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Urban refugees and asylum-seekers:

Health status and access to appropriate healthcare service system

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Migration is a phenomenon that happens more than once it was. It is globally estimated that in 2017 there were 763 million internal migrants and 250 million international migrants. One out of seven or approximately 65 million of them were forced migrant while 22.5 million of these persons becoming refugees and asylum-seekers.[1] [2] UNHCR pointed out that half of the refugees reside in camps while a majority of another half live in urban areas.[3]

Thailand is not only a country that has been a host for migrants from its neighboring countries for several decades, but it also hosts refugees and asylum seekers from several parts of the world, including Asia, Europe, and Africa. Statistics from The Border Consortiums show that about ten thousands of refugees from Myanmar residing in nine camps in Thailand.[4] At the same time, those 8,000 residing outside the camps and four-fifths of them live in Bangkok and periphery. A majority of these refugees were from South Asia particularly Pakistan.[5] Although UNHCR is an organization that takes responsibility in granting refugee status, some of them were not granted. This leads them illegally living in Thailand and bring them to a difficult situation in accessing basic service, particularly health services, like other countries.[6]

The right to health of refugees and migrants has been recognized by the WHO Constitution of 1948 and core international human rights treaties, but some of them still do not access

[1] Duncan, H. and I. Popp, WORLD MIGRATION REPORT 2018. 2017.

[2] United Nations High Commissioner for Refugees, UNHCR statistical yearbook 2015. 2017, United Nations High Commissioner for Refugees Geneva.

[3] Spiegel, P., Urban refugee health: meeting the challenges. Forced Migration Review, 2010(34): p. 22.

[4] The Border Consortium, Refugee and IDP Camp Populations: December 2017. 2017.

[5] UNHCR, Population Statistics. 2018, UNHCR.

[6] Bradby, H., et al., Public health aspects of migrant health: a review of the evidence on health status for refugees and asylum seekers in the European Region. 2015.

healthcare services.[7] It is known that refugees are the vulnerable population that is at risk for health problems and the need for appropriate healthcare, but they lack both resources and social support.[8] [9] This is because they are at poor economic and poor living conditions, particularly during the migration process from a place of origin to destination. These inevitably affect their health.[10] [11] [12] [13] [14]

Although Thailand has not ratified the 1951 Geneva Convention and the 1967 Protocol, it attempts to help these people with humanitarian assistance. The latest action of the Thai government in 2017 was to implement commitments to protect refugee rights by establishing an effective refugee-screening mechanism[15] and taking off several groups of irregular migrants.[16] To affirm the above commitments, the Thai government needs to prepare healthcare services to this population.

Previous studies on urban refugees in Thailand are quite limited. A majority of the study was the focus on refugees residing in camps, followed by refugees in the detention center. These are two closed settings and have specific non-government organizations to take care of. Although

[7] WHO, WHO Constitution, in Geneva: WHO. 1948.

[8] Hadgkiss, E.J. and A.M. Renzaho, The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev, 2014. 38(2): p. 142-59.

[9] McKeary, M. and B. Newbold, Barriers to care: The challenges for Canadian refugees and their health care providers. Journal of Refugee Studies, 2010. 23(4): p. 523-545.

[10] Adams, K.M., L.D. Gardiner, and N. Assefi, Healthcare challenges from the developing world: post-immigration refugee medicine. Bmj, 2004. 328(7455): p. 1548-52.

[11] Harris, M. and N. Zwar, Refugee health. Aust Fam Physician, 2005. 34(10): p. 825-9.

[12] Doocy, S., et al., Prevalence, care-seeking, and health service utilization for non-communicable diseases among Syrian refugees and host communities in Lebanon. Conflict and Health, 2016. 10: p. 21.

[13] Hunter, P., The refugee crisis challenges national health care systems: countries accepting large numbers of refugees are struggling to meet their health care needs, which range from infectious to chronic diseases to mental illnesses. EMBO reports, 2016. 17(4): p. 492-495.

[14] Ammar, W., et al., Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health, 2016. 6(2).

[15] สำนักเลขาธิการนายกรัฐมนตรี, กฎหมายสำคัญที่มีความจำเป็นเร่งด่วนที่ต้องเร่งรัดปรับปรุงหรือยกร่างกฎหมายขึ้นใหม่ [ร่างพระราชบัญญัติคนเข้าเมือง (ฉบับที่ ..) พ.ศ. ....] in มติคณะรัฐมนตรี ลงวันที่ 10 มกราคม 2560 2560, สำนักเลขาธิการนายกรัฐมนตรี.

[16] International Federation for Human Rights, Implement Commitments to Protect Refugee Rights - End detention, forcible returns of refugees. 2017, International Federation for Human Rights.

Thailand has a health system for migrants, refugees are not covered by such a system. Thus a desk review on health status and healthcare provision for refugees will shed light on how to provide healthcare services to urban refugees in Thailand.

Literature related to health status and healthcare for refugees

This report will review previous studies which focus on the health status of refugees and asylum-seekers and access and use of healthcare service of refugees and asylum-seekers. Also, it will review a state of knowledge of health status and access and use of healthcare in Thailand.

Health status and measuring the health of refugees and asylum-seekers

Previous studies found that refugees and asylum-seekers face both physical and mental problems.[17] [18] Physical illnesses include both communicable and non-communicable diseases. During a process of their movements from place to place, they have faced poverty, poor living conditions, poor nutrition while access to healthcare is extremely difficult. The high risk among them is children, women and the elderly.[19] [20] This results in a higher prevalence of certain diseases than the general population.[21] [22]

Regarding the mental health issue, previous studies pointed out that acute mental health problems and trauma symptoms are major problems. These included depression, post-traumatic-

[17] Hadgkiss, E.J. and A.M. Renzaho, The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev, 2014. 38(2): p. 142-59.

[18] Harris, M. and N. Zwar, Refugee health. Aust Fam Physician, 2005. 34(10): p. 825-9.

[19] Hadgkiss, E.J. and A.M. Renzaho, The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev, 2014. 38(2): p. 142-59.

[20] Langlois, E.V., et al., Refugees: towards better access to health-care services. Lancet (London, England), 2016. 387(10016): p. 319-321.

[21] As above.

[22] Norredam, M., A. Mygind, and A. Krasnik, Access to health care for asylum seekers in the European Union—a comparative study of country policies. The European Journal of Public Health, 2005. 16(3): p. 285-289.

stress disorder (PTSD) which resulted from violence, torture, violated rights and trauma during a move from place to place and resettlement.[23] [24] [25] [26]

In terms of measuring the health status of refugees and asylum-seekers, previous studies used both subjective and objective measures. The subjective measure is mostly based on self-reported health while objective measures are based on medical records or clinical data.[27] [28] [29] [30]

Access and use of healthcare service of refugees and asylum-seekers

Previous evident reveals that refugees and asylum-seekers can access primary care service preventive health services.[31] There are many factors involved with such access and use, for instance, contextual factor, demographic characteristics, health-seeking behavior, and health outcome.

To begin with the contextual factor, the previous study revealed that economic policies and politics influenced the healthcare system and health status of the population.[32] Income level of

[23] Hadgkiss, E.J. and A.M. Renzaho, The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev, 2014. 38(2): p. 142-59.

[24] Harris, M. and N. Zwar, Refugee health. Aust Fam Physician, 2005. 34(10): p. 825-9.

[25] Silove, D., P. Ventevogel, and S. Rees, The contemporary refugee crisis: an overview of mental health challenges. World Psychiatry, 2017. 16(2): p. 130-139.

[26] Fazel, M., J. Wheeler, and J. Danesh, Prevalence of serious mental disorder in 7000 refugees resettled in western countries: a systematic review. The Lancet, 2005. 365(9467): p. 1309-1314.

[27] Dowling, A., J. Enticott, and G. Russell, Measuring self-rated health status among resettled adult refugee populations to inform practice and policy - a scoping review. BMC Health Serv Res, 2017. 17(1): p. 817.

[28] Hollifield, M., et al., Measuring trauma and health status in refugees: a critical review. Jama, 2002. 288(5): p. 611-21.

[29] Sigvardsdotter, E., et al., Refugee trauma measurement: a review of existing checklists. Public Health Reviews, 2016. 37(1): p. 10.

[30] Davidson, G.R., K.E. Murray, and R.D. Schweitzer, Review of refugee mental health assessment: Best practices and recommendations. Journal of Pacific Rim Psychology, 2010. 4(1): p. 72-85.

[31] Hadgkiss, E.J. and A.M. Renzaho, The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev, 2014. 38(2): p. 142-59.

[32] Andersen, R.M., Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? Journal of Health

the country and ratification of refugee conventions are also related to healthcare provision for refugees and asylum-seekers.[33] Also, the health system in each destination country is different from each other. Providing healthcare to refugees in each destination country is depended on its system and how it allows refugees to get healthcare services.[34]

Demographic characteristics of the population also an important factor that involves in access and use of healthcare services of refugees and asylum-seekers. These include predisposing factors, enabling factor and need factors.

Predisposing factors consisted of age, gender, education, ethnicity, residential status, beliefs and network.[35] For instance, females are more likely to access and use healthcare more than males.[36] The elderly frequently used healthcare service than other groups because of degenerative diseases.[37] Education and economic status also influence the use of healthcare services, particularly, preventive care services.[38, 39] Belief is also another factor that influences the perception of using healthcare service.[40] A systematic review of Hadgkiss and Renzaho (2014) found that a lack of health knowledge and understanding of the healthcare system led

and Social Behavior, 1995. 36(1): p. 1-10.

[33] Janmyr, M., No Country of Asylum: 'Legitimizing' Lebanon's Rejection of the 1951 Refugee Convention. International Journal of Refugee Law, 2017. 29(3): p. 438-465.

[34] McKeary, M. and B. Newbold, Barriers to care: The challenges for Canadian refugees and their health care providers. Journal of Refugee Studies, 2010. 23(4): p. 523-545.

[35] Andersen, R.M., Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? Journal of Health and Social Behavior, 1995. 36(1): p. 1-10.

[36] Dhingra, S.S., et al., Determining prevalence and correlates of psychiatric treatment with Andersen's behavioral model of health services use. Psychiatric Services, 2010. 61(5): p. 524-528.

[37] Andersen, R.M., Revisiting the behavioral model and access to medical care: does it matter? Journal of health and social behavior, 1995: p. 1-10.

[38] Hernández-Quevedo, C. and D. Jiménez-Rubio, A comparison of the health status and health care utilization patterns between foreigners and the national population in Spain: new evidence from the Spanish National Health Survey. Social Science & Medicine, 2009. 69(3): p. 370-378.

[39] Szwarcwald, C.L., P.R. Souza-Júnior, and G.N. Damacena, Socioeconomic inequalities in the use of outpatient services in Brazil according to health care need: evidence from the World Health Survey. BMC health services research, 2010. 10(1): p. 217.

[40] Andersen, R.M., Revisiting the behavioral model and access to medical care: does it matter? Journal of health and social behavior, 1995: p. 1-10.

them to a lack of access to healthcare services.[41] Also, language barriers and culture prevented them from accessing healthcare services.[42]

Regarding enabling factor, it includes financial and social support.[43, 44] Financial support helps to increase the ability to pay while social support will increase the use of friends and relatives. For instance, a study in Canada revealed that refugees could not access and use healthcare service because they were lack of ability to pay as well as a lack of financial support.[45] A study in the USA also pointed out that refugees were not only lack of ability to pay for treatment but also lack of ability to afford the cost of transportation.[46] Another study revealed that family relationship was involved with the use of health service since it played an important role in health information.[47] However, the newcomer of refugees is a lack of both financial and social support.

Need factor also plays an important role in access and use of healthcare service. It deepens how do refugees perceive their health status. Their previous experience will help them to evaluate their health status before deciding to use healthcare service or not.[48] Refugees with good health

[41] Pace, M., et al., Health Services for Refugees in the United States: Policies and Recommendations. Public Policy and Administration Research, 2015. 5(8): p. 63-68.

[42] Chavez, L.R., Undocumented immigrants and their use of medical services in Orange County, California. Social Science & Medicine, 2012. 74(6): p. 887-893.

[43] Andersen, R.M., Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? Journal of Health and Social Behavior, 1995. 36(1): p. 1-10.

[44] Yang, P.Q. and S.H. Hwang, Explaining Immigrant Health Service Utilization: A Theoretical Framework. Sage Open, 2016. 6(2): p. 2158244016648137.

[45] Wahoush, E.O., Equitable health-care access: the experiences of refugee and refugee claimant mothers with an ill preschooler. CJNR (Canadian Journal of Nursing Research), 2009. 41(3): p. 186-206.

[46] Morris, M.D., et al., Healthcare Barriers of Refugees Post-resettlement. Journal of Community Health, 2009. 34(6): p. 529.

[47] Nandi, A., et al., Access to and use of health services among undocumented Mexican immigrants in a US urban area. American Journal of Public Health, 2008. 98(11): p. 2011-2020.

[48] Andersen, R.M., Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? Journal of Health and Social Behavior, 1995. 36(1): p. 1-10.

status were less likely to use healthcare service than those refugees with poor health.[49] In general, self-evaluation or evaluation of health by.[50]

Regarding health-seeking behavior, it depends on illness severity and type of healthcare service.[51] A study in Bangladesh found that lightly more than half (55 percent) of refugees (Rohingya) received treatment from a physician while 4 percent of them did not get any treatment and the rest get treatment from other sources.[52] A majority of Bhutanese in the USA used healthcare service from community health personnel.[53] Another study showed that 53.9 percent of Syrian refugees in Jordan use public healthcare service, followed by 29.6 percent use private healthcare service and 16.6 used healthcare service from NGOs.[54]

The last factor in the outcome of healthcare use is satisfaction. A systematic review showed that previous experience influenced perceptions of users regarding efficacy, quality of received services. Attitudes towards healthcare providers and trust were also involved with access to and use of next healthcare services.[55] For instance, a study in Bangladesh indicated that only 6 percent of Rohingya refugees were satisfied with received service and 40 percent needed better healthcare services.[56]

Healthcare system and healthcare service delivery for refugees and asylum-seekers

[49] Morris, S., M. Sutton, and H. Gravelle, Inequity and inequality in the use of health care in England: an empirical investigation. Social science & medicine, 2005. 60(6): p. 1251-1266.

[50] DeSalvo, K.B. and P. Muntner, Discordance between physician and patient self-rated health and all-cause mortality. The Ochsner Journal, 2011. 11(3): p. 232-240.

[51] Andersen, R.M., Revisiting the Behavioral Model and Access to Medical Care: Does it Matter? Journal of Health and Social Behavior, 1995. 36(1): p. 1-10.

[52] Al Masud, A., et al., Health Problems and Health Care Seeking Behaviour of Rohingya Refugees. Journal of Medical Research and Innovation, 2017. 1(1): p. 21-29.

[53] As above.

[54] Doocy, S., et al., Health Service Utilization among Syrian Refugees with Chronic Health Conditions in Jordan. PLOS ONE, 2016. 11(4): p. e0150088.

[55] Hadgkiss, E.J. and A.M. Renzaho, The physical health status, service utilization and barriers to accessing care for asylum seekers residing in the community: a systematic review of the literature. Aust Health Rev, 2014. 38(2): p. 142-59.

[56] Al Masud, A., et al., Health Problems and Health Care Seeking Behaviour of Rohingya Refugees. Journal of Medical Research and Innovation, 2017. 1(1): p. 21-29.

This report focuses on the healthcare system and healthcare service delivery for refugees and asylum-seekers from countries with a high concentration of refugee population, for instance, EU countries, USA, Canada and Australia.

Europe

At the end of 2015, there were more than 2 million refugees in Europe. Some countries were transit countries where migrants were locked in the camps with poor living conditions. This led to illness even though it can be prevented. At the same time, healthcare services in some destination countries are limited and some countries do not have healthcare services for refugees. This was the responsibility of NGOs to provide healthcare service. However, this healthcare provision was not linked with the existing healthcare system in the destination countries.[57]

UNHCR has suggested the countries where refugees are not in the camps to integrate healthcare service for refuges into the existing system under the 2005 International Health Regulations. This needs to get support from related organizations.[58] It can be divided into the healthcare provision for migrants in Europe into three groups, namely, less than minimum rights, similar minimum rights and more than minimum rights.[59]

The first group which provides less than minimum rights includes countries with strictly limited access to healthcare services. This makes refugees cannot access to any healthcare services since they cannot pay. For instance, in Finland and Ireland, refugees can access emergency care but it is not clear about the cost. In Sweden, Austria, Bulgaria and Latvia refuges can access emergency care at the full cost. While in Chez Republic refuges can access emergency care with full cost and they are allowed to buy private health insurance.[60]

The second group is the countries that provide similar rights to refugees. These countries provide emergency healthcare services to refugees without cost. These countries include

[57] Carballo, M., et al., Evolving migrant crisis in Europe: implications for health systems. The Lancet Global Health. 5(3): p. e252-e253.

[58] Spiegel, P., Urban refugee health: meeting the challenges. Forced Migration Review, 2010(34): p. 22.

[59] Mediterranean Affairs, Migrants' right to health: EU policies and focus on Italy. 2018, Mediterranean Affairs.

[60] As above.

Germany and Hungary. In some countries, such as Cyprus, Denmark, Estonia, Lithuania, Poland, UK, and Slovenia provide emergency care and other services with some conditions.[61]

The last group is the countries that provide healthcare services more than minimum rights. These include the Netherlands, Portuguese, France, Spain, and Italy. In these countries, refugees can access not only emergency care but also primary care and secondary care. However, there are still some conditions in accessing special care.[62]

UK

In the UK right to health of refugees and asylum-seekers based on the National Health Service (NHS). Thus once granted refugee status, they can access to primary care through tertiary care. Also, dental and optical care, prescription and transportation between the healthcare transferring are included.[63] For those who are waiting for refugee status will get only emergency care.[64]

USA

The USA is a primary country that hosts refugees. Although the exit of the USA from the Refugee Act of 1980, it stills supports refugees in terms of the law, finance, and medical aids. These include programs and policies. For instance, policies on health insurance and health promotion and, the program on the Survivors of Torture. However, it is evident that some of the refugees still do not access these policies and programи because it is difficult for refugees to understand the health system and do not know how to get access to.[65]

Canada

[61] As above.

[62] As Above.

[63] Angela, B., Meeting the needs of refugees and asylum seekers in the UK: an information pack for health care workers. London: National Health Service, 2002.

[64] Statutory Instruments, The National Health Service (Charges to Overseas Visitors) (Amendment) Regulations 2017, in No. 756 E. National Health Service, Editor. 2017, National Health Service, England.

[65] Pace, M., et al., Health Services for Refugees in the United States: Policies and Recommendations. Public Policy and Administration Research, 2015. 5(8): p. 63-68.

Canada is one important country that hosts refugees since 1950. In 2016, it received 47,000 refugees which are the biggest number in its history. These refugees were from Asia (Afghanistan and the Middle East) and Africa.[66] Canada has established the Interim Federal Health Program (IFHP) to provide healthcare for refugees since 1957. The service includes basic healthcare, optical and dental care at the provincial level.[67]

Australia

Australia has started health policies for refugees and asylum-seekers since 1990. However, these are liked with VISA status and residential areas (offshore and onshore). Refugees and asylum-seekers have the rights to access to health screening and healthcare under some certain programs. These programs included Australian's humanitarian program, policy on health screening for offshore and onshore applicants, policy on medical care for offshore and onshore applicants, offshore resettlement program, onshore protection program and community based onshore applicants).[68]

Thailand

Although Thailand has two health systems for migrants there is no healthcare provision system for refugees and asylum-seekers. The two systems of health systems for migrants include healthcare card which is under the Ministry of Public health and Social Security.

It can be concluded that from the above literature the health system for refugees and asylum-seekers is depended on the healthcare system in the destination country. However, it is suggested that the resilience health system be considered.[69] Since the resilience health system reflects the capability of the health system to support the access to healthcare service with

[66] Government of Canada, Health care – Refugees. 2018, Government of Canada.

[67] Alexander, C., Health care and refugees in Canada. CMAJ : Canadian Medical Association Journal, 2014. 186(8): p. 614-615.

[68] Correa-Velez, I., S.M. Gifford, and S.J. Bice, Australian health policy on access to medical care for refugees and asylum seekers. Australia and New Zealand Health Policy, 2005. 2: p. 23-23.

[69] Langlois, E.V., et al., Refugees: towards better access to health-care services. Lancet (London, England), 2016. 387(10016): p. 319-321.

sustainability particularly during the health or economic crisis.[70] [71] [72] Apart from universal health coverage and health security, the resilience health system is also an important component of health system strengthening.[73]

The focus of previous studies in Thailand mostly on refugees residing in camps. Only a few studies are related to urban refugees and focus on the detention center.

Regarding studies on the health of camp refugees, some studies emphasized both physical and mental health. Physical health issues include health behaviors and disease prevention. For instance, a study on alcohol use among reproductive-age men in Mae La refugee camp found that slightly more than one-third of respondents used alcohol.[74] Another study on the risk of abortion found what hard work and health status influenced the risk of getting an abortion.[75] A study on reproductive health and quality of life among adolescents in camps pointed out that they were lack of knowledge on reproductive health and had a low quality of life.[76] One study on handwashing showed that only 15 percent of camp populations could wash their hands properly.[77] Another study on malaria control in camps found that a good malaria case management could health to prevent and control malaria.[78]

[70] Ammar, W., et al., Health system resilience: Lebanon and the Syrian refugee crisis. Journal of global health, 2016. 6(2).

[71] Kruk, M.E., et al., What is a resilient health system? Lessons from Ebola. The Lancet, 2015. 385(9980): p. 1910-1912.

[72] Thomas, S., et al., A framework for assessing health system resilience in an economic crisis: Ireland as a test case. BMC health services research, 2013. 13(1): p. 450.

[73] Kruk, M.E., et al., What is a resilient health system? Lessons from Ebola. The Lancet, 2015. 385(9980): p. 1910-1912.

[74] Nadine, E., et al., Risky alcohol use among reproductive-age men, not women, in Mae La refugee camp, Thailand, 2009. Conflict and Health, 2012. 6(1): p. 7-7.

[75] Suksinchai, S., Miscarriage among displace people: a case study of Karen women in Tak province, Thailand, in the Institute for Population and Social Research. 1999, Mahidol University: Nakhon Pathom.

[76] Benner, M.T., et al., Reproductive health and quality of life of young Burmese refugees in Thailand. Conflict and health, 2010. 4(1): p. 5.

[77] Biran, A., et al., Hygiene and sanitation practices amongst residents of three long-term refugee camps in Thailand, Ethiopia and Kenya. Tropical Medicine & International Health, 2012. 17(9): p. 1133-1141.

[78] Rowland, M. and F. Nosten, Malaria epidemiology and control in refugee camps and complex emergencies. Annals of Tropical Medicine & Parasitology, 2001. 95(8): p. 741-754.

There are some studies focus on mental health. One study was on stress among children in Ban Mai Nai Soi camp found that socioeconomic status, living conditions and changes in the family structure were related to the stress of children.[79] Another study on the mental of Karen residing in camps revealed that they were at risk of post-traumatic stress disorder (PTSD).[80] Also, one study among pregnant refugees found that they faced emotional disturbances, somatic symptoms, and socially inappropriate behavior. These were caused by economic difficulty, lack of family support and worried about the future.[81]

Concerning the health of refugees in the detention center, there are some studies. For instance, a study on living conditions of children in the detention center found that the environment was not good enough for their health and they lived in a poor living condition which lack of safety as well as the risk of being exploited as well.[82] A study on social determinants of health among urban refugees also found that being stigmatized or marginalized population (e.g. stateless, ethnic minority) and being populations with limited accessibility to healthcare services (e.g. lack of health insurance, living in remote area) and being populations with long-term health needs with risk of negligence or abuse (e.g. elderly, disabled persons were difficult to access and use of healthcare services). These were caused by a lack of opportunities, lack of resources that were related to social status, social capital and human capital.[83]

There are a few studies on urban refugees in Thailand. For instance, a study compared the situation between urban refugees in Thailand and Hong Kong. It indicated that they were left behind in both countries and it was difficult for them to go to the third country. They were hopeless and faced social insecurity, particularly refugees residing in urban Thailand. Also,

[79] Meyer, S., et al., The nature and impact of chronic stressors on refugee children in Ban Mai Nai Soi camp, Thailand. Glob Public Health, 2013. 8(9): p. 1027-47.

[80] Cardozo, B.L., et al., Karenni refugees living in Thai–Burmese border camps: traumatic experiences, mental health outcomes, and social functioning. Social Science & Medicine, 2004. 58(12): p. 2637-2644.

[81] Fellmeth, G., et al., Pregnant migrant and refugee women's perceptions of mental illness on the Thai-Myanmar border: a qualitative study. BMC Pregnancy and Childbirth, 2015. 15: p. 93.

[82] สุรพงษ์ กองจันทึก และคณะ, การศึกษาเบื้องต้นเกี่ยวกับสถานการณ์ของเด็กในสถานกักตัวคนต่างด้าว สำนักงานตรวจคนเข้าเมืองซอยสวนพลู กรุงเทพมหานคร. 2556: Save the children.

[83] บวรศม ลีระพันธ์, et al., แนวคิด และ แนวทาง ปฏิบัติ เพื่อ ตอบ สนอง ต่อ ความ ต้องการ ด้าน สุขภาพ ของ ประชากร กลุ่ม เปราะ บาง ใน ประเทศไทย. วารสารวิจัยระบบสาธารณสุข 2559. ฉบับที่ 4 ตุลาคม-ธันวาคม (ปีที 10).

lack of social support led them to exploited work and lack of protection since they had no choice.[84]

[84] Shum, T.C., Refugees' transnational mobility: A study of Asylum seeking in Hong Kong and Urban Thailand. Refugee Survey Quarterly, 2014. 33(4): p. 50-80.