the first time in years after living in Thailand for almost 10 years.

"I could neither eat nor sleep. I was exhausted. I struggled to breathe. Even handling a pen to write is impossible. I used to think I wouldn't catch it. Supposing that I did, it might be because that I was too stressed out. With tuberculosis, I couldn't

find a hospital to have a treatment, I returned to Burma paying four – five hundred thousand kyat. I believed I was under the black spell. I'd better going to Burma to do a expelling ceremony "

Sheuc, female, 23 years old

Upon returning from Burma, she felt better. Shortly after that, she had the same symptoms including fatigue, the loss of appetite. She went back to the hospital. She explained that prior to the sacred ceremony to find a solution; the doctor could not detect it because it was shielded invisible by black magic. After the ceremony, it was evidently shown in the diagnosis that she was infected with tuberculosis. This is consistent with a traditional belief in spirits and the spirits of their ancestors.

6.1.3 Tuberculosis is caused by heredity.

Tuberculosis is a bacterial disease spreading through the respiratory system. It is easy to spread to surrounding people. Some Burmese immigrants, who were not familiar with science, believed that tuberculosis is a hereditary disease. When a parent had the disease, it was likely that his child might be infected with it as well. Like the case of Htabe's. She was responsible for packaging aluminum rods. She began with a chronic cough without any suspicion that it had been a sign of tuberculosis. Until her cough was manifested with blood coming out in an un-usual amount. She began to wonder if she had the disease. She rushed to Sinsamut Hospital Sinsamut. She was very ill and had to be admitted to the hospital for five nights.

"We used to think that there was no one is our family infected with tuberculosis in our family. The whole family also believed it. If a parent becomes infected, the child is likely to be infected as well. We thought if our grandparents did not have it, we would not either."

Htabe, female, 41 years old

Even though Dhi, the field officer of the Foundation, once believed that tuberculosis was a genetic disease as well. Until he worked on health issues and was given a series of health and scientific knowledge, he knew that the disease spreads through breathing.

"Before I was very convinced about what it was. But these days, I was less in such a belief. Formerly I believed that if a parent or a relative became infected, other family members would be infected, too. Before I worked here, I used to have the belief, too. In Burma, if a person was infected, it would mean that his relatives were infected, too. Not many people know that tuberculosis can spread through the air. In a training time, tuberculosis does not come from animal or any other thing but a hereditary disease passing from relatives. Today, the belief still exists but is becoming lesser and lesser."

Dhi, male, 26 years old

The belief that tuberculosis was a contagious disease passing through heredity, made more immigrants, who had uninfected relatives, were falsely confident that they would not catch the disease in spite of the fact that the symptoms were obvious of tuberculosis, these caused a delay among infected immigrants into the treatment.

6.1.4 Tuberculosis as an environment-induced disease

Infected immigrant workers often did not know that they already had the pathogen in their body. The majority of workers, who come to work in Thailand, would know that they were infected with tuberculosis consisting of 2 groups; namely, those who knew it after having their health checked for the registration of labor and those who ready had clear symptoms of the disease. Therefore, some people believed that their working environment with a lot of dust, smoke, heat and coldness, an uncomfortably small workplace and cramped work were the cause of the illness is tuberculosis of them.

SanDar had been working in a seafood processing factory. In her workplace, there was extreme coldness along with the processing techniques of processing breaded fish with the powder-pouring machine creating white powder puff all over the place. This makes it difficult for her to breathe. She, therefore, believed that her working environment made her sick.

"I have never had a serious sickness, but when I am in my room, I feel happy. When I am at work, they turn on the air conditioner. It is cool in there. I like it. My heart is also cool. I can't breathe easily. Feeling bad, I remain in the room. My throat turns dry."

SanDar, female, 28 years old

"In the factory, I release the frozen fish (breaded, frozen fish) and then they released the flour. I don't cover my nose. During work, I don't cover it. Covering the nose makes it difficult to breathe. After some time, I began coughing, a kind of cough without the sputum. The symptom got worse. They released it and I put it in the container and weigh it. The fine powder blew into my nose. I was waiting for one month. After a month, the symptom still persisted. It's a cough with my throat being dry. I couldn't eat. I lost appetite. I couldn't stand it no more. I had to tell my boss. I told that I was not well that I had to see the doctor. He told me to go to the hospital. I did but nothing went better. I changed my doctors but it didn't disappear."

SanDar, female, 28 years old

Both Htabe and Win were workers in an aluminum factory. Female workers in the factory had to pack the aluminum bars into the box. In the factory, it was rather hot and the workers had to work overtime. She thought that hard work and a little time to rest were the cause of her illness.

"I had a chest pain. It might be because of hard work. I got weaker and weaker. This year I had illness. Thirsty, I always wanted to drink cold drinking water. It was hard to be like this. As I was moving, there was a sweat. It was good to sweat."

Htabe, female, 41 years old

"This is an aluminum smelter. Some of it is dirty. Some has color on it. It is very dangerous. Lead is used by liquidizing in the smelter with a smoke billowing out. I breathe it in. Well, I did have a protective mask on. Still I felt it. Even coving with 3-4 masks at a time, checking I found thick sputum off my nose."

Win, male, 34 years old

Phyu worked in the gluing section for running shoes in Klong Sue, a small industrial community. In the process of gluing shoes, she had to use extreme heat to melt the glue. In her thought, it was a vapor from the glue that caused damage to her lungs. Finally it made her sick with tuberculosis.

"When gluing the logo to the shoes I had to cover my mouth. It is very strong and hot inside. It might be happening from the inside. Before being infected with tuberculosis, I worked using some chemical solution. After a long period, it damaged my lungs and I had cancer. "

Phyu, female, 22 years old

Sheuc worked in a frozen food factory. Her job was to check the size of the product to see whether it was under the standard or not. Seafood was stored in the ice under an extremely cold room. to maintain the quality and freshness of the food . She thought that working in an extremely cold environment for a long time caused her to be sick.

"I had a high fever. I went to the doctor in 2-3 clinics. To me, it might be because I had joined water splashing during Songkran water for too long. Or it might be because of the ice and the cold stuff."

Sheuc, female, 23 years old

The belief about the environment as a factor causing TB is a set of belief which the immigrant workers had brought from Burma because, general Burmese people still believed that the extremely cold weather caused a cold and other respiratory diseases including tuberculosis.

"My great grandfather took my grandma to take a bath at night. The rain came. She had a cold, probably tuberculosis. Now she is still alone, coughing."

Moc, female, 55 years old

The construction of meaning about the cause of illness reflects in their work life, which is hard, dirty work and difficult that they had to live in every day. More than half of their time was spent on work. They did not believe that they were a pathogen but the harsh environment made them sick.

6.1.4 Tuberculosis as a lung disease

The language used by the illness of the villagers often referred to a disease based on the infected organ. TB is a disease that can happen to all of the body organs. However, more than 80 percent occur in the lungs and the respiratory tract. The workers called the disease by the infected organ. The lung in Burmese is called "Asho". Therefore, tuberculosis was called Asho as well.

"In Burma, TB is also called TB."

Zin, female, 26 years old

"Asho mean lung disease. I had a cough for several years. In Burma, I took medicine for six. About one or two month, I became ill again."

Moc, female, 55 years old

6.1.5 Tuberculosis as a type of cancer

Burmese immigrants often considered that tuberculosis was a serious disease, known in Burmese as "Kinza" or "Kenza" with the symptom of bleeding cough.

"I 've often seen it in Burma. It is called Kensa or lung cancer. Or perhaps it is brain cancer. TB is very similar to this."

Win, male, 34 years old

The description of tuberculosis as a kind of serious disease known in Burmese as "Kinza" or "Kenza" is similar to what Phyu believed that glue was the adhesive substance eating up her lungs.

6.2 Healing themselves: Health Seeking Behavior

In explaining the cause of tuberculosis, some patients might be wondering what affects them. Some misunderstood that tuberculosis was caused by heredity or by the environment. These descriptions have led to the pursuit of a treatment based on faith along with limitations and conditions in their social context.

Grocery stores are a place where consumer products and medicines can be found, located within a community, where immigrant workers have their place of stay. The stores became the first choice in healing of disease in less severe cases. The majority of workers often began treatment with a medicine in stores to relieve symptoms; such as pain killers, cough drops and ointment because they did not wish to waste time waiting for a medical check.

SanDar worked in a seafood processing factory. She believed that the powder and the extreme coldness in production caused a problem in her respiratory

system. She, therefore, chose to purchase drugs at the pharmacy by giving information that she just had a cold and sore throat only.

"[Going to the hospital]) is a waste of time. A lot of people are there. When I go to the pharmacy I told the pharmacist I could not breathe normally. I just had a cold and a sore throat for him. Then I will be given 10 sets of medicine for 80baht".

SanDar, female, 28 years old

"War Tuek Clinic" is a place for general medication and midwifery, where those with social security insurance was able to get money back after paying for treatment with Srivijaya Hospital, located a few blocks away from the temple. The clinic was the same place, where the health officials said that a medical certificate could be obtained for 60 baht. After SanDar had taken medicine bought from the pharmacy, and the symptoms still persisted. She therefore had increased a concentration of the treatment by going to the clinic near her place for fear of wasting her working time. She was ready to pay instead of getting benefit from social security or going to a public hospital.

"Going to a clinic near my home costs me 200 baht, but if I go to the clinic at the market, I will not lose a penny because I have my social security. But I do not want to wait because there are a lot of people. With that situation, I don't care for paying money."

SanDar, female, 28 years old

Patterns of self- healing of ailing immigrant workers were not very different. For example, in Htabe case, she felt discomfort, having a fever, she went to buy "a set of pain killer" from a grocery store in the community. After she felt it did not recover, she went to the doctor at the health center and clinic for drug injection and other medicine. Clinic, therefore, had become a private medical service, where workers often seek. The clinic was an alternative besides by buying medicine at a

store. Until the situation got worse, Htabe became very sick and coughed with blood by the amount of a glass, she then sought treatment in Sinsamut Hospital.

"Before moving here, I was at a steel plant. When I first came here, I was unemployed. The unemployment lasted 3 months, making me stay home for 2 months. At that time, I began to feel chest pain. My body grew frail. I went to buy generic drugs at the shops around here. A set was previously sold for 5 baht. Now it is 10 per set. I went to apply for a job at the aluminum factory. I was there for 2 weeks or perhaps 15 days. This disease began. I had chest pain, then cough and then felt cold throughout the body. At that time, Win also asked where I had been. I replied to him that I went to the doctor at a clinic and a healthcare station at the other side of community. I took medicine and got an injection. After 3 hours of the injection, I recovered living as a normal person. However, 3 days after that, I suffered the same symptoms. Finally, I went to the hospital, staying there for 5 nights Sinsamut Hospital."

Htabe, female, 41 years old

According to the medical record and check-up of Htabe's sputum, it was found that she had a 3 level of tuberculosis meaning having the highest amount of sputum. The reason why she went to the hospital late because she never thought she was infected with tuberculosis.

"The symptom began around 8 o'clock in the morning until one in the afternoon when I felt cold. After 2 P.M., I felt better. The period between the mornings until two in the afternoon, I felt breathing difficulties and coughing. Two days after that the symptom kept repeating. When I knew I was infected with the disease, I was not afraid. But when I had blood coming up, I was afraid. I was afraid that the body would be weaker and

weaker with a chronic coughing. Finally, I decided to go to the hospital because the coughing came with blood as much as filling a full glass. "

Htabe, female, 41 years old

Entering a treatment too late might be making the medication less successful. Aye's case was a good example as she had taken TB medicine for more than one year but not yet fully recovered.

"I started with a cough, chest pain, and back pain. The pain grew more severe. I went to Mahachai II Clinic. I received no treatment. The doctor checked my medical record and told me to go to the hospital. At the hospital, I went for sputum examination and then had an X-Ray. I have been taking medicine for more than a year. I still do not recover. I am desperate, wanting to stop taking it."

Aye, female, 23 years old

Even though some immigrant workers went for TB drugs at Sinsamut Hospital, they still had less confidence in the hospital than in the clinic, where they usually received medical services.

"If I still do not recover, I will go to see Doctor Kaona. I will ask him for an X-Ray. There have been a lot of people going there. A lot of them recovered. Many people suffered the same disease like I do. They refused to go to the hospital. But the doctor issued an appointment to come."

SanDar, female, 28 years old

6.3 Hospital as an alienated space

"A Burmese interpreter, please go to the examination room on the 2nd floor" the voice announced over for a second time loudly across the hospital to alert an interpreter from the healthcare unit to provide services to migrant workers from Burma who cannot speak Thai. The "interpreter" has become one of the units that allows the hospital services even more comfortable.

"The trouble is that Burmese workers are dependent solely on the interpreter alone. I do not know what they say. We do not know if the information provided is mutually understood. The problem now is that hospital has currently had one interpreter named Naing. She knows about this."

Phakamas, a communicable disease control officer

Although the hospital has a Burmese interpreter to facilitate the staff in the hospital, there are other obstacles being a barrier to chase away the immigrant workers from the hospital. The author used to visit Khaing because of the fact that she had a drug allergy with a rash on the body. The residence of Khaing's and another seven worker fellows, was an abandoned building with 2 floors located within Wat Ket area. All of them had shared rooms with a condition similar to the old classroom with a broken blackboard in the room. The author did not meet Khaing that day, but meeting with her male friend, Aung, in this building. He went out talking. When he learned that we came home from Sinsamut Hospital. The man had reflected what he found in the hospital detailing that the officers talked them down. He would like them to treat the workers as humans. The author asked what he and his friends always did when they got sick. The only answer is that the clinic. Furthermore, when being asked about the cost, he said it was no difference. According to him, taking a taxi, he would pay a hundred baht. Similar to SanDar and Zin who had been improperly treated by the hospital staff, reflecting the quality of service. The healthcare providers did not speak politely and also likely scolded at her. Sometimes she was not fully treated as she should.

"I'm too lazy to see him. He had asked me in a very impolite way --the doctor at the Bodhi tree. He asked me in a very mean manner. I mean that small doctor."

SanDar, female, 28 years old

"It should be a very serious case to be diagnosed. Otherwise, they wouldn't. "

Zin, female, 26 years old

Sinsamut Hospital is considered a secondary hospital with a full-coverage of medical services with almost of all medical services. Each day, there were a large number of patients waiting for services. There were multiple stages to get through and several departments have the patient in contact. The majority of signs were written in Thai. However, there were just some written in Burmese; such as arrows on the pavement, the restroom signs, a sign to the copy center and one leading to the payment section. Since the hospital has a Burmese interpreter in service, most immigrants complained about wasting their time for the waiting. The clinic is a popular choice of immigrant workers rather than the hospital.

"I don't like going to the hospital because it takes a lot of time. They usually assign me to take drugs alone. However, going to the clinic, everything was done within the same room. There are many rooms to go at the hospital. That makes me confused. Well, in a serious case, I went to the hospital. In a less serious one, I just went to the clinic because I don't want to waste my time. If the doctor at the clinic do not tell me to go to (hospital)I won't do. I don't like being sent back and forth".

Htabe, female, age 41 years old

"It took a lot of time to wait at the hospital. I like going to the clinic. I think I would be cured after taking whatever medication there is."

Zin, female, age 26 years old

The cost of service at the hospital for patients with no health insurance was quite expensive and there were also other costs such as travel expenses.

"Without the insurance card, I would be charged 799 baht. It costs 200 baht for taking a motorcycle taxi to the hospital. Whatever the amount, I have to pay. I am afraid the money I owned doesn't cover"

Moc, female, 55 years old

"I have to pay 270 to 300 baht for each visit. The drug is expensive. In Burma, drugs are available for free. Now I fully recovered. After taking drug rash, I had a rash for two days. I did nothing to get rid of it. It just disappeared."

Khaing, male, 39 years old

"Because of my illness, I came to the hospital. A chronic coughing continued for 5 months. I was issued a TB certificate. I understood what it said. I was infected (with symptoms written in the pamphlet distributed). My fear was that it wouldn't be cured. After taking medicine for seven days, it was gradually better."

Sheuc, female, age 23 years old

Some immigrant workers had chosen Sinsamut Hospital as their main choice for different reasons; such as, the familiarity with the Burmese interpreter, along with an impression with the hospital staff or a confidence in the effectiveness of treatment.

"I know a hospital interpreter at Sinsamut Hospital. When there was a worker going there, I would call him to let him take a good care of the worker. I told him that for those who are not Thai unable to read Thai, it is his mission to know the TR 38 form. He already knows what the code name is, what the name is. In reply, he agreed to follow the instruction."

Win, male, aged 34 years old

"I usually come to Sinsamut Hospital. The Burmese immigrants like it. In cases of women about to give birth, the hospital is better than the other. The staff was good, unnecessarily relying upon an interpreter. Well, some doctors scolded me. I used to bring a friend there. "

Sheuc, female, age 23 years old

"In fact, there is nothing to be afraid of at the hospital. There I was at ease. The doctor at the hospital told me it would soon be gone. I thought I was at the hospital at the moment. It would be cured. I was afraid of nothing."

Htabe, female, age 41 year old

6.4 The pathogen versus drug: the struggling body, negotiation, surrender and misery

TB patients often seek remedies illness of self or family members who are infected with TB by a belief in the cause of the disease. When being treated with a simple method did not work, the hospital with a scientific procedure had fragmented lives, illness and disease apart. The hospital emphasized the cure of "tuberculosis" that is caused by bacteria. Therefore, in remedy, for the use of antibiotics to kill bacteria in the body of the patient, the hospital had a program to educate, motivate and monitor drug taking practices. To treat patients successfully in curing the disease meaning the

treatment of tuberculosis, TB patients were forced to be willing to negotiate with the rules and resistant to the advice of doctors in different levels.

6.4.1 Those who comply with the doctor's medical power

Among 5 out of 13 participants in the research accepted and follow the doctor's advice strictly. Of these, there were 4 women and only one man in having the discipline to practice the consistency of drug taking, mask wearing and the separation of apparatus, including the management of a new environment to let the air flow and a separation of sleeping area.

Khaing was an immigrant worker, who came to work in Thailand for 8 years. Besides, he was still listed as illegal immigrant worker because he had no Tor Ror 38 / 1 card and a passport. He currently worked as a construction worker, staying in Wat Kat area, almost never going anywhere else outside. Tuberculosis was a disease unknown to him. Infected, he thought it was a general fever. He went to the store to buy some medicine. When it did not get better, He went to the health station for an injection, After that, for a month, he went for a health check and found that he was infected by tuberculosis.

Illegal and unregistered immigrants, who could be allowed to remain in the country temporarily by applying for Tor Ror. 38/1 Card, were excluded from the Thai health insurance system. When they got ill, they had to pay for full medical expenses. In Khaing case, normally he had to pay for full medical bills. But he was fortunate to have been accepted for a special project of a foundation to assist immigrants infected with TB and HIV. Luck sometimes came with a disaster. When he took TB medicine, the author was told by a foundation officer that he was allergic symptoms, fatigue, and weakness with a rash and, therefore, had to visit him because he could go to work as usual. When the author met him again at the TB clinic, he described the allergy and the doctor's suggestion for rash ointment not taking more drugs.

Although Khaing really received knowledge from the medical personnel that tuberculosis could be cured if TB drugs were taken preventing the disease from spreading. He also realizes that the germ was in the body. Thus he avoided living with family members or colleagues as normal for fear of the spreading to others.

"The doctor said that the cure could win the disease. I do not fear anything. I take drugs at about eight o'clock everyday based on the time on my watch. I am afraid that it would infect my children. My belongings were set apart from those of others'."

Khaing, male, 39 years old

Khaing lived with his wife and his two children. In addition to having a construction job, he was responsible for cooking and cleaning the house. He also takes care of all the family members, along with caring for himself. The foundation officials realized that Khaing had followed the instructions. They gave him a mask he wore another box of masks. He would use it for work in the construction site because sometimes the dust caused by cement and sand made him cough. His colleagues did not have questioned anything. While in residence, he was wearing a mask for fear that his children will be infected. He separated his food containers, avoiding having food with his wife and children for two months until the officer of the foundation told him that his symptom was beyond the spreading period. He was very happy to be living and having food with my children again.

6.4.2 The negotiator: selecting a choice based on their own benefit

7 out of the 13 participants were female and a man, who followed the advice of the healthcare personnel. However, they did not strictly follow in every aspect because some of them had a limited time to work, a crowded household to care for, and a problematic behavior of drug taking.

Phyu was a Mon female worker in a shoe maker factory. She was responsible for gluing shoes. The author had visited her since the doctor advised her to stop working for a month. She had a compensation of 5,000baht. During the first period of the author's visit, she had taken only 12 days. She described that she took 4 pills at 3 P.M., looking at the clock. She was very tired, having the symptom of small coughing and eating normally Phyu did not wear a mask. However, she knew that her spoons, bowls and other eating utensils had to be separated from that of others. She had her own container for the sputum. In conversation, she avoided talking about wearing a mask by saying that *"TB is curable by taking drug for six consecutive*

months." Meanwhile, her mother had never heard of TB disease but did not know its cause even though she understood what symptoms could be coughing with blood and taking medicine for 6 months.

After a home visit by a medical team to educate her about preventing the spread of TB by wearing the mask, the author met her several times. Each time she did not show any anxiety at all. Fortunately, she had no allergic the drugs taken. Then she recovered and was able to work normal normally before she had submitted a medical certificate to the factory to show that she could work normally. Although it had been almost 6 months of medication, she was still wearing a mask when talking to her friends along with the separation of utensils from those of others as soon as some friends went to her room to pick up her glass. Phyu was also working with a mask on. She felt much more familiar and comfortable with the mask and wanted others to wear it, too.

"I know that while working I have to have my mouth covered. With tuberculosis, I had difficulty breathing. But it is okay now. I feel more comfortable."

Phyu, female, age 22 years old

Some immigrant workers did not understand what the doctor explained to them. The author met Sheuc at her residence in the white Building Three away from the city of Sinsamut for about 5 kilometers. She was enjoying the game at a vending machine at a shop selling snacks close to her place. Generally, she had to work at eight o'clock at night until 6 o'clock in the morning. After work she would normally took TB drugs at 7 A.M. The author greeted her and asked about her medication. It was apparent that she did not or took the medicine because of some misunderstanding. It was that time when the author began explaining about the importance of a regular drug usage.

"I haven't taken it yet. The drug is said to be taken before going to bed. I work over-time, being up all night. I'll take it tonight. Tonight I don't work. I'll take it in the evening before bedtime."

Sheuc, female, 23 years old

TB infected patients had to adapt themselves because they had to take drugs on time. Some of them work on a night shift while others work a day shift. Sometimes there was an overlapping of working hours. The instructions for drug taking had to take into account the context of the life of the patient as an important factor. Fortunately, Sheuc was not allergic to the drug with a positive attitude towards continuous medication at the hospital that

"After taking medicine, the urine is orange. However, I have no symptoms of drug allergy. Infected, I had to take medicine every day, beginning at 7 A.M. and night time when I work."

Sheuc, female, age 23 years old

6.4.3 The resistant: denying for being infected and refusing to take drug

There were those, who did not follow the doctor's advice; one was male and the other female. Taking drug was considered the most important form of treatment in a process of curing patients with tuberculosis because, without drug, the body of the patient would deteriorate and eventually the person would die. The impact also came in a form of spreading tuberculosis to surrounding people including family members, fellow workers and the general public, including the Thai people.

A team of medical personnel had a mission to follow to maintain the continuity of drug taking among patients, who failed to show up according to a medical appointment. As in the case of Kyaw's, whom the hospital officer called to see the doctor in the previous week, the answer from his foreman was that he had returned home to Burma. On the Wednesday afternoon of the same week, the author went with the hospital staff to visit a fish sweetening factory where Kyaw was known to work. The team had to wait for almost 30 minutes outside the building. The foreman, who was also a Burmese immigrant, came in to question the purpose of a home visit. After we had described that the team was from the hospital, normally visiting patients without any association with the police, we were allowed to walk into the factory to meet Kyaw, the infected worker, who turned out to be resistant to the

doctor's appointment. The author and the team went into the inner most part of the plant as Kyaw was willing to have a talk in his place. At the time, he agreed to have his sputum tested again on the coming Thursday. It was that time when the team understood the reasons why he had resisted the continuing medication; his wife told him to stop taking drug and also he was afraid that his employer would know that he had been infected with tuberculosis.

"My wife said that I had already recovered (fully cured). I don't need to follow the appointment. I was afraid that the factory owner would know about it. I know that TB is contagious, but I don't know how it spreads. I take the TB drugs around 8-9 P.M not regularly because there was a lot of work on the fish. I also had nausea after drug taking. My wife didn't know that I was infected with TB. She blamed me for not quitting smoking."

Kyaw, male, 30 years old

Kyaw was dissatisfied with the fact that he had to wait that long and did not understand why he had to go to hospital as he no longer coughed. During that day, there were more than 30 TB infected patients waiting for service. Kyaw had to "wait" for a very long time because he was not a patient by appointment. His medical profile was either prepared in advance. The interpreter explained to him; "Today, it is for a sputum test. You have to wait for a while for the lab result. When it turned out that Kyaw was still infected, he was instructed by the interpreter to "take the medicine on time" and put his sputum to test again next time.

"I didn't cough. The nurse came to bring me to the sputum test. I don't understand how it spreads. I don't understand why I had to beat the hospital. It was not an appointment day. I don't understand why the hospital had to call, demanding me to take medicine every day."

Kyaw, male, 30 years old

On the opposite of the chair where patients were sitting, the Burmese interpreter and the field staff of the foundation were trying to persuade Than to take medicine on time in a regular manner because she turned out to be very resistant to drug taking. She started the drugs on April 26 by taking the RIMSTAR at the amount of 4 pills before switching to the medicine given by Doctor Kaona, the physician at a clinic, thinking that the doctor's medicine was better and smaller in size. She had to pay 600-800 baht for the drug. She took 10 to 12 tablets at a time. It took 2 hours for the staff to persuade her. Than refused to take medicine even though she was forced. That day, Chan, the foundation officer, came from the hospital, claiming that the medicine would be changed into a smaller in the future. Even though Than was acknowledged that tuberculosis could be cured by taking medicine, she did not want a big tablet. She was suggested by the Burmese interpreter to stuff medicine inside a piece of ripe banana before swallowing it.

"I know that the disease could be treated by taking medicine. I still do it. However, I don't like medicine with big tablets and take it alternatively in the other methods. With a big tablet, I can't take it. I used to go to see another doctor. I was given another drug that is easier to take."

Than, female, 26 year old

The author noticed that Than wore her mask covering only the mouth and exposing the nose to make breathing easier. Then the author asked her if she wore the mask like this at home. In reply, she said she did but the doctor did not recommend anything more than that.

6.4.4 The plight of tuberculosis-infected immigrant workers

Aye had been working in a factory for a period of four years. Even though she worked 12 hours a day for six days a week, she had never been so seriously ill that she had to go to the hospital. Sometime, she felt exhausted. She would go to see the doctor at a clinic to receive vitamin complex injection. On the annual health check for work permit, she discovered that she had been infected with tuberculosis. After a 2-week sick leave as demanded by the doctor, the personnel department of the plant

turned out not welcoming her to return to work by telling her to quit it. She was very upset with the words of the HR officer because of she had been working diligently for the factory without any absence or a leave. When she and her fellow workers were asked to work overtime, they did say a word of rejection. She recounted that she felt exhausted so the doctor at the clinic gave her a vitamin injection. But when it was discovered that she had tuberculosis, she faced with a turning point in life to be out of work.

"At the factory for 3 - 4 years, I had never been severely ill. I never had to go to hospital until the day of extending my work permit. The doctor told me my lungs went bad in need of a sputum examination for three times. As learning that I was infected with tuberculosis, I was frightened in fear of it being a chronic disease. The doctor told me to have a 2-week leave. But the factory told me to stop working. I was very upset with the remark."

Aye, female, 23 years old

The author met Aye for the first time as she started TB treatment. That was when she stopped working by a recommendation of her doctor. She lived at the old wooden house behind Wat Krok monastery. The area was where workers, Thai and Burmese, who worked for the temple, had been living. It was an elevated wooden house with the ladder eroding across the stairs. At her residence, there were windows but the place was in a very cramped conditions. It was an empty room with no proportion having 3 mosquito nets, generally spreading close to one another, were placed in roll next to the wall. Aye was lying on a mattress. On the other side, the windows were kept closed all the time because her sister worked in a factory during the night and came back to rest in the late afternoon. Her brother and her mother worked for the temple during the day. She could not open the windows to let the sunlight for disinfection.

She was one of those, who were allergic to the TB drugs. She felt exhausted and could not eat. Eventually, her doctor had to switch to a new TB drug to

prevent her from vomiting daily. However, she was lucky to have her mother, brothers and sisters to encourage her.

"I will be back to Burma. I told the factory that I would go home for a treatment. I was told to quit the job. I would return to work after that. Since then it has not worked so I thought that if medicines have five months to recover back to Burma. I went to visit my grandmother. Now, I have not lost it over the years, I would not want to eat it then."

Aye, female, 23 years old

Aye was less fortunate than other immigrants because she was infected with a drug -resistant tuberculosis. She continued taking medicine for almost two years. Although now she got a lot better being able to leave home on her own. The abbot allowed her to work for small job; such as gluing the candles measure. One day, the author found Aye at Sinsamut Hospital. She did not come to receive services from the TB clinic. However, I noticed an unusual lump on her neck. She recounted the following story.

"Today I came to check the lump on my neck. The doctor examined my neck but the result was not yet announced. The testing costs 4,950 baht. I am still there to help small jobs at the temple. Sometimes, I made candles for sale to those who pay homage to the Buddha image. The abbot hired her to work 15 days for 2,500 baht. I spend the whole time working for the temple."

Aye, female, 23 years old

Aye was among immigrant workers, who had received social security. She was infected with tuberculosis and did not return to work at the factory because her health was worse than the early stages of taking TB drugs. She had sent money to fund social security. However, when she did not work, failing to send money to the fund in

order to maintain her own status, she was not eligible for medical expenses. She ended up with losing all the benefits. The cost of the tuberculosis treatment she received from the Foundation has been a special project of the Global Fund. However, the cost of treating a lump on her throat had to be on her own expenses. Sometimes she thought that the lump in the throat was caused by prolonged drug usage. Now the doctor had shifted to a new formula of TB drugs with more effective effect. So she was injected with the drug along with consumption. Sometimes, Aye lamented with the author about her fate that she had been good all her life. She did not understand why she had to be affected by a chronic disease. She was tired of taking drug and seeing the doctor. She wanted to return to Burma to live with her grandmother, wishing not to be a burden to her mothers and sisters and brothers in Thailand. During TB treatment, her health was improved with no allergy reaction, she returned to Burma one time during Songkran. However, she was not allowed to leave home. Grandmother let her stay home doing nothing. She felt bored so she went back to live with the mother in Thailand.

6.5 The caring of self-health.

After being admitted to the hospital's treatment system, TB patients would be provided TB drugs; such as Rifamycin, Isoniazid, Ethambutol, Pyrazinamide, and Vitamin-B Complex. The patient would be suggested to take drugs regularly and cared for their health by Burmese interpreter, as Phyu told us in the following statement.

"Knowing what to eat every day of the separation of belongings, Naing told me to open the windows. I am afraid that other people might be infected. When I stay in the room alone, I don't wear a mask. The pill is nowadays small in size. I have no fear. I am not sure when I will be cured but my doctor said it takes 6 months. It hurts to know that it is me who is infected while other Burmese people don't."

Phyu, female, 22 years old

In Phyu case, folk medicine in the form of Burmese tonic was also used. The drug allows her to have a greater appetite commonly available in the Burmese-styled market or in grocery stores in the community. She recounted that normal people could take it, too to enrich the body. The author did not find that herbal medicine or folk medicine could be used to treat tuberculosis. Most drugs were supplied by the hospital such as in the case of Sheuc, who worked as an employee checking the size of the shrimp in the freezing plant. She worked at a night shift because she would be given the "sleep-depriving wage" with an additional of 20 baht per day. The following is what she described her daily life during the taking of TB drugs.

"I woke up in the afternoon. About 6 o'clock in the evening, she would leave the room to eat dinner with her husband. After that, about half past seven, she would be on the bike to park it at the roadside before crossing the bridge to the opposite. Time to clock in is 2 P.M. At the 6 o'clock, my work ends. Then I bike back to my room take the pill and sleep at 7 o'clock in the morning."

Sheuc, female, 23 years old

However, some TB patients taking medicine on the advice of the medical personnel and had a strict regulation on a forbidden because she believed, according to her observation, that it would cause a more severe allergic reaction after the consumption of the eggplant plant family, dried fish and energy drink.

"TB patients aren't allowed to eat because they would get itchy. After eating eggplant with dried fish, I felt the blood circulating up my face. Fermented stuff and M-100 (energy drink) are also forbidden. Eating a purple eggplant also causes the difficulties."

Zin, female, 26 years old

6.6 Living with others: being accepted or offended; openly or hidden

6.6.1 Tuberculosis; we can live together

Although TB is a serious disease according to the immigrant workers' definition, they could live with other infected fellow workers without any negative attitude. They encouraged one another. Such as in a case of SanDar's whose residence was shared in a large wooden two-story house covered with thatched roof. It was very hot during daytime. Her bedroom was in a small corner of this house. There was no air flow and sunlight was almost impossible to get in. The area of the house was approximately 1 x 2 meters. However, she was satisfied with her personal space because if she had stayed in the other room, it would be very hot. The members in this house lived like a family. They had their own pots of rice. But in general they tended to share food with other members. With a relatively close-knit relationship of members within the house, SanDar had a very good care by friends during her loss of appetite. They cooked SanDar's favorite food to share with her, asking caringly about the illness and gave her encouragement.

Win was a Mon worker in an aluminum smelting factory. He's like a big brother to take care of younger friends. When Win saw a friend's skin with a burned wound in factory, he would be going to ask caringly what it was. After that he would tell the fellow worker to see the personnel staff. Then he would complained why his workers failed to care for one another. In this factory, a lot of dangerous chemicals were used. It is fortunate that Htabe had shared his residence in the same building and worked in the same factory with Win because they had a close-knit relationship and wanted to help other workers, who could not speak Thai. When a fellow worker fell ill, Win, being able to speak Thai fluently, would serve as in interpreter for the hospital staff.

"If I had to move away somewhere else, the people here would be in difficulty. My sister still has not yet resigned. There are 5-6 women here. My sister couldn't speak fluent Thai. I had to bring her to the hospital. At the hospital, it is still difficult when the doctor asked her and she didn't understand it."

Win, male, 34 years old

Win asked about how Htabe felt daily and treated her as if she was his sister. Although Htabe's body Drawn was frail after a 5-day hospitalization, the fellow workers in the same building did not show any fear because they knew that Win went to care for her regularly. While other workers, living separately without any interaction did not care about whether Htabe had to wear a mask. Besides, Win had to oversee other workers in other factories, who did not shared the same residence as well.

In the case of Phyu case, during her first stage of TB infection, her mother had a duty to bring food and drug. However, from then on, her mother Phyu did not stay with her because the mother had to take care of a newly born baby in another community not far away from where they lived. Therefore, the fellow workers had a significant role in caring for Phyu and warning her about taking medicine, along with doing the DOT without showing any disgust toward what she was.

"At almost 3 P.M., he would walk down to ask if I had taken drug. The people the here love me. I would tell them to be careful when talking with me. They told me they were not afraid. I told them they should because I had TB. It would be dangerous if they caught it. In using a bottle of water, I would ask them, which belonged to me. They had to separate it. They are afraid that I would be sad. They give me snacks. I do not eat them, not because I am angry. I have to wait until I recover."

Phyu, female, 22 years old

Maw told a story about her experience in taking care of a friend. One day, a foundation official visited a house as kind for a volunteer to act as a DOT watcher. Maw actively volunteered for this duty. At the 3 pm every day, she would walk into Phyu to ask how the symptoms were, along with giving her courage and reminded her of regular drug taking.

"Is that the time before having a cough, right? She then told us. If the cough is so severe that she could not be sleeping, losing to

much weight. She had to go to the doctor immediately. It does not hurt a bit. If we take drug on time, we would soon recover."

Maw, female, a DOT Watcher

Immigrant workers, who know that they were infected with tuberculosis often did not hide the story from their family, relatives or fellow workers. When their friends knew it, it is likely that they would still be the same. Such as a case of Maw and Phyu, who were close friends, working in the same shoe factory. She never showed any disgust toward her friend. Instead, their relationship grew even closer thatPhy Win Friends had to stay far for fear of infection with tuberculosis.

"A friend infected with tuberculosis is not what we need to fear. However, Phyu ends to stay away. She lives in another direction. She told us about the disease. We understand it now."

Maw, female, a DOT watcher

6.4.2 Better keeping it as a secret: Fear of being fired and unemployed

Immigrants often kept their story a secret from the employer for fear of being fired and never work. But some of them thought it was useless for their employers to know about it because they had to work. A home visit to TB infected immigrant workers and their residence in the area was nor convenient. The author had to do the visit because of the fear that the factory owner would know about it. The patient would risk being fired from their jobs as in the case of Kyaw's expression of not wanting the health team to visit his house because he lived in the sweetening fish factory. There used to be a former case of a fellow worker being fired for having scrofula.

"I know that I am infected with TB. I fear that my boss would know it."

Kyaw, male, 30 years old

Like Than, who had refused to let the author to visit the home because he was afraid that the dormitory owner would know it. A person before him was dismissed from that place because of the disease. Than's daily life involved having dinner at 6 o'clock and then went to work. He had a work shift at 7 P.M. She usually finished her job around 7 A.M. As she was at her room, her mother would cook for her and mashed TB drugs for her consumption about 9 o'clock in the morning before going to bed. She was living with relatives, who showed not disgust, sharing eating utensils and refusing to live separately.

During working hours, she had to wear a mask according to the factory's regulations. However, when she lived with her mother and sister, she did not wear it because during her time of stay, her mother and sister went for a night shift. She had to be at her room alone.

CHAPTER VII

CONCLUSION, DISCUSSION AND SUGGESTION

This study is aimed to investigate the illness experience of Burmese immigrants infected with tuberculosis under the service, management, control and treatment of tuberculosis existing in a cross-border context is by describing such phenomena under the framework of transnationalism, neo-liberalism, governmentality and illness experience.

This study is a qualitative research based on the methods of ethnography to investigate the illness experience of Burmese immigrants infected with tuberculosis in health facility in the Thai state by the techniques of data collection including 1) in-depth interviews with TB immigrants TB and their related service providers; 2) participatory observation; 3) exchanging ideas about activities in daily living in the patient's community; 4) collecting everyday conversation within the health facility. The researcher had chosen Sinsamut Hospital as a starting point in data collection and expanded it to the community of TB patients living in Muang district in Sinsamut province. The duration of the study was between March-May 2012 as shown in the following summary.

7.1 Conclusion

7.1.1 Context of transnationalism

Burmese immigrant workers in Thailand consisting of the Burmese and the ethnicities including the Karen, the Mon people and the Tai Yai required to live together in the same community and workplace. They have a variety of beliefs, traditions, and culture coexisting in an attempt to have a minimal conflict as possible. Meanwhile, immigrant workers of the same ethnic group often assisted and cared for one another because of their common goal, which is "working" transforming their labor

into capital to become the "currency" to send it to the family in their home country. They started a job through a network of friends or relatives who had come before. In the beginning, they tended to get a small payment in a heavy, dirty and dangerous job, mainly working in factories six days a week, or 12 hours a day. They often lived near the workplace. In their communities in which they live, there were grocery stores or flea markets selling products from Burma including fresh herbs, dried food, clothes, books and CDs/movies. Technology and telecommunication have effectively broken the boundaries of countries while linking the lives of immigrant workers in Thailand and their bordering hometowns effectively. According to Appadurai (1990), globalization is a process of crossing the state power and boundary into the bonding of different countries penetrating in all across dimensions and boundaries in terms of culture, information, ideology and ethnicity. The research also confirms the circulation of culture in 5 dimensions mentioned above made ethnic identity adapt and survive in the context of transnationalism.

7.1.2 Policies and practices of the state in control of tuberculosis in migrant workers as governmentality

Thailand's public health policy toward immigrant workers was based on the myth of nation state and the idea of nationalism, validating the identity of immigrants as a germ undermining stability issues of health of the nation state and the Thai people. Immigrants were forced to show a medical certificate to be registered to have a legal status for a work permit. TB infected patients had to be brought to the treatment system until they were fully cured to guarantee that they were healthy capable of productivity for the employer and being safe in terms of health and safety to the state. As Thailand did not know the number of immigrants entering the country a form of population control by providing the registration and screening for specific diseases were strictly performed against forbidden diseases.

Securitization is a process aimed at reducing the lives of immigrant workers into the object of observation by the state. Healthcare agents served to monitor the surveillance and monitoring the health of workers for fear that the workers would bring contagious illness to spread, ultimately affecting the stability of the health of the Thai people. In a practical level, Sinsamut Hospital had a treatment of TB

infected immigrants with an interpreter providing knowledge of how to care for health and the management of their environment. When patients believed that they had a very powerful drug in treatment, they would also possess the power to fight against the disease by taking complete medication and taking drug on time. The hospital also provided a tuberculosis clinic once a week by providing space for the staff to have a convenient monitoring of the behavior of patients. Therefore, every patient, who had entered the area TB clinic, would have to be docile and were willing to wear a mask to show the health personnel that they manually, followed the instructions strictly.

When TB patients were discovered, they would be screened for exposure to tuberculosis. The medical checking of their sputum examination was ready to confirm the results of treatment and might give those in the community a status of a DOT watcher, a practitioner, who exercised power on the body, to control time and space to make patients docile with the state controlling and overseeing the continuation. This is a form of surveillance directed through medication besides a follow-up home visit to monitor the drug taking habits and regular medication. It is a new practice of discipline in the lives of the patients including an inspection of the environment in their residence to prevent the spreading to others. This process of building confidence in health prevented those patients from spreading tuberculosis to fellow workers and Thai counterparts. This is in the form of power monitoring and medical knowledge in the health care delivered to the patient through an interpreter that it remains as intact as it is not endangered through medical norms to stabilize the social health in the Thai society. In this research, it was found that not all of the immigrant workers followed the advice of medical personnel. Instead, they selected and chose only convenient and affordable way to their own practice. They also brought their traditional medical culture in application with the modern one. Meanwhile there were some, who refused to have a medical treatment by denying the existence of their illness.

7.1.3 Cross-cultural care of immigrants infected with tuberculosis.

Immigrants infected with tuberculosis had a different definition of the disease. Some of them did not know the cause of the infection affecting their own health. Some believed that it was caused by black magic, their poor working

environment with extreme heat, coldness and smoke. When they got ill, they would buy drug based on the symptom before getting to a clinic or healthcare center. When the symptom got worse, they would seek assistance from the hospital.

The hospital was almost the last resort that they would choose to have a service because of alienation, being unfamiliar with the services with several departments. Although there was a Burmese interpreter in service was still not able to bridge the gap in communication and understanding, and changing the behavior in health.

In the provision of meaning about the body of TB infected immigrants, a study found that they considered themselves being able to spread tuberculosis to surrounding people because they had accepted the medical knowledge. The health club was an organization set up to help members, who were migrant workers infected with tuberculosis. However, the patients did not feel the need to participate in club activities. Their role was simply a temporary member. To their perception, they had already been under surveillance from the Thai people. Infected with tuberculosis, they even felt being under a closer observation. Immigrants had been transformed into their own "labor" as a form of their own machine of money production. And they had to work to achieve capital accumulation to create wealth for the sake of their family at home.

Immigrant workers infected with tuberculosis often declared their illness with their own fellow workers working in the same workplace and staying in the same community and in the same work. Meanwhile, they tended to hide it away from their employers for fear of disrupting their employment.

7.2 Discussion

7.2.1 Transnational labor in a context of transnationalism

The results of this study found that the explanation of immigrants Thailand was based on 5 cultural dimensions to see the lives of immigrant workers who have been in misery and exploitation in a more covering manner. However, it was found that there was a lack perspective on the dimension of gender in health. Immigrants

from Burma also displayed their ethnic identities in various merit-making fairs. Religious beliefs are tied to their lifestyle. Burmese migrants of various ethnicities also display their own unique identity through their dress and cultural traditions. The dress was different from what was worn as a uniform or clothing in a normal day. In addition, the work of Jiemin Bao (1998) states that the identity of the Chinese diaspora in Thailand was based on the family space. After having stayed in the country for a while, the Chinese in residence were exposed to cultural values and social norms of the country, accepting the idea that a man should be ordained to be a complete person, and so on.

Burmese immigrant workers, who came to work in Thailand, often started out being indebted and had to pay for a commission to do their jobs. At first, they have to work hard to get themselves and their family out of debt as with a study by Suriya Samutgupta and Phattana Kiti-asa (2542) in studying Thai female immigrant workers in Japan, explained that those women were seeking to pay for debts and sent money to their homeland Thailand but not studied in view of Buddhism. Meanwhile this research suggests that immigrants were willing to do merit-making. Although it was done in Thailand, it was still seen as promoting or preserving Buddhism as well.

In studies on immigration of Thai female immigrants being married to western men by Panithi Suksomboon (2009), it was found that cross-cultural marriage of a Thai woman and a Dutch man provided an opportunity for her to start a new life and a chance to immigrate and work in a developed country. The role of women was expected to provide financial support to families in Thailand. However the difference of defining the family in the two cultures, there were troubles in sending money back to the woman's parents. In Rattana Boonmattaya's work (2548), a view is given that Thai woman are married to a foreign husbands had the role of a good daughter. With economic success and a better life, they sent money home, pay debt, raised their children, did a home repair and supported religious activities in the home country. But this study found that immigrants from Burma often sent money back home to care for their family in Burma to show gratitude to their parents. The amount was much less because of several conditions depending on their own individual debt, being single or under a family care regardless of their gender role.

7.2.2 State policy as process health security

In organizing a systematic management of migrant workers in Thailand, a research by Tawil (2554) suggests that the MOU regarding the hiring of immigrant workers coming from 3 neighboring countries during 2002 to 2003 to solve the illegal migrants as a new strategy for controlling illegal transnational labor aimed as a result of globalization based on the discourse of neoliberalism and labor protection. The regional management accepted the principle of the free market as a mechanism for managing the economy effectively. The state supports a free market by reducing barriers and encourage the flow of capital, goods and people by dismantling debacles while promoting the movements of capital, goods and humans (Koasa-ard and Dore, 2003, cited in Pruek Thaotawin; Suthee Sutrahom, 2011). According to this research, it was found that the system of labor registration is a process of generating health security for the Thai people based on the stigmatization of immigrant workers because the people feel insecure when they have to live with those who are aliens to them and the concept of human rights. Common fear includes the feeling that foreigners would grab the benefits and cause problems / to be a burden to their country. As a result the people would be paid a lower wage. There would be more crimes and burdens. With all these feelings, it would be better to exclude the immigrants from settling permanently. On the one hand, the registration of immigrant workers is a way to shift the workers to have the right to health insurance in equal to their Thai counterparts. However, in the work of Coutin (2011), there is a term used for describing immigrants "crimmigration". The state has a legal measure in order to control to generate securitization. This is consistent with the work of Sunpuwan & Niyomsilpa (2012) in studying perspectives of the people living in the bordering provinces. It turned out that the majority of the people believed that immigrant workers are not safe and likely to spread diseases and take large shares on employment. However, the work of Hall (2012) pointed out at another perspective that immigrant workers in Thailand were fragile making social and individual securities even more difficult.

In a study by Ogur (2003) with regard to infected diseases from the country of origin seen as an "exotic pathogens" he offered a view that cultural differences in understanding causes of a disease and treatment, linguistic difference and a limitation of communication made the status of immigrant workers limited

including a lack of health coverage by their employers and discriminable policies. In the case of tuberculosis infection, immigrants in America working not less than five years had to pass a primary care and PPD testing for tuberculosis because TB patients in the United States were mostly those who came from overseas including cases of resistant-typed TB because infected people in some countries could not afford the drugs (Ogur, 2003). This research found that the fear of TB infection among migrants was based on what was embedded in the ethnic origin inferior to Thailand. Immigrants were often regarded by the medical personnel as a carrier of a new epidemic of tuberculosis as once happening to AIDS patients with tuberculosis. Medical examination of immigrant workers from Burma was therefore classified as workers with a good health safe for the health of the Thai people. This is correlated with the work of Jayasuriya (2006) who discovered that after the events of 9/11, the U.S. had changed its policy to increase the stability and security called “disciplinary neoliberalism” by a careful surveillance of trips into the country underscoring that aliens came in bring instability and undermining security in the import country.

7.2.3 An experience of cross-cultural health care

Immigrant workers defined the meaning of TB as a serious disease in a close category to a lung disease caused by black magic and by working environment. Therefore, at the beginning, they were often not aware that their illness was tuberculosis. They would turn to a treatment based on folk beliefs, buying medicine based on the symptoms and finally went to the doctor's clinic.

After TB infected immigrants were brought to the treatment system. Some people might be allergic to the drug or facing difficulties in drug taking. However none of them denied or resisted the use of drug. Some negotiated how to swallow a pill by requesting for a smaller tablet so they could consume more easily. They wanted to be completely cured of TB. Therefore, the continuous DOT since the first pill to the last might not be necessary. The body of the infected immigrants TB was a docile body surrendering to the treatment. The provision of meaning treated the body as a capital. The patients had to follow the recommendations of public health officials including the taking of drug at the presence of the care taker, a consent to a home visit, wearing masks when they went to see a doctor. Although they were not aware of tuberculosis, they realized the loss of income. A recovery from the illness means a full

return to function. Discipline and behavioral health upheld by immigrants was not due to be under an observation but because of capitalism that dominated their mind. Discipline and good health habits were thought to make them recover so that they could return to work in accumulate of wealth benefiting themselves and their families. Besides, it was also found that tuberculosis wasn't an identity in need to hide away from fellow workers together but to hide the identity of being a patient to their Thai employer.

The majority of immigrants felt alienated with the state's hospitals. They were confident that the clinic was better because it is less complex. In treating TB-affected immigrant workers, the medical service system would treat their bodies as docile. Additionally, being a patient and an immigrant worker would be further suppressed. As a result, the hospital became more of an alienated area. Ethnocentrism was felt, excluding one ethnicity from others, generating the feeling of disgust, not wanting the people to live peacefully together. There was a gap in communication making patterns of medical treatment misunderstood; such as taking a smaller tablet is better than a combination one.

The modern medical system of medicine is recognized by Burmese immigrant workers. However, there is a limitation in terms of language. Sinsamut Hospital, therefore, employs Burmese interpreters between the practitioners and the Burmese patients. The interpreter exists between the identity of the TB-affected immigrants and health personnel in the hospital. This study found that during the treatment of TB patients, who are migrant workers, using an interpreter being a one-way communication and the DOT being an investigation undermining the ability of self-reliance causing more alienation in everyday life. Similarly, a study by Gastaldo (1997) has analyzed that health education is a set of power in manipulating the body of individual and society. Illness is not natural. It is related to economic and social issues. Birth and death involve the state in management to drive the economy forward.

This research found that health education is a link between the human rights of individuals and the management of the state to establish health security. To investigate health by providing health education for a population of immigrant workers regarded as temporary residents by controlling the population to be aware of the spread of tuberculosis by defining what is a healthy behavior and promotion of

related disciplines is a goal to eradicate tuberculosis. Some principles are essential to be applied in life using the interpreters in managing the health care system by reducing a linguistic gap along with understanding the context of their lives rather than simply providing knowledge to them by Thai health personnel.

7.3 Suggestions

7.3.1 Policy-related suggestions

1.) Policy-related issues concerning the minimization of a gap in communication with patients who are migrant worker by improving a two-way communication, emphasizes respect and equality.

2.) A policy with an action to dismantle the myths about migrant workers perceived by medical personnel is a cause of inequality that is deeply embedded in the social system, such as culture, training and communication in the hospital's services.

3.) A policy is needed in providing health services for migrant workers as required by the patients on a basis of specificity and sensitivity of their way of life or culture of the immigrant in ethnic diversity rather than considering a risk on a basis of epidemiology stigmatizing immigrant workers as a disease.

7.3.2 Suggestions for further research

1.) A study on an illness experience of immigrant workers afflicted by diseases both infectious and non-communicable diseases to understand how to understand and experience in the pursuit of self-healing of the workers. This will help strengthen understanding and reduce prejudice toward ethnic minority in services of the medical personnel.

2.) A research on a perspective of medical personnel towards immigrant workers, ethnicity and marginalized people to understand their attitudes towards immigrant workers, ethnicity and marginalized people, leading to a fine, accurate view in providing medical services, which should cultivate the concept of the right to health care as human right from various educational institutions where medical training is practiced.

3.) A study of the role of an interpreter in the hospital, who has to adapt and survive in a world of cultural and traditional beliefs leading to an adjustment of how to communicate when there is an interpreter acting as an intermediary between service providers and service recipients and makes communication more efficient.

4.) An involvement of every sector in society including the private and the government ones along with the immigrant workers to reduce the risk or illness of the workers in the context of competition-focused work to accommodate the flow of people from different countries in ASEAN.

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APPENDIX

Research Participants

Alias name	Sex	Race	Age	Occupation	Period of living in Thailand	Legal Status and Health Service Access Rights
1. Zin	female	Mon	26	Fish and shrimp grocery worker	7 – 8 years	Illegal migrant, no health service access rights, supported TB treatment from GF project
2. Kyaw	Male	Mon	30	Sweetening fish factory worker	2 years	Legal migrant, has passport and social insurance rights
3. Moc	female	Karen	55	Unemployed	2 years	Illegal migrant, no health service access rights, and paid TB treatment by herself
4. Phyu	female	Mon	22	Shoes maker factory worker	7 years	Legal migrant, has passport and social insurance rights. Her father died by TB in Burma.
5. Sheuc	female	Mon	23	Frozen Seafood factory worker	12 years	Legal migrant, has passport and social insurance rights
6. Bo	Male	Karen	34	Fish ball factory worker	30 years	Illegal migrant, no health service access rights, supported TB treatment from GF project

Alias name	Sex	Race	Age	Occupation	Period of living in Thailand	Legal Status and Health Service Access Rights
7. Myo	female	Mon	23	Fish grocery worker	4 years	Illegal migrant, no health service access rights, supported TB treatment from GF project
8. Khain g	male	Burm ease	39	Construction labor	10 years	Illegal migrant, no health service access rights, supported TB treatment from GF project
9. SanD ar	female	Mon	28	Frozen Seafood factory worker	10 years	Legal migrant, has passport and social insurance rights
10. Aye	female	Mon	23	Frozen Seafood factory worker	6 years	Legal migrant, has passport and social insurance rights. After resigned, she cannot use social insurance rights and she was supported TB treatment from GF project
11.Htabe	female	Mon	41	Aluminum melting factory worker	15 years	Illegal migrant, no passport, has migrant labor card and health insurance rights (30 Baht per visit)

Alias name	Sex	Race	Age	Occupation	Period of living in Thailand	Legal Status and Health Service Access Rights
12. Than	female	Mon	26	Frozen Seafood factory worker	7 years	Illegal migrant, no health service access rights, supported TB treatment from GF project
13. Tun	female	Shan	41	Tank factory worker	10 years	Illegal migrant, has passport and migrant labor card and health insurance rights (30 Baht per visit)

BIOGRAPHY

NAME	SupaVittaporn
DATE OF BIRTH	18 August 1975
PLACE OF BIRTH	Sukhothai, Thailand
INSTITUTIONS ATTENDED	Mahidol University, 1993 - 1997 Bachelor of Science (Public Health) Khonkean University, 2000 - 2004 Master of Science (Social Development) Mahidol University, 2008-2015 Doctor of Philosophy (Medical and Health Social Sciences)
HOME ADDRESS	4/20 Ramkamheang 30/1 Huamak Bangkapi Bangkok 10240 E-mail : supa.vitt@hotmail.com
EMPLOYMENT ADDRESS	Health Counterparts Consulting, 10/36 Ramkamheang 30/1 Rd. Ban Sukhothai 16th Bldg. Huamak Bangkapi Bangkok 10240