SELECTED DATA ON HEALTH STATUS OF MIGRANT WOMEN RESPONDENTS

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ABSTRACT: Reproductive health is "a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. Implicit in this is the right of men and women to be informed and to have access to safe, effective and affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that enable women to go safely through pregnancy and childbirth." The survey on Health Problems of Migrant Workers included a section on Women's Health covering aspects of reproductive health. This was based on concerns over reproductive health needs of migrant women workers, particularly since the large majority are in the reproductive age-group, and the utilisation of government healthcare facilities. The latter has implications for the potential burden on public healthcare services in terms of resources and costs.

Specifically, the Women's Health section included questions on pregnancy, place of delivery of last baby (born in Malaysia), postnatal care related to this delivery, and mode of payment. For those currently pregnant, questions were asked of sources of antenatal care, postnatal care and respective modes of payment for those services. This section also included questions on current contraceptive practices, source of supplies, and mode of payment for contraceptive methods. *(JUMMEC 2002; 1:15-23)*

KEYWORDS: Reproductive health, Contraceptive methods, Antenatal care, Postnatal care, Health-care services.

Introduction

Reproductive health is "*a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes..... Implicit in this is the right of men and women to be informed and to have access to safe, effective and affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that enable women to go safely through pregnancy and childbirth.*" The survey on Health Problems of Migrant Workers included a section on Women's Health covering aspects of reproductive health. This was based on concerns over reproductive health needs of migrant women workers, particularly since the large majority are in the reproductive age-group, and the utilisation of government healthcare facilities. The latter has implications for the potential burden on public healthcare services in terms of resources and costs.

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Results and Discussion

In total, 102 women respondents were recruited as respondents in the present survey on migrant health. They comprised workers from more than five countries, primarily from Thailand (n=50) and Indonesia (n=38). Eight respondents were from Myanmar, two each from the Philippines and Bangladesh, and one categorised under 'Others'. With the exception of Indonesian women, 33.3% of whom were single, the large majority (>80%) from all other countries were currently or previously married. Their ages ranged from 19 to 60 years, and averaged 33.78 years (median 33). The oldest respondent, aged 60 years, was from Thai-

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land. In terms of religion, 96% were Muslim (n=97). Two (2%) were Christian (one each from Philippines and Others), and another two (2%), both from Myanmar, were Buddhist.

According to data based on issuance of temporary work permits in Peninsular Malaysia by the Immigration Department from July 1992 to December 1995, 65% of migrant workers are from Indonesia, 21% from Bangladesh, 7.1% from Philippines, 5.4% from Thailand, and 1.6% from several other countries, notably, India, Pakistan, Myanmar, Nepal, Sri Lanka (Kassim 1996). Although these national data were not segregated by sex, there seems to be prima facie indication that the distribution of the Migrant Worker Survey respondents by country of origin differs from the documented breakdown of migrant workers nation-wide. The survey seems also to have recruited an older group of workers. Information on method and location of recruitment will be useful in explaining these differences.

In view of the small numbers of respondents from other countries, notably, Bangladesh, Philippines and Myanmar, a more detailed presentation of data was confined to those from Thailand and Indonesia, comprising a total of 88 respondents. The Thai workers were recruited from Kelantan, while the Indonesians were primarily from the Klang Valley. Since migrants from the two countries probably have unique characteristics, e.g., cultural background, social factors related to migration, and relations with local citizens, the descriptive analyses below were stratified by country of origin in most cases.

Socio-Demographic Background

The average age of respondents differed significantly (p=0.04) by nationality with Thais being older by almost 10 years (mean 37.54 years, median 38) compared to Indonesians (mean 28.87 years, median 27).

By religion, all the Indonesian and Thai respondents were Muslims. The Thai respondents were recruited from Kelantan, the state proximate to southern Thailand which has a large Muslim population.

The average educational attainment of the respondents was 4.7 years (median 4) (Table 1). The Indonesian women in the sample had significantly (p<0.0001) more years of education (mean 7.8, median 6) than the Thais (mean 2.4, median 2). Among Indonesians, these ranged from none to 19 years, whereas among the Thais, the range was from none to nine years. The younger generation among the Indonesians may have been more likely to have entered and/or stayed in school compared to the older Thais. This difference may also be due to differences in hiring practices for workers from the two countries.

A majority was currently married in both groups, but slightly more Indonesians (33.3%) were single, widowed or divorced (s/w/d) compared to Thais (16.0%) (Table 2). All of the unmarried Indonesians were, in fact, single (never married) whereas the unmarried Thais comprised six widowed (12.0%) and two divorced/separated women (4.0%). Although the difference is not statistically significant, it supports the fact that the Indonesians are generally younger and, hence, more likely to be not married yet.

Table 1. Years of education by nationality

Nationality	Years of Education				
	N	mean	median	sd	range
Indonesian	38	7.79	6.00	4.10	0-19
Thai	50	2.40	2.00	2.58	0-9
TOTAL	88	4.73	4.00	4.26	0-19

Table 2. Distribution of women respondents by nationality and marital status

Nationality	Marital Status					
	married		s/w/dn		TOTAL	
	n	(%)	n	(%)	N	(%)
Indonesian	26	(66.7)	13	(33.3)	39	(100)
Thai	42	(84.0)	8	(16.0)	50	(100)
TOTAL	68	(76.4)	21	(23.6)	89	(100)

Note: s/w/d – single/widowed/divorced

Table 3. Distribution of respondents by total number of children

Nationality	Total number of children							
	None		2-Jan		>2		Total	
	n	%	n	%	N	%	N	%
Indonesian	2	8.7	17	73.9	4	17.4	23	100
Thai	2	4.0	10	20.0	38	76.0	50	100
Total	4	5.5	27	37.0	42	57.5	73	100

Note: 16 cases not applicable or missing (all Indonesian)

Children

Most of the respondents also have children, averaging 3.3 (median 3) in number (Table 3). Thai women (mean 3.3, median 4) have significantly (p<0.0001) more children than Indonesians (mean 1.8, median 2). This difference in total number of children is understandable in view of the older age of the Thai women. By grouped number of children, the most common is three or more children. Correspondingly, a higher proportion of Thai women have three or more children, ranging from none to nine. Indonesian women have fewer children, ranging from none to four, with the most common being two (n=11; 47.8%) or one (n= 6; 26.0%).

When asked about children presently in Malaysia, the number averaged 2.4. Again, Thai women (mean 2.6,

median 2) reported more children than Indonesians (mean 1.3, median 1) but the difference is not statistically significant. Among ever-married women, considerably more Thais (79%) than Indonesians (29%) have children in Malaysia. Only six Indonesians, five with one child and one with three, said they have children in this country compared to 38 Thai women, with number of children ranging from one to nine. The ages of these children are not known. However, since most of these respondents are relatively young, it can be assumed that their children are generally of school-going age or younger.

Table 4. Duration since year of first arrival in Malaysia

Nationality	N	Duration (years)			
		mean	median	sd	range
Indonesian	38	2.45	2.0	1.9	<1-8
Thai	50	8.20	7.5	6.6	<1-30
TOTAL	88	5.70	3.0	5.9	<1-30

Table 5. Distribution of respondents by nationality and type of accommodation

Nationality	Kongsi house		Squatter house		Employer's house		Hostel/employer provided housing		Others		TOTAL	
	n	%	n	%	n	%	n	%	n	%	N	%
Indonesian	5	13.2	1	2.6	10	26.3	18	47.4	4	10.5	38	100
Thai	4	8	0	0	2	4	44	88	0	0	50	100
TOTAL	9	10.2	1	1.1	12	13.6	62	70.5	4	4.5	88	100

Among other basic needs, migrant workers who have children in the host country need childcare and/or schooling facilities, as well as, health services for their children. The 1994 United Nations' International Conference on Population and Development has set forth a Programme of Action that states "*Governments of receiving countries are urged to consider extending to documented migrants who meet appropriate length-of-stay requirements, and to members of their families, regular treatment equal to that accorded their own nationals with members of their families, regular treatment equal to that accorded their own nationals with regard to basic human rights*".

By occupation, there were distinct differences between Thais and Indonesians. The large majority of Thai migrants cited their occupation as rubber tapping (92%). A few were cleaners (4%), and one worked as a factory worker (2%) while another one worked as a dressmaker (2%). Among the Indonesians, occupations were more varied – 31% worked as house maids, 28% in food-related occupations (mostly satay-makers, with two cooks and one food-stall worker), 18% cleaners, 18% in factory-related work (primarily production operators, with one factory and one general worker), and five percent were construction workers.

Migration history

In terms of their migration history, these 88 respondents were almost equally divided among those who arrived here less than five years ago (52.3%) from the time of the survey in 1998, i.e., 1995 to 1998, and those who did five or more years ago (47.7%), i.e., 1994 or earlier. However, there was a distinct difference ($p<0.0001$) between Indonesian and Thai respondents – most Indonesians are more recent migrants (81.6% having first arrived less than five years ago compared to 30.0% of Thais). Put in another way, as shown in the table below, Indonesian women have been here for an average of 2.4 years (median 2) since first arrival compared to Thais who average 5.7 years (median 3) stay (Table 4). The range of duration of stay since first arrival was considerably wider among Thais. This duration does not imply, however, that these migrant workers did not return to their countries during that period.

Accommodation

In terms of type of accommodation, most respondents said they live in a hostel or employer-provided living quarters. Far more of the Thais (88%) have these types of accommodation compared to Indonesians (47.4%) (Table 5).

Although only one Thai reported living on a construction site, four cited a *kongsi* house as their abode. This may be a misunderstanding of what onstitutes a *kongsi* house, but it is generally associated with temporary group housing on construction sites. Another two Thais reported living in their employer's house. Slightly more than a quarter of the Indonesians live in their employer's house, with five staying in a *kongsi* dwelling and one in a squatter house. Again, based on responses to type of residential area above, only two respondents cited construction site.

Information on their co-habitants showed that most live with their family or relatives, particularly among the Thais. In fact, all except one Thai, live with their families (98%); the exception reportedly lives with friends. Among the Indonesians, 10 live with their employers (supporting the data on accommodation above), and another 10 share a home with friends,

whereas the others stay equally with fellow employees (n=6), family/relatives (n=6) or others (n=6).

That proper accommodation provided to workers is a positive finding. Basic utilities, such as piped water, electricity and toilet facilities, are available where the workers live. The basic need for adequate housing seems to be met. However, problems of crowding, especially for shared housing, hostels or *kongsi* housing, and safety are relevant from a health perspective. Since the Thais in this sample appear to be more settled in homes with their family members, these issues of possible overcrowding and safety applies in particular to Indonesian workers.

Lifestyle Habits

Certain causes of ill-health can be attributed to personal behaviours, such as diet, smoking and alcohol consumption. Among the survey respondents, most, if not all, reported never smoking nor drinking nor using recreational drugs. Among Thai respondents 18% claimed to smoke cigarettes while another two (4.0%) said they did previously (Table 6). In contrast, three Indonesians reported previously smoking cigarettes.

In terms of these behaviours, especially for alcohol consumption and drug use, these women appear to have a healthy lifestyle overall. Data on other. healthy behaviours, notably, diet and exercise, were not collected.

Reproductive Health

Selected questions related to childbearing were asked of these migrant women workers. These consisted of questions on pregnancy history, place of delivery and postnatal services for the last child born in Malaysia, antenatal services for current pregnancy and source of payment for these services. Respondents were also asked about current contraceptive practices and the source of and payment for supplies.

Pregnancy and obstetric services

Among ever-married (currently married, divorced, widowed) women, 82.9% have experienced pregnancy (Table 7). None of the single women, with one missing case, reported being ever-pregnant. There were significantly (p=0.001) more Thai ever-married women (94%) who had been pregnant compared to Indonesians (61.5%). As reported earlier, the Thais in this survey were relatively older and all were currently or previously married.

Only four Indonesians (15.4% of ever married women) had delivered their last baby in Malaysia; two in government hospitals/clinics, one in a private hospital/clinic and one by a traditional birth attendant (Table 8). In contrast, 48% (n=24) of ever-married Thais had delivered their last baby in Malaysia. Among these 24 Thai women, most had delivered in a government facility (66.7%), while 29.2% (n=7) had deliveries assisted by a traditional birth attendant and one in a private hospital/clinic (4.2%).

Table 6. Distribution of respondents by nationality and selected personal behaviours

Behaviour	Nationality					
	Indonesian		Thai		Total	
	n	%	n	%	N	%
Smoking						
- Never	35	92.1	39	78.0	74	84.1
- yes, previously	3	7.9	2	4.0	5	5.7
- yes, currently	0	0.0	9	18.0	9	10.2
Total	38	100.0	50	100.0	88	100.0
Drinking alcohol						
- never	37	97.4	50	100.0	87	98.9
- yes, previously	1	2.6	0	0.0	1	1.1
Total	38	100.0	50	100.0	88	100.0
Using recreational drugs						
- never	38	100.0	50	100.0	88	100.0

Table 7. Distribution of ever-married respondents by nationality and pregnancy history

Nationality	Ever-Pregnant				Total	
	Yes		never			
	N	%	n	%	N	%
Indonesian	16	61.5	10	38.5	26	100
Thai	47	94.0	3	6.0	50	100
Total	63	82.9	13	17.1	76	100

P=0.001 (Fisher's Exact Test)-

In terms of payment for the service, all four Indonesian women claimed to have paid for the service themselves (self-paying). Among Thai women, half (n=12) had their deliveries paid for by their employer, whereas 37.5% (n=9) reported they delivered for 'free'. These women consisted of three who had delivered in a government hospital, five by a traditional birth attendant and the one woman who had delivered at a private hospital/clinic. A free delivery at a private healthcare centre seems unlikely but may be possible as a charity case. The information cannot be verified. Among those who had delivered at a government hospital, 11 (68.8%) said that their employer had paid for it. Three said it was free and two said they paid themselves.

Among the women who delivered their last baby in Malaysia, all but one, an Indonesian, had received postnatal care and mainly at a government hospital/clinic

Table 8. Distribution of respondents by nationality, place of delivery of last baby in Malaysia and mode of payment for services

Nationality	Place of Delivery	Mode of Payment: Self-paying n	Self-paying %	Employer n	Employer %	Free n	Free %	TOTAL N	TOTAL %
Indonesian	- Government hospital/clinics	2	100	-	-	-	-	2	100
	- Private hospital/clinics	1	100	-	-	-	-	1	100
	'- Traditional birth attendant	1	100	-	-	-	-	1	100
	- TOTAL	4	100	-	-	-	-	4	100
Thai	- Government hospital/clinics	2	12.5	11	68.8	3	18.8	16	100
	- Private hospital/clinics	-	-	-	-	1	100	1	100
	'- Traditional birth attendant	1	14.3	1	14.3	5	71.4	7	100
	- TOTAL	3	12.5	12	50	9	37.5	24	100

(71.4%), as shown in Table 9. By country of origin, two (50%) of the Indonesians and 75% of the Thais had obtained postnatal care at a government facility. The one other Indonesian who delivered her last baby in Malaysia had obtained postnatal services from a private clinic, whereas the remaining Thais had their postnatal checks at a private hospital/clinic. In terms of payment for this service, all the Indonesians compared to only two Thais, claimed to have paid for their postnatal care themselves. Among the Thais, half said that their employer paid while another 37.5% said that their postnatal care was obtained free.

Only two respondents were currently pregnant at time of interview, both of whom are Thai. Both women were receiving antenatal care, one at a government for free, and the other at a private clinic paid for by the employer.

Contraceptive practices

Among women who said they have experienced sexual intercourse, 19 reported using some form of contraceptive at time of interview, comprising 28% of those who responded to this question of current contraception (n=68) (Table 10). In terms of all respondents (N=89), this constituted 21% of the women or 31% of currently married women. All 19 are ever-married women, twelve of whom are Indonesians and seven are Thais. Current contraceptive use rate is significantly higher among Indonesians. Current contraceptive practice is relatively low among the Thai women, in particular, considering that the majority are currently married.

Table 9. Distribution of respondents by nationality, place for postnatal services and mode of payment

Nationality	Source of Postnatal Services	Mode of Payment: Self-paying n	Self-paying %	Employer n	Employer %	Free n	Free %	TOTAL N	TOTAL %
Indonesian	- Government hospital/clinics	2	100	-	-	-	-	2	100
	- Private hospital/clinics	1	100	-	-	-	-	1	100
	- None	1	100	-	-	-	-	1	100
	- TOTAL	4	100	-	-	-	-	4	100
Thai	- Government hospital/clinics	2	11.1	8	44.4	8	44.4	18	100
	- Private hospital/clinics	1	16.7	4	66.7	1	16.7	6	100
	- TOTAL	3	12.5	12	50	9	37.5	24	100

For comparison, data on contraceptive use in selected Southeast Asian countries show contraceptive practice rates averaging 55% for all methods among married (in-union) women. Specifically, contraceptive rates for Indonesian and Thai foreign workers are 55% and 72%, respectively. In other words, unlike for Indonesian women, the situation among Thai migrant workers recruited for this survey differ markedly from that in Thailand in terms of contraceptive use. Furthermore, most of the women surveyed, especially among Thais, reported living with family or relatives, which may include their spouse. Since there is no information on whether they have contact with their spouse or other sexual partner(s), no assumptions can be made on exposure to pregnancy risk. At the same time, the absence of a co-habitating spouse may explain, in part, the reason for low contraceptive use among this sample of women.

Table 10. Distribution of sexually experienced women respondents by nationality and current contraceptive use

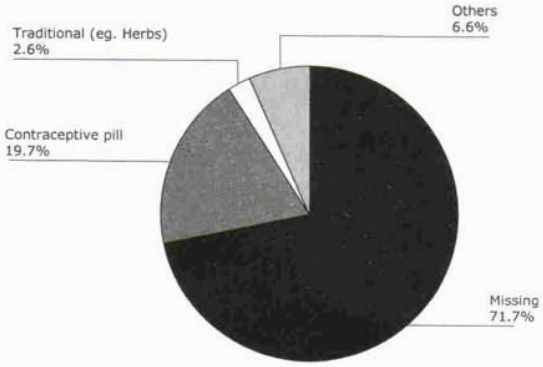
Nationality	Contraceptive Use				TOTAL	
	yes		no			
	n	%	n	%	n	%
Indonesian	12	54.5	10	45.5	22	100
Thai	7	15.2	39	84.8	46	100
TOTAL	19	27.9	49	72.1	68	100

Table 11. Distribution of contraceptive users by nationality, source of supply and mode of payment for supplies

Nationality	Source of Contraceptive Supply	Mode of Payment						TOTAL*	
		Self-paying		Employer		Others			
Indonesian	- Government hospital/clinics	3	75.0	-	-	-		4	75
	- Private hospital/clinics	4	100	-		-		4	100
	- Pharmacy	2	100	-		-		2	100
	- Others	1	50.0	-		-		2	100
	- TOTAL	10	83.3	-	1	8.3		12	91.6
Thai	- Government hospital/clinics	1	25	1	25.0	1	25.0	4	75
	- Pharmacy	2	100	-		-		2	100
	- Others	1	100	-		-		1	100
	- TOTAL	4	57.1	1	14.3	1	14.3	7	85.7

Note: *Column total <100% because of "not available" data

By method, the oral contraceptive pill (20%) was the most common among sexually experienced women (predominantly currently married).



Distribution of Contraceptive methods among sexually experienced women

Compared to data worldwide, female sterilisation (23%) is most common in Asia, including China, followed by the use of Intra-Uterine Device (16%). As in this survey, non-contraceptors are the majority (42%) in Asia. In this survey, among those currently using contraceptives, nine (60%) women were using the pill, comprising three Indonesians and six Thais. Two Thais reported using traditional methods (herbs, etc.) while four Indonesians reported other methods.

On source of supply, only 12 women provided information. Among the seven Indonesian women user, two obtained their contraceptives from a government hospital/clinic, one from a private hospital/clinic, another from a pharmacy and another from elsewhere ('Others') (Table 11). Among the eight Thais, four obtained their supplies from a government services, two from a pharmacy and one from "Others", that is, more Thais appear to be using government facilities.

Finally with regards to payment, 10 Indonesians reported that they paid for their contraceptives themselves and one named 'others' whereas only four Thais reported self-paying, one said that her employer paid whilst another named 'others' as the source of payment.

Sexual health

Among the respondents, 85% had experienced sexual intercourse (Table 12). All sexually experienced women were either currently or previously married. All of those who reported no experience were unmarried women (13 Indonesians). Among sexually experienced Thai women, all were currently married, while eight were separated or divorced. That is, no never-married women claimed to have had sexual intercourse.

Among sexually experienced women, a large majority (94%) reported having only one partner in the last five years, whilst four Thai women reported having two partners (Table 13)'. These consist of two currently married and two divorced/separated women. A very large majority named their spouse as their sex partner in the last five years. No respondent reported having had a casual sex partner, homosexual partner, or commercial sex worker.

It can, thus, be surmised that those women who reported having two partners had been married twice. A question was also asked of condom use ("Do you use a condom each time you have sexual intercourse?"). In this regard, all but two women answered 'no'; the exceptions answering 'sometimes' (None responded"'yes, each time"). These two women are currently married Indonesians whose sex partner was reported as their spouse.

A low utilisation rate for condoms as a contraceptive method supports data from many countries. The average for Asia has been cited as three percent, and even lower in Latin America and Africa, compared to developed countries where condom use is 14%[5]. That is, condoms are less popular as a method of contraception in Asia. In this case, low condom use is another reflection of low contraceptive utilisation overall. Since there is no information on the presence of a current sex partner, spouse or otherwise, among these respondents, low contraceptive, and condom, use could be due to low frequency or absence of sexual activity.

The relatively recent HIV/AIDS epidemic has drawn much attention to safe sex practices and use of condoms as protection against sexually transmitted diseases. Various campaigns and strategies to control the spread of this infection have been implemented, including Information, Education and Communication (IEC) activities and condom promotion efforts. However, since this survey was aimed at deriving a broad profile of the health of migrant worker covering several areas, no and knowledge of HIV/AIDS in this survey. specific questions were asked in the interview related to STDs, such as, reasons for condom use, Hence, no inference can be drawn regarding this behaviour.

Table 12. Distribution of women respondents by nationality and experience with sexual intercourse

Nationality	Ever Had Sexual Intercourse				TOTAL	
	yes		no			
	n	%	n	%	n	%
Indonesian	26	66.7	13	33.3	39	100
Thai	50	100	-	-	50	100
TOTAL	76	85.4	13	14.6	89	100

Table 13. Distribution of sexually experienced respondents by nationality and number of sex partners in the last five years

Nationality	Number of Sex Partner				TOTAL	
	1		2			
	n	%	n	%	n	%
Indonesian	24	100	-	-	24	100
Thai	44	91.7	4	8.3	48	100
TOTAL	68	94.4	4	5.6	72	100

Blood Tests for STDs

Blood tests were carried out on samples from 32 women to screen for syphilis by the rapid plasma reagin (RPR) method and the more specific *Treponema pallidum* hemagglutination assay TPHA), and to screen for Human Immunodeficiency Virus (HIV).

Only one woman yielded a positive test for RPR out of 32 tests among sexually experienced women (3.1% reactive rate). This case was an Indonesian sexually experienced woman. All TPHA and HIV tests were negative. In the absence of complete testing of all respondents, these results are not useful for describing nor estimating the prevalence of sexually transmitted diseases in this population.

Physical Health

Body Mass Index

Height and weight measurements were taken for all respondents, and body mass index (BMI) calculated as kilogram/meter^2. No significant difference in BMI was found between Indonesian (mean 53.9, median 53.3) and Thai (mean 51.6, median 50.0) women. Since older age tends to be associated with higher values, BMI was also stratified by two age-groups, <30 and >30 years. From Chart 1, it can be seen that mean BMI is higher for older Indonesians (mean 57.2 median 54.7) than younger women (51.2, median 52.0). This was not observed for Thais. However, this index has a wider variation among older Thai women (range 39 to 70) compared to younger (range 43 to 59). It should be noted that BMI data were available for only 20 Indonesians (52.6%) compared to 50 Thais (100%).

Summary and Conclusions

The present analysis of the health status of women migrants was confined to respondents from Indonesia and Thailand. Other nationals were omitted from this analysis because of small numbers. The main findings are summarised below.

There were significant differences between Thais and Indonesians in the sample on various aspects, such as age, educational level, marital status and number of children and migration history. Thai women were significant older, with lesser years of education, and more children. Slightly more (but not significantly) Indonesians were single. Among ever-married women, considerably more Thais than Indonesians had children living in Malaysia. This has implications for schooling and child health care needs. Thai women had also first come to Malaysia significantly earlier than Indonesians. As such, they may be more adapted to life in the host country.

Most of the women reported that they live in residential areas in houses or hostels provided by their employer. Despite the majority citing employer-provided residence, most Thais also said that they live with family members. Only a minority, more so amongst Indonesians, stated '*kongsi*' housing. Nonetheless, utilities, such as piped water, electricity and toilet facilities, were available to all respondents. That is, basic housing needs appear to be met. However, there was no information to assess the level of crowding, particularly, for those living in '*kongsi*' housing or hostels. In terms of reproductive health, and based on the average number of children, the fertility rate of the migrant women does not appear to be high, especially among the Indonesians. This may partly be attributed to their younger age compared to the Thai women. Furthermore, significantly more Thai women had delivered their last baby in Malaysia. With regard to concerns over the use of public health care facilities by migrants, findings related to maternal health services revealed that half of the small percentage of Indonesian women and a majority of the Thais who delivered their last baby in Malaysia did so in a government hospital. Be that as it may, most reported to have either paid for the services themselves or were paid for by their employers.

Use of government health care services was more common for postnatal care. The majority of respondents had received postnatal care at a government facility, but again, most said that they or their employer had paid for the services. Only two women, both Thais, were pregnant at time of survey. All women were receiving antenatal care for the current pregnancy, one at a government hospital/clinic and one at a private clinic paid for by her employer.

The majority of women were not using contraceptives at time of survey. Around 30% of currently married

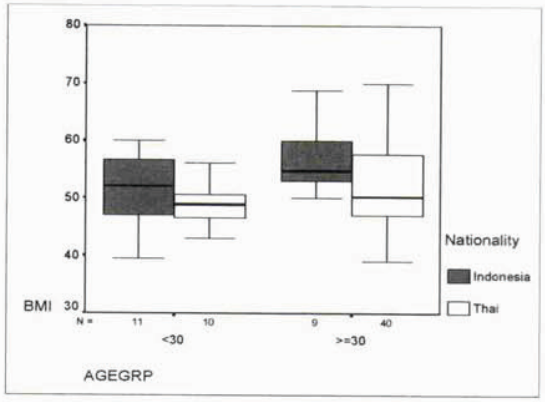


Chart 1. Box plots of BMI vby age-group and nationality

women said they were using contraception. Contraceptive use was significantly higher among Indonesians than Thais. In fact, the situation among the Thai respondents differ markedly from the national data on contraceptive use in Thailand. Since the majority of the Thais are currently married and many stated that they live with family members, which may include their spouse, they may be exposed to risk of pregnancy. The most common method was the oral contraceptive pill. The source of supplies for the Thai woman was more commonly a government facility compared to the Indonesians.

The majority of respondents said that they had experienced sexual intercourse. All those who had not were single never-married women (all Indonesians). A majority reported only one partner in the past five years, whilst four Thais reported two partners; two currently married and two divorced/separated women. No respondent named a casual, homosexual or commercial sex partner in the past five years. Condom use was very low among sexually experienced respondents. Only two women, both currently married Indonesians, reported using condoms 'sometimes'. Overall, in terms of sexually transmitted diseases based their on sexual behaviour, these women appear to be at low risk. However, many women become infected despite having only one sex partner because of the high-risk activities of their partner.

In terms of sexually transmitted diseases, data on this sub-set of women respondents revealed only one positive test for syphilis, and none for HIV. The positive case for syphilis was an Indonesian currently married woman.

Overall, the data from this survey were based on a relatively small number of women migrant workers selected purposively from selected sites and was focussed on selected aspects of reproductive health. It should be noted that, with regards to women migrant workers, a

major concern is violence. The United Nations High Commissioner for Human Rights, in its Sub-Commission resolution 1996/10 on migrant workers, has highlighted its concern over the rising "... *reports of abuses and violence committed against the persons of women migrant workers by some employers in some host countries.*" Violence against women has implications for health, both physical and mental. Domestic workers, which form a sizeable portion of the migrant women workforce in Malaysia, may be more vulnerable. This aspect was not addressed in the present survey but deserves future attention as a specific health issue for women workers.

References

1. United Nations (1995). Summary of the Programme of Action of the International Conference on Population and Development. Chapter VII, Reproductive rights and reproductive health. New York: United Nations.
2. Kassim A (1996). An overview of migrant workers in Malaysia. Paper presented at the One-Day Workshop on Migrant Workers in Malaysia organised by Institute of Advanced Studies (IPT), University of Malaya, 23rd October 1996.
3. United Nations (1995). Summary of the Programme of Action of the International Conference on Population and Development. Chapter X, International Migration. New York: United Nations.
4. Population Reference Bureau (1998). World Population Data Sheet. Book Edition. Demographic Data and Estimates for the Countries and Regions of the World. Washington DC: PRB.
5. Population Action International (1997). Contraceptive Choice: Worldwide Access to Family Planning. 1997 Report on Progress Towards World Population Stabilization. Washington DC: PAI.
6. United Nations High Commissioner for Human Rights (1996). Migrant workers. Sub-Commission resolution 1996/10. The Sub-Commission on Prevention of Discrimination and Protection of Minorities. URL http://www.unhchr.ch/html/menu4/subres/9610.htm (21st July 1999).