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Health Promotion of Local Migrant Workers in a Highly Urbanized City

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Abstract - This descriptive study explores the health promotion of local migrant workers in a highly urbanized city in Southern Philippines. The respondents were the 164 workers in five of the biggest retail stores in the city. Modified questionnaires, supplemented with focus group dicussions, were the main tools employed. Permission to conduct the study was requested from the Department of Labor and Employement and the store management. Written informed consent from the study participants was also sought. Data gathered were then processed using descriptive statistics. Results show that the male and female migrant workers are barely legal, just off their teenage life, attended college, mostly single, belonged to medium-sized families, with fathers either farmers or private employees and mothers who were housewives with no gainful employment. The workers had various physical and mental health problems, as well as poor health-seeking behaviors. The findings have various implications on program planning and policy making in related private and government agencies to promote the health of local migrant workers.

Keywords - health promotion, migrant workers, health problems, health-seeking behaviors

INTRODUCTION

Cagayan de Oro City today is said to be the hottest business prospect in Mindanao. As the capital of Region 10, it has helped the region become the second most economically active in the Philippines (National Statistical Coordination Board, 2006). For this economic development, Cagayan de Oro City has become the melting pot of local migrant workers coming from both nearby and distant provinces.

An intrinsic component of development is migration as it brings about many changes in both the economic and social fronts. Migration has the potential of enhancing people's quality of life as it offers job opportunities. More often than not, earning an income is seen as a positive factor for people to be able to provide for their basic needs. However, occupational exposures to hazardous substances, processes, and working conditions increased the risk of workers to develop work-related illnesses. According to DOLE (Department of Labor and Employment, 2007), these work-related diseases are cancer, cardiovascular, nervous, renal, and chronic respiratory disorders.

Furthermore, the International Labor Organization (ILO, 2006) estimates that 2.2 million work-related deaths occur annually around the world. Significantly, work-related cancer and heart diseases account for over half of all occupational fatalities. These trends reflect, to a large extent, the experience in the Philippines with 32.2 million workers employed in the country and 8 million overseas workers.

This present plight among local migrant workers is compounded due to the dearth of data on their health status and level of empowerment. This preliminary study is, therefore, very important in bridging the knowledge gap on the characteristics and health status of migrant workers in Cagayan de Oro City.

The data of the study can be used by the Department of Labor and Employment (DOLE), Department of Health (DOH), City Health Office of Cagayan de Oro, related NGOs, and other private industries as basis in the formulation of health promotional- related policies and programs aimed at enhancing the health status of the local migrant workers in Cagayan de Oro City. The data will also be equally relevant even to the international

sector like the World Health Organization (WHO) and International Labor Organization (ILO).

FRAMEWORK

Migration trends show that there is a rural-urban flow of migrants in the Philippines (POPCOM, 2007). Migration flow is generally linked with the level of urbanization that a city has already reached (Bilsborrow, 1993). Cagayan de Oro City draws a huge number of migrants from both far and nearby rural areas. Previous studies in the Philippines attest that female migrants outnumber male migrant workers. In NCR, majority of the local migrants are young, single, female and between the ages of 15-34 (Carcallas, 1999; Gultiano and Xenos, 2005).

There is an obvious problem in the current state of occupational health in the Philippines. Survey on Occupational Safety and Health Condition in Selected Regions (2000) by the Occupational Safety and Health Center (OSHC) showed that only 42.8% of the companies surveyed have written safety and health policy, 52% have safety and health committee, 42.48% have programs for safety and health activities, 48% employ physician or nurse, 14.7% hire safety officers/engineers, and 28.76% have their supervisors trained on occupational safety and health. This survey reveals the poor safety and health promotions for workers in most manufacturing establishments.

Moreover, according to Jenning's Philippine Occupational Health and Safety situationer in 2001, the retail industry is almost totally casualised. Some conditions for that disadvantaged worker particularly the salespeople who are mostly women include having to stand all day (to be caught sitting down can lead to dismissal), seeking permission to go to the toilet resulting in a high incidence of urinary tract diseases, and undergoing a physical examination to discover abdominal-marks. Those found to have children are not employed.

Another study by OSHC (2001) looked into the health status of workers exposed to organic solvents in selected semiconductor and microelectronics industries. The results revealthat the semiconductor and microelectronics industries employ mostly young female workers. They handle organic solvents during routine work operations. To reduce operator exposure, the companies employ control measures such as local and general exhaust systems. The survey of symptoms indicates that the prevalent bodily systems affected are the central nervous system, respiratory system, and the skin.

These findings call for a need to improve the health and safety in the above-related workplaces to protect the workers.

Validating the cases of health risks to workers are the recent surveys on workers' compensation claims in the Philippines (2002), which include those in the offices of SSS (Social Security System), GSIS (Government Service Insurance System), and ECC (Employees Compensation Commission). The five leading diseases identified were cardiovascular diseases, cerebrovascular accidents, pulmonary tuberculosis, cancer, and musculoskeletal-related diseases. Laborers/maintenance workers accounted for the majority of the claimants, followed by professional/technical workers and teachers.

Thus, in 2001, in an attempt to address problems related to occupational safety and health, a National Plan on Occupational Safety and Health was implemented by a multisectoral body (Lomuntad-San Jose, 2001). According to the study, despite concerted efforts, various problems were met during the implementation process such as severe manpower and budgetary constraints, low awareness, overlapping of roles and functions of institutions involved in occupational safety and health, as well as a paucity of baseline data. Thus, alternative strategies have been proposed in the areas of enforcement, control, legislations, training and education on occupational safety and health, research and other technical services.

The Philippines has been perennially experiencing occupational-related health and safety problems despite the presence of the labor law. Presidential Decree Number 442 or commonly known as The Labor Code of the Philippines is a consolidation of labor and social laws. It is made to afford protection to labor and to promote employment and human resources development. It also ensures industrial peace based on social justice. Book four (4) of the code particularly espouses the health, safety and social welfare benefits. Chapter one of book four stipulates that every employer shall be responsible to provide first-aid treatment to his/her employees. Furthermore, it is also the duty of every employer to provide his/her employees with free medical and dental attendants (such as doctors, nurses and dentists) and facilities. A comprehensive occupational health program must also be developed and implemented for the employees. In chapter two (2), the mandatory enforcement of safety and health standards to eliminate or reduce occupational safety and health hazards in the workplace is emphasized. Stipulated as well are the employees' compensation and state insurance fund policies, medical disability and death benefits, the Philippine Medical Care Plan (MEDICARE), and appropriate and necessary adult education programs.

To facilitate changes to improve the health and safety of the workers, many researchers considered individual empowerment as an intervention. A good number of foreign studies were conducted in terms of the relationship of empowerment and health promotion. For instance, according to Wallerstein (2000) in New Mexico, the opposite of empowerment, which is powerlessness, or the lack of control over destiny, emerged as a risk factor for disease.

OBJECTIVES OF THE STUDY

The study sought to determine the background characteristics of local migrant workers in CDOC in terms of socio-economic and demographic profile and to describe the health profile of the local migrant workers.

RESEARCH METHODOLOGY

This study is exploratory and descriptive in nature. Both qualitative and quantitative approaches were utilized. The researchers included the workers in the retail industry in Cagayan de Oro City as respondents. Five (5) of the biggest retail stores in the city were targeted as research settings. The original plan was to do random sampling among the local migrant workers in these 5 stores. However, only those who were chosen by the management or human resource officer and who were willing to participate and were available for interview were included in the study. It was intended that 20 male and 20 female migrant workers in each store (total of 200 respondents) be involved. However, only 164 questionnaires were returned.

To determine the respondents' background and health proper, a modified questionnaire based on the Total Health Assessment Questionnaire by Austin (2008) was used. Questionnaire was tested for reliability which yielded a Cronbach alpha of 0.769, Indicating that the questionnaire is highly reliable. To further validate the data, a four-group discussion (FGD) on the level of empowerment was conducted.

Prior to the fieldwork, formal communications were sent to DOLE Region X Director for approval and endorsement and to the Human Resource Management Office of each retail/department store for permission to float the questionnaire to its workers.

The questionnaires with a transmittal letter where then distributed to the respondents. Coding was used to keep the confidentiality of the response. The data were analyzed using frequency, percentage, and mean. Interview

responses were also content analyzed, coded, and tabulated according to common themes.

RESULTS AND DISCUSSION

The majority of the local migrant workers were young and single. They were aged 21-26 years old. This finding is consistent with the findings of other local studies that the Philippine migration is dominated by young and single workers (Carcallas, 1999).

A third of the respondents finished high school and more than half went to college. However, of those who went to college, only about 60 percent graduated from college. Less than five (5%) percent of the respondents reached high school and finished a vocational course. The data show that indeed Filipinos have a high level of literacy. However, these college graduates usually end up as minimum wage earners; or even below minimum. This phenomenon can be attributed to the fact that employment opportunities are scarce for the unskilled and inexperienced and for persons whose education does not match industry needs and that employment competition is stiff.

Most of the migrant workers were middle children and belonged to medium size Catholic family (of 6-8 members or 4-6 children). Large size families used to dominate in the 1950s to 1980s. Presently, however, owing to the economic decline, a small size has become the ideal family size. Since most of the respondents come from families of low economic status, they are usually expected to help the family earn after finishing secondary or tertiary education (Gultiano and Xenos, 2005; Carcallas, 1999).

As to parents' occupation, the respondents' fathers were either farmers or private company employees were working as security guards, drivers, construction workers, janitors, electricians, and factory workers. Moreover, the other third of the fathers were either deceased or with no work at all. On the other hand, their mothers were mostly housekeepers (70 %). Having a deceased or an unemployed or low earning parent in a medium to large size family is enough reason to compel a young adult work for family.

More than eighty percent (80%) of the respondents came from Mindanao. About a third, in particular, came from the nearby Bukidnon Province and one-fourth from the surrounding towns of Misamis Oriental. Still, a number came from the Visayas, while only one from Manila. The mean age of migration was 19, although a few migrated when they were still 12 – 15 years

old. Almost forty percent (40%) claimed that it was entirely their own decision to move to Cagayan de Oro City, while less than a third of the respondents were influenced by their parents.

According to the study of Quisumbing and McNiven in 2005, internal migration in the Philippines is a fundamental part of rural livelihood strategies and rural transformation, and not only to escape poor rural areas. Research undertaken by the International Food Policy Research Institute (IFPRI) and the Research Institute for the Mindanao Culture, Xavier University (RIMCU) in the mid-1980s and repeated in 2003-2004 found that *poblacions* and cities attract better educated individuals to either find a job or further their education.

The data further reveal similar themes on the common push-and-pull factors of migration. The topmost factor is obviously the economic factor, followed by educational, then social and personal factors. These data mirror in particular the country profile of the Philippines as presented in the Library of Congress (Federal of Research Division, 2006). Poverty is said to be a serious problem in the Philippines. According to the World Bank, in 2003, per capita gross national income was US$1,080, below the US$1,390 average for lower-middle-income countries. Reflecting regional disparities, in 2003 about 11 percent of Filipinos lived on less than US$1 per day and 40 percent on less than US$2 per day. The overall poverty rate declined from 33 percent (25.4 million people) in 2000 to 30.4 percent (23.5 million people) in 2003. Also, poverty is more concentrated in rural than in urban areas.

On a positive note, despite poverty in most rural areas in the country, tertiary education is still given much importance. Many of the respondents shared that they were working students while studying in college. They believe that finishing a college degree would provide them a better future and an edge in getting a good paying job.

As retail store workers, their assignments or positions vary, from cashier to sales assistant, promo girl, stock clerk, merchandiser, quality assurance checker, electrician, and packers. The average monthly income of these workers is 5,000 pesos or 192 pesos per day. As against, the minimum wage per day of 240 pesos or an approximate monthly income of 6,000 pesos. The salary ranges vary depending on the establishments. Only about ten percent (10%) of these local migrant workers received the minimum wage. The rest (90%) were paid lower than the minimum wage. This finding supports that of Ronquillo and Lorenzo in 2005 that one out of every five employed workers was underemployed or underpaid and working part-time or employed below

his/her full potential. Todaro (as cited by Carcallas, 1999) said that this rural to urban migration will continue for as long as the perceived expected urban wage is relatively higher than the rural wage.

More than half of their meager income were spent for food, lodging, transportation, and utility bills (electric, water, and mobile phone). Only about one-fourth (1/4) of the income was sent to their families. Not all, however, sent money to their families in the province. Quite a number (36 out of 164) used their income solely for their own consumption. Moreover, less than one-eight of the income was used to buy clothing, shoes, and toiletries. Some of the male migrant workers also reported having a portion of the "others" spent for night out or for dating girls. Also, a portion of the "others" was spent for leisure to prevent fatigue or boredom.

It is sad to note, but not surprising, that the smallest chunk of the salary (if there is still some left) is spent for health such as buying medicines for common illnesses and vitamins and setting aside money for emergencies.

Table 1. *Health profile of local migrant workers in Cagayan de Oro City*

Health Profile	Both Sexes		Males		Females	
	Frequency	Rank	F	Rank	F	Rank
Family History						
Hypertension	81	1	44	1	41	1
Diabetes	28	2	14	2	14	2
Heart problems	24	3	13	3	11	3
High cholesterol	6	4.5	3	4.5	3	4.5
Cancer	6	4.5	3	4.5	3	4.5
Current health complaints						
GENERAL						
Headache	111	1	59	1	52	1
Fever	103	2	55	2	48	2
Loss of sleep	51	3	30	3	21	3
Forgetfulness	27	4	11	4	16	4
Nervousness	21	5	6	5	15	5
Dizziness	7	6	3	6.5	4	6
Chills	6	7	3	6.5	3	7
Numbness	1	8	0	-	1	8
AVERAGE	20.44	1	20.88	1	20.00	2

Cont. of Table 1

PAIN IN THE-						
Back	69	1	30	1	39	1
Feet	46	2	19	3	27	2
Arms	42	3	22	2	20	3
Hands	24	4	10	4.5	14	4
Hips	22	5	10	4.5	12	5
AVERAGE	20.30	2	18.20	2	22.40	1
GASTROINTESTINAL						
Stomach pain	62	1	29	1	33	1
Diarrhea	40	2	17	2	23	2
Poor Appetite	15	3	5	4.5	10	3
Bowel changes	13	4	5	4.5	8	4
Indigestion	10	5	5	4.5	5	6
Constipation	9	6.5	5	4.5	4	7
Nausea	9	6.5	3	9	6	5
Excessive thirst	6	8	4	7.5	2	9.5
Flatulence	6	9	4	7.5	2	9.5
Vomiting	5	10	2	10	3	8
AVERAGE	8.39	3	7.18	4	9.60	3

Current health complaints	Both Sexes		Males		Females	
	Frequency	Rank	F	Rank	F	Rank
EYE, EAR, NOSE, THROAT						
Sinus problems	44	1	21	1	23	1
Bleeding gums	18	2	13	2	5	3.5
Persistent cough	15	3	11	3	4	5
Blurred vision	12	4	7	5	5	3.5
Nose bleeding	11	5	10	4	1	9
Loss of hearing	10	6	4	9	6	2
Earache	8	7	6	6	2	7
Ear discharge	7	8.5	5	7.5	2	7
Ringing in the ears	7	8.5	5	7.5	2	7
Difficulty swallowing	3	10	3	10	0	-
Hoarseness of voice	1	11	1	11	0	-
AVERAGE	6.17	4	7.81	3	4.54	5
SKIN						
Itching / rashes	27	1	13	1	14	1
Bruise easily	5	2	1	3	4	2
Changes in moles	2	3	1	3	1	3
Sores that won't heal	1	4	1	3	0	-
AVERAGE	4.37	5	4.00	5	4.75	4
GENITO-URINARY						
Painful urination	13	1	6	1	7	1
Blood in urine	2	2	0	-	2	2
AVERAGE	3.75	6	3.00	6	4.50	6

Cont. of Table 1

CARDIOVASCULAR						
Varicose veins			2	4.5	11	1
High blood pressure	13	1	5	1	4	2
Irregular/ rapid	9	2	4	2.5	3	3
heartbeat	7	3	4	2.5	1	4.5
Chest pain	5	4	2	4.5	1	4.5
Low blood pressure	3	5				
AVERAGE	3.41	7	2.83	7	4.00	7

As to the health profile of the local migrant workers, Table 1 reveals that hypertension and diabetes were two of the most common heredo-familial diseases among the respondents. Such case is also true to whole Filipino citizenry. As of 2002 (country profile), hypertension and diabetes are indeed two of the leading causes of morbidity. Cardiovascular diseases, specifically, account for more than 25 percent of all deaths. One out of five adult Filipinos is hypertensive and not even aware of the condition while 90 percent of the country's population has one or more of the risk factors that contributes to high blood pressure (Philippine Society of Hypertension, 2008).

Hypertension refers to an intermittent or sustained elevation in the blood pressure. It is a major cause of stroke, cardiac disease, and renal failure. Detecting and treating it before complications develop greatly improves the patient's prognosis. Scientists have not been able to identify a single cause for hypertension. Certain risk factors, however, appear to increase the likelihood of hypertension. Nonmodifiable risk factors- those that cannot be changed- include a family history of hypertension, age, ethnicity, and diabetes mellitus. Modifiable risk factors- those that can be changed- include blood sugar levels, physical activity levels, smoking, and salt and alcohol intake. Smoking cessation, reduced salt and caffeine and alcohol intake; weight reduction, improved meal planning, increased physical activity, and managing stress can all help to decrease blood pressure (Medical-Surgical Nursing, 2008).

Diabetes mellitus, on the other hand, is a group of metabolic diseases in which defects in insulin secretion or action result in high blood sugar level (hyperglycemia). As reported 4.1% of Filipinos have diabetes mellitus. At the current estimate of the population, this means 2.5 million Filipinos with diabetes, with an equal number to the undiagnosed. It is a serious disease that can cause complications such as blindness, kidney failure, heart attacks, and strokes. Aside from physiological defects (type 1 diabetes), heredity is responsible for up to 90% of cases of type 2 diabetes. Obesity is also a major

contributing factor. A newer finding is likewise the link between diabetes and a condition called metabolic syndrome, sometimes called syndrome X.

According to the American Heart Association and the National Heart, Lung and Blood Institute, metabolic syndrome is diagnosed when at least three (3) of the following criteria are met: elevated waist circumference (abdominal obesity), triglyceride level of 150 mg/dl or higher, high-density lipoprotein (HDL or "good cholesterol") lower than 50 mg/dl for women, blood pressure level of 130/85 mmHg or higher, and fasting blood sugar of 100 mg/dl or higher (Williams and Hopper, 2007). Any one who fits this profile should be monitored closely for the onset of type 2 diabetes and heart disease. They should be counseled on the importance of a diet low in saturated fats and cholesterol, weight loss, physical activity, and control of blood pressure. With good education and self-care, people with diabetes can prevent or delay these complications and lead full, productive lives. A major role of the company nurse is helping these migrant workers learn to care for themselves.

In terms of current health complaints for the past 12 months, topmost were the headache, fever, and loss of sleep. Causes may vary that include everyday physical and mental stress and infection. Ranked record was complaint of muscular pain on the back, feet, and arms. Muscular pains are common among workers during much physical labor.

Third in rank were the gastrointestinal-related problems, which commonly consisted of stomach pain and diarrhea. The causes of these may vary from eating to habits, type of foods eaten, and food hygiene (food preparation). During the interview, many respondents reported that they usually eating foods in cafeteria, sari-sari stores, eateries, or street foods because the foods are cheap.

Fourth were, particularly sinus problems to include rhinitis or common colds and acute or chronic sinusitis. These conditions involve the inflammation of the nasal mucous membranes or inflammation of one or more sinuses due to bacterial or viral infections, or as a reaction to allergens such as pollen, dust, molds, or some foods. Both the physical home and working environments and the health status of the employee may contribute to the occurrence of sinus problems.

Next were the skin-related complaints, such as itching and/or rashes, and genito-urinary tract (painful urination). Female respondents reported that they usually delay urination until break time and that their water intake is limited when they are at work. Lastly, a few of the female-respondents complained of having varicose veins, particularly on the lower extremities.

Varicose veins are described as elongated, tortuous, dilated veins. The exact cause is unknown but the condition tends to be familial. Any factor that may contribute to increasing hydrostatic pressure within the leg, such as prolonged standing, pregnancy and obesity, may promote venous dilation. Most of these respondents stand for 4-8 hours a day as part of the job.

Though the above data reflect the health conditions of the respondents, there are limitations as to the accuracy and completeness of the data because of the manner they were gathered. Health status can best be examined through actual physical assessment and not by mere perception of the person on the signs and symptoms felt or experienced.

There seems to be a common pattern of both family health history and health complaints for both sexes. However, more females opened up their health problems than males did. Other health problems noted that (not shown in the table) are specific to women were extreme menstrual pain (18), bleeding between periods (2), breast lump (2), hot flashes, (1) and vaginal discharge (1).

The World Health Organization defines health as a "state of complete physical, mental and social wellness, not merely the absence of disease or infirmity." People in a state of emotional, physical, and social well-being fulfill life responsibilities, function effectively in daily life, and are satisfied with their interpersonal relationships and themselves. Thus, an equally significant indicator of a person's health status is their mental health. According to Videbeck (2002), no single, universal definition of mental health exists, but one can infer a person's mental health from his or her behavior.

Table 2 presents the mental health of the respondents. With highest frequency among the indicators was perceiving stress as a major problem, followed by having trouble sleeping. Mental health, as described in Medical-Surgical Nursing (2007), is the ability to be flexible, be successful, form close relationships, make appropriate judgments, solve problems, cope with daily stress, and have a positive sense of self. It is natural for emotions to ebb and flow from day-to-day in response to the degree of stress that is experienced. People who remain mentally healthy are able to keep their stress in perspective. Others are not able to do so as shown in the table. A number of the respondents cried frequently because of varying problems, panicked when stressed, thought of hurting self, and even attempted suicide. Over time, they may develop physical or emotional illnesses as a result of the constant stress in their life, these respondents eventually affecting their overall health and putting a strain on their work.

Table 2. *Mental health profile migrant workers in Cagayan de Oro City*

Mental Health	Both Sexes		Males		Females	
	Frequency	Rank	F	Rank	F	Rank
Stress is a major problem	66	1	23	1	43	1
Have trouble sleeping	48	2	17	2	31	2
Cries frequently	28	3	6	4	22	3
Panics when stressed	23	4	7	3	16	4
Have seriously thought about hurting self	14	5	3	6	11	5
Have been to a counselor	11	6	5	5	6	6
Have attempted suicide	7	7	2	7	5	7

It is, therefore, imperative that these respondents be taught about effective stress management. Coping is the way one adapts psychologically, physically, and behaviorally to a stressor. Individuals have different methods of coping or dealing with their stressors. The company nurse can be a vital source of information on the healthy choices for dealing with stressors. The process of effective coping is sometimes called adaptation. Allowing the person to practice new coping techniques will give him or her confidence to adapt and will decrease the stress that can accompany change.

The data convey that there is a common trend on the ranking of the indicators for both sexes. However, obviously more women (almost double in numbers) than men shared that they were constantly beset with such conditions.

Another indicator of health status is a person's health-seeking behavior. Health-seeking behaviors as defined in Kozier (2004) are the actions people take to understand their health state, maintain an optimal state of health, prevent illness and injury, reach their maximum physical and mental potential, as well as health practices during illness. Behaviors such as eating wisely, exercising, paying attention to signs of illness, following treatment advice from appropriate health agency and experts, avoiding known health hazards such as smoking are examples. Under health-seeking behaviors are health screenings/check-ups, medical consultations, healthy lifestyle, and health planning.

Table 3. *Health-seeking behavior of local migrant workers in Cagayan de Oro City*

Health Screenings & Practices when ill	Both Sexes (n=164)		Males (n=88)		Females (n=76)	
	F	%	F	%	F	%
VACCINATIONS						
Tetanus	9	5.5	6	6.8	3	3.9
Flu	6	3.7	5	5.7	1	1.3
CHECK UPS						
Blood pressure	34	20.7	22	25	12	15.8
Cholesterol level	1	0.6	1	1.2	0	-
Skin examination	2	1.2	1	1.2	1	1.3
Pap smear(women)/prostate exam (men)	4	2.4	1	1.2	3	3.9
PRACTICES WHEN SICK						
Done self-care/ self-treatment	79	48.2	36	41	43	56.6
Visited doctor's clinic for consultations	17	10.4	14	16	3	3.9
Treatment with alternative medicines	12	7.3	10	11.4	2	2.6
Gone to hospital for treatment	5	3.0	4	4.6	1	1.3
Hospital confinement during illness	3	1.8	3	3.4	0	-

Tables 3 to 5 reveal the health-seeking behaviors of the respondents. Data on health screenings are very alarming since only a small number of the respondents subjected themselves for health examinations and vaccinations. Promoting health and wellness always starts with prevention, which levels are primary, secondary, and tertiary prevention.

Primary prevention includes generalized health promotion and specific protection against disease. It precedes disease or dysfunction and is applied to generally healthy individuals. Examples of primary prevention activities are health education about accident and poisoning prevention, standards of nutrition and growth and development for each stage of life, exercise requirements, stress management, protection against occupational hazards, immunizations, risk assessments for specific disease, family planning services and marriage counseling, environmental sanitation and provision of adequate housing, recreation, and safe work conditions.

Moreover, secondary prevention involves early detection of disease, prompt intervention, and health maintenance for individuals experiencing health problems, and prevention of complications and disabilities. Examples are regular medical and dental check-ups and self-examination for breast and

testicular cancer. Finally, tertiary prevention begins after an illness, when a defect or disability is fixed, stabilized, or irreversible. Its focus is to help rehabilitate individuals and restore them to an optimum level of functioning within the constraints of the disability.

Both primary and secondary levels of prevention are applicable to or may be adapted in any workplace setting. The company physician in partnership with the company nurse must come up with a health promotion and disease prevention program among its employees. Bringing health promotional and disease prevention activities will make health care accessible and affordable to the workers, particularly those receiving only minimum or below minimum wages. More often than not, the cost of health care is a barrier to its utilization.

More males had better health-seeking behavior than the females. However, during the FGD, men revealed that they are not familiar with prostate exam. Among females, few submitted themselves for pap smear because of its cost (between 300 – 400 pesos). Most respondents disclosed that health-related expenses, such as medical consultations and immunizations, are not their priority. In terms of practices during illness, females are more likely to do self-care or self-treatment than males. Conversely, more males consulted medical doctors when ill, used alternative medications as treatment, and went to a hospital for treatment or for confinement compared to their female counterparts.

According to Kozier (2004), an individual's standard of living (reflecting occupation, income, and education) is related to health, morbidity, and mortality. Hygiene, food habits, and the propensity to seek health care advice and follow health regimens vary among high-income and low-income groups. For example, preventing illness may not be as important as generating and maintaining an income among the poor. Even when prevention is a priority, the poor may not be able to afford regular medical examinations, housing, or nutritious food that promote health.

Moreover, low-income families often define health in terms of work; if people can work, they are healthy. They also do not have regular preventive medical check-ups because they cannot afford them. It is more important for them to work than to lose a day's pay visiting a physician. Reliance on public health services and inability to afford health care insurance limit both the low-income person's access to health care and the type of care available.

Another variable considered to contribute to the health status of people is their lifestyle. Lifestyles are personal habits of the individual that may affect health. Specific indicators include smoking, alcohol consumption, eating

habits, and physical activity or exercise.

The data reveal a positive result. Less than 15% of the respondents smoked, averaging of 1-3 sticks per day for about 1-3 years already. Also, about 20% of the respondents drank occassionally. Smoking is implicated in lung cancer, emphysema, and cardiovascular diseases, while alcohol is physically and mentally debilitating. Thus, smoking and drinking must be emphasized in health talks for employees.

In terms of eating habits, most respondents ate about 1-3 servings of vegetables and fruits daily. Only a few frequently ate "fast" foods. About 40% drank coffee everyday, while others drank tea (30%) and/ or cola (15%) daily. Inappropriate eating and being overweight are likewise closely related to the incidence of heart disease, diabetes and hypertension.

Table 4. *Lifestyle or health-related behaviors among local migrant workers in Cagayan de Oro City*

Lifestyle/Health- related behaviors	Both Sexes (n=164)		Males (n=88)		Females (n=76)	
	F	%	F	%	F	%
Smoking habit:						
• Never smoked	105		50		55	
• Used to smoke	36		19		17	
• Still smoke	23		19		4	
	164		88		76	
Number of cigarettes per day						
• 1 – 3 sticks	18	64.0	16		2	
• 4 – 6 sticks	4	22.0	4		-	
• 7 – 10 sticks	1	14.0	1	56.8	-	72.4
		100		21.6		22.4
				21.6		5.2
Number of years of smoking				100	1	100
• 1 – 3 years	13		12		1	
• 4 – 6 years	7		6		1	
• 7 – 10 years	4		4		-	
Number of alcoholic drinks in a week						
• 1 – 3 glasses	30		23		7	
• 4 – 6 glasses	1		1		-	

Cont. of Table 4

Number of fruits/ vegetables serving/day						
• 1 – 3 servings	78		46		32	
• 4 – 6 servings	11	47.6	7		4	42.1
TOTAL	89	6.7	53	52.3	36	5.3
Frequency of eating in a fast food		54.3		8.0		47.4
• 1 – 3/week (always)	11		6	60.3	5	
• 2/month (frequently)	16	6.7	2		14	6.6
• Once a month (sometimes)	33	9.8	27	6.8	6	18.4
• 6/ year (seldom)	5	20.1	0	2.3	5	7.9
TOTAL	65	3.1	35	30.7	30	6.6
Caffeine drinks (multiple responses)		39.7		0		39.5
• coffee	60		34	38.8	26	
• cola	49		30		19	
• tea	16		11		5	
Number of times engage in moderate-intensity physical activity in a week						
• 3 – 6/ week (always)	6		6		-	
• Once a week (frequently)	19		19		-	
• 2 – 3/ month (sometimes)	34		24		10	
• Once a month (seldom)	3		2		1	
TOTAL	62		51		11	

In terms of physical activity, only 40% exercised. Of the 40%, only a few exercised 3-6 times a week. Most of them exercised once or twice a month only. Exercises are ideally done regularly, about 30 minutes to an hour, 3 to 4 times a week, involving isotonic, isometric, and aerobic exercises. Among its proven benefits are increased sense of well-being, improved self-concept, ability to cope with stress, improved energy level and work performance, improved quality of sleep, improved cardiovascular and respiratory status, firmed muscle tone, increased strength and endurance, increased balance and coordination, and decreased serum triglyceride and cholesterol levels.

Program for lifestyle and behavior change, which enhances the quality of life and extends lifespan, requires the participation of the individual. Worksite wellness programs, in particular, may include accident prevention for a machine operator or electrician, back-saver program for an individual involved in heavy lifting, screening for high blood pressure or blood sugar, and health enhancement programs such as physical fitness and relaxation techniques.

Table 5. *Health planning among local mograntworkers in Cagayan de Oro City*

Health planning	Both Sexes (n=164)		Males (n=88)		Females (n=76)	
	Frequency	Rank	F	%	F	%
Changes done during the past 12 months to enhance health:						
• Increased physical activity	58	1	39	44.3	19	25
• Lost weight	55	2	26	29.6	29	38.2
• Reduced alcohol use	41	3	29	33	12	16
• Reduced fat intake	30	4	20	22.7	10	13.2
• Coped better with stress	26	5	11	12.5	15	19.7
• Quit or cut down smoking	17	6	14	16	3	3.9
Planned to do in the next 6 months to keep healthy or improve health:						
• To increase physical activity	91	1	51	58	40	52.6
• To reduce fat intake	40	2	21	24	19	25
• To reduce alcohol use	32	3.5	22	25	10	13.2
• To cope better with stress	32	3.5	17	19.3	15	19.7
• To lose weight	31	5	18	20.5	13	17.1
• To quit or cut down smoking	20	6	17	19.3	3	3.9

Aside from family health history, health complaints, health-seeking behavior and lifestyle, the respondents were also asked about the activities they had for the past 12 months to enhance health and the activities they planned to do for the next 6 months to keep healthy or to improve health. Table 5 shows the data on health planning. Ranked first was exercise followed by weight loss and reduction of alcohol in take. Ranked lowest were reducing fat intake, coping better with stress, and quitting smoking. The data indicate that they do know how to promote health. However, details of the cited activities were not known in the study.

As to their plans for the next 6 months, still first in rank was increased physical activities or exercise, followed by reduction of fat and alcohol intake. What they planned indicates how they value health. Health promotion plan has to be developed according to the needs, desires and priorities of the individuals. Data reveal that males had more and better plan for health than the females activities to keep healthy and are also planning activities to enhance health.

Health promotion programs always start with assessing and diagnosing the health needs, desires, and priorities of the individuals involved and

followed by the planning the activities or interventions to achieve the goals of the individuals, the frequency and duration of the activities, and the method of evaluation.

The role of the company nurse or the health team is to guide the employees in the planning and to facilitate the implementation of the plan. The health personnel must act as a resource person(s) rather than as adviser(s) or counselor(s). It is important to emphasize the small steps to behavioral change, to review the goals and plans, and to make sure they are realistic, measurable, and acceptable to the employee.

Pender (1987), as cited in Kozier (2004), outlines several steps in the process of health promotion planning, which must be carried out jointly by the health personnel and the employee: 1) identify health care goals–the employee selects 2 to 3 top-priority goals or areas for improvement; 2) identify possible behavior changes–determine what specific behavior changes are needed to bring about the desired outcome; 3) assign priorities to behavior changes- behavior must be acceptable to the individual if it is to be adopted and integrated; 4) make a commitment to change behavior- increasingly, a formal, written behavioral contract is being used to motivate the client to follow through the selected actions; 5) identify effective reinforcements and rewards; 6) determine barriers to change; and 7) develop a schedule for implementing the behavior change. Another essential aspect of planning is identifying support resources available to the client. The resources may that of the community or the establishment or the company, such as a gym

CONCLUSIONS

In the light of the above findings, the following conclusions are drawn:

Local workers migrate to the highly urbanized city for lack of job opportunities in the province, for their desire to go to school while working, to help financially their families, and for sheer adventure or experience.

The migrant workers have varied health problems as evidenced by their health complaints such as headache, fever, and loss of sleep, bleeding gums, persistent cough, itching and rashes, and painful urination. These symptoms are the body's responses to life and work stresses.

Thrust into the world of work and away from the security of their families and have to face life and work alone, the migrant workers are vulnerable to

symptoms of mental health problems. Sleep problems, crying, and panic are indicators of inability to manage stress to the extent that, out of desperation, they tend to hurt on themselves and attempt suicide.

Health-seeking behaviors are mostly on self-care when they get sick and rarely on visiting a doctor since they cannot pay health services. At most, they only avail of blood pressure check-up and vaccinations.

The migrant workers generally live a healthy lifestyle with a majority being non-smokers, occasional drinkers, vegetable eaters, coffee drinkers, and active physically.

The migrant workers' health plan is indicative of their health consciousness.

RECOMMENDATIONS

Based on the implications cited above, the following are recommended:

The Commission on Higher Education (CHED), Department of Labor and Employment (DOLE), and Higher Education Institutions (HEIs) should open avenues for completion of college education to college level employees. Finishing a college degree will increase their chances of finding better and stables job.

The Department of Labor and Employment and other related agencies should strictly monitor the implementation of the minimum wage law. The Department of Labor and Employment and establishment must consider policy changes that promote health among the rank-and-file local migrant workers. Health programs must be institutionalized and must consider the health needs of the workers.

For further studies, additional variables may be included such as the ethnicity of the employee/migrant workers as this may influence their attitude towards health, empowerment and work.

NOTE:

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