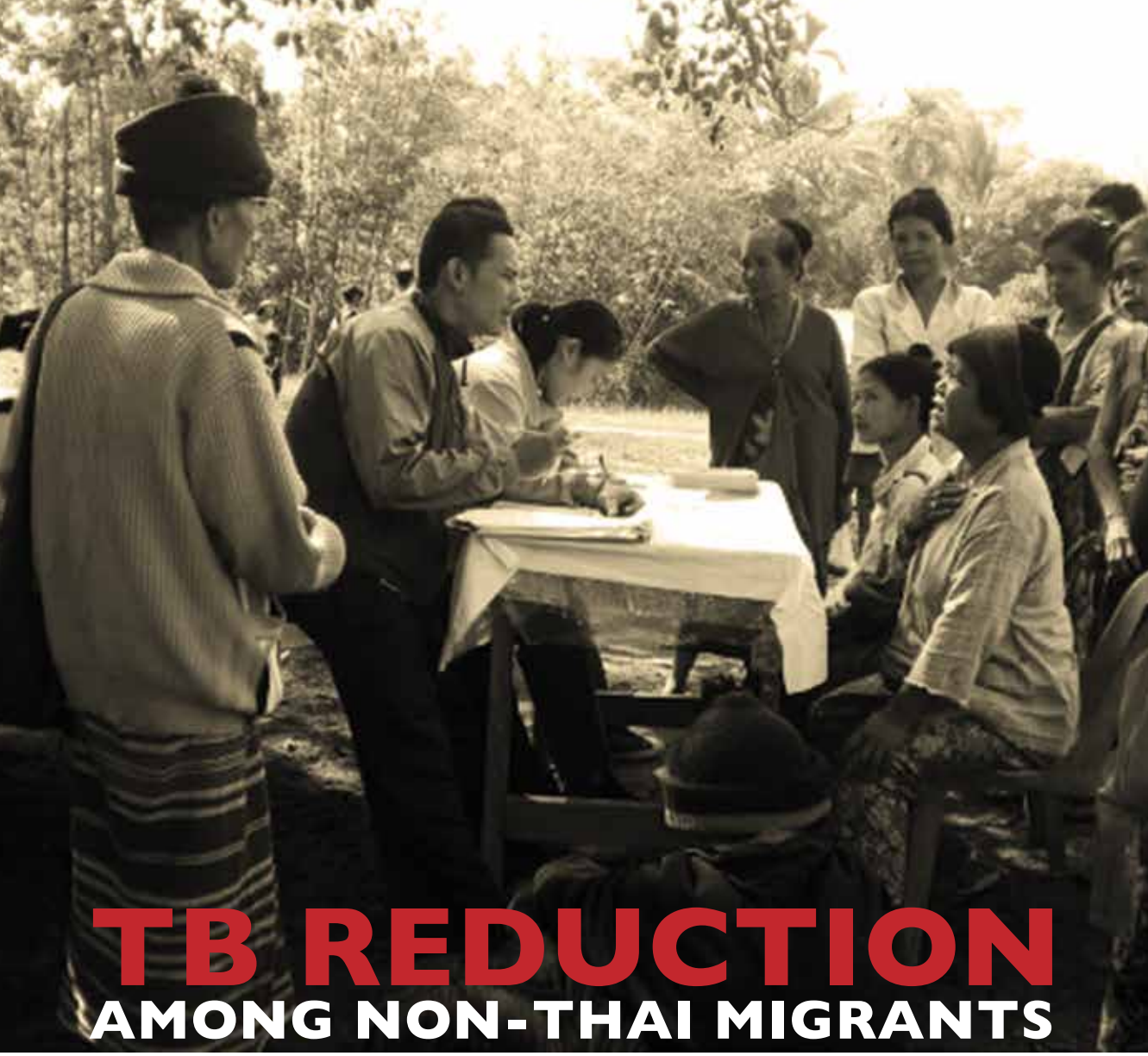

TB REDUCTION AMONG NON-THAI MIGRANTS (TB-RAM) PROJECT

YEAR 4 ANNUAL REPORT

Investing in our future
The Global Fund
To Fight AIDS, Tuberculosis and Malaria

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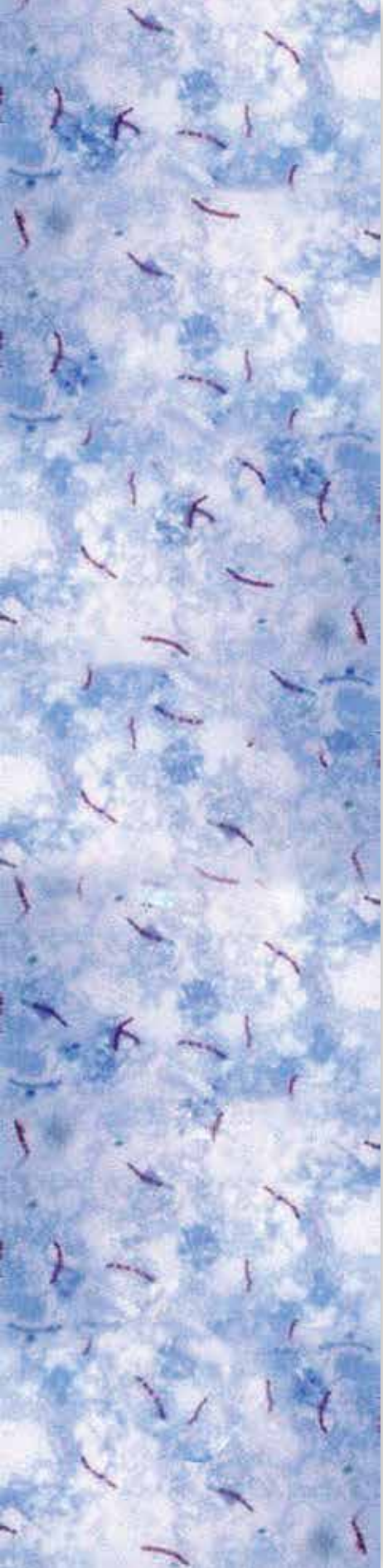

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About World Vision

World VIsion is aChristian relief, development and advocacy organization dedicated to working with children, families and communities to overcome poverty and injustice. Motivated by our Christian faith, World Vision is dedicated to working with the world's most vulnerable people. World Vision serves all people. regardless of religion, race, ethnicity or gender.

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This publication was supported by the Global Fund to fight AIDS,TB and Malaria and World Vision Foundation of Thailand

Written by Mary Grace Gayoso-Pasion

With Contributions from :
Sawapa Tangsawapak
Dr. Nay Htut Ko Ko
Dr. Nang Sarm Phong

Message from the PR Manager

Despite the Royal Thai Government's attempt at regulating migrants coming from its neighboring countries, there remains a large part of migrants workers from Myanmar not going through the official registration due various obstacles unique to them. The implication of unregistered migrants is their lack of access to basic healthcare including availability of free TB treatment. In Year 4, TB RAM has capitalized on the efforts of its previous years, including the strengthened relationships among the stakeholders both at the regional, national and local levels: the Department of Disease Control, Bureau of Tuberculosis, WHO SEAR and Thailand, Stop TB Partnership, Raksthai Foundation (Care International), IOM, TB RAM Implementing partners (American Refugee Committee International and Kwae River Christian Hospital), Provincial and District Public Health officers, provincial hospitals, local administration, local communities, and particularly with the migrant workers themselves who are our direct beneficiary. It also capitalizes on the number of mobilized, trained volunteers and CBOs on the ground, having already knowledge of TB, being familiarized with the referral system and the treatment protocol under supervision of TBRAM project staff.

I would like to take this opportunity to salute the efforts of the people on the ground, in particular the migrant field staff as well as the migrant health volunteers themselves. They have been the driving force to our successful effort in the community-based intervention for TB control. Sometimes, their efforts become mere numbers and we forget the sweat and toil they go through at the community level. There are so many other treatment-related factors that are beyond this written report including the fear of migrant workers or patients being arrested (for not having proper documentation for their stay in Thailand), the difficult negotiation with some employers whose businesses could be jeopardized if caught with hiring these illegal migrants or even the struggle of staff convincing the community against their long-held superstitious belief on TB cure.

Lastly, I would like to express gratitude towards the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria as well as our government and civil society partners for their role in the fight against TB for these vulnerable populations living along Thai/Myammar border. TB RAM should not dwell in its success in fulfilling its commitment with its donor given much work is to be done to ensure equity of health access for these vulnerable populations who are also contributing towards the thriving Thailand's economy. There's also one thing we must all remember, to fight off the prejudice/discrimination that comes with migrant workers – that they themselves do not necessarily bring about the disease but because of the working and living conditions under which they must endure, have caused them to be vulnerable to HIV/AIDS, TB and other communicable/non-communicable diseases.

Executive Summary

Year 4 has been the point of celebration for TB RAM. Aside from achieving its programmatic, Performance-Based Funding (PBF) indicators and hence being awarded with A1 by GF ATM, it was able to conduct two major evaluation activities including Operational Research and End-Term KAP as well as participating in national TB events including 2nd Stop TB Partnership Thailand and World TB Day. Out of the 10 committed targets with GF ATM, it was able to achieve 8 out of 10 indicators including TB suspect referral, treatment success, PITC, MHV training, conducting communities meetings and management meetings between PR and SRs.

In Year 4, TB RAM was able to identify 376 smear positive TB patients out of 7,150 suspects referred for sputum examination. Among these TB patients detected, it was able to support 343 patients or 91% for TB treatment. The average Treatment Success Rate this year is 81% under 100% community-based DOT mostly by the project's Migrant Health Volunteers as well as the patients' families and friends. However, the treatment failure rate remains high this year (8%) given the average failure rate among member states belonging to WHO SEAR is less than 2% (WHO SEAR, 2011). In terms of TB/HIV co-infection, out of the total 507 TB patients counseled and tested this year, 11% of which were found to be HIV positive. Local communities continued to be mobilized within the project with the establishment of 39 additional health posts, intended to serve as a community focal point for TB screening, sputum collection, TB and other health education. By the end of Year 4, a total of 2,666 MHVs were built to ensure the quality of TB cases to be referred to health facilities.

Operational Research conducted in Year 4 set out to identify key factors contributed to TB treatment outcomes of migrants as well as the challenges faced by the project through qualitative analysis of field investigation and literature review. The Treatment success rate during the 4-year period stood at 85%. There have been 15 key factors identified to favorably, unfavorably affecting the treatment outcomes, some of which include the patients' intention or motivation to be cured, doctor-patients relationship, spiritual and religious beliefs, Self-Help group support, TB treatment partners, the degree of stigma and discrimination and the patients' socio-economic status. Major recommendations to the project include the need to develop strategic behavior-change interventions, expanding self-help groups initiatives in all

project sites, to develop strategic advocacy plan to enhance migrants' access to healthcare through improved knowledge and use of existing public healthcare schemes available to registered migrant workers and to encourage Thai employers to formally register their migrant workers for healthcare entitlement.

The Knowledge, Attitude and Practice (KAP) Survey conducted in Year 4 has assessed the changes in TB knowledge, attitude and practices among the targeted migrant communities as a result of the project's ACSM (Advocacy, Communications and Social Mobilization) interventions. A multi-sampling method has been applied in 14 districts within the project's coverage sites. A total of 1,142 respondents aged 18 and above have been interviewed using a set of questionnaires to reflect similar focus in baseline KAP survey conducted in Year 1. Overall, the general TB knowledge improved significantly compared to previous KAP survey, for instance, 76% of respondents recognized coughing 2 weeks or more as key TB symptom compare to 50% back in Year 1. On the perception, majority of the respondents in the community no longer perceived TB as a incurable disease (only 8% considered TB to be incurable compare to 69% from baseline survey). On Attitudes and Practices, up to 80.7% of the respondents are willing to visit relatives/friends with TB and 70% of the respondents perceived their communities to be supportive of TB patients (within the communities) which reflect perceived high level of acceptance. On another note, TB RAM is recommended to improve TB education coverage as well as addressing TB knowledge gaps. Similar to OR recommendation, keys strategic BCC interventions to be employed systematically in order to encourage the transition from knowledge into appropriate practices.

On the financial front, consolidated expenditure in Year 4 is **$ 1,510,203** for its interventions. Human Resource made up 52% of total expenses while Living Support took up 19%. A further 5% has been spent on Monitoring and Evaluation while 8% is spent on training or capacity building of both project staff and migrant health volunteers. The total Year 4 burn rate is 87%.

As the year progresses, TB RAM shall intensify its advocacy efforts in order to ensure sustainability for the targeted migrants to have access to basic healthcare. Strengthening health system for migrant populations should therefore be considered as a good investment and not a "cost" for the country in the long run.

The TB-Reduction Among Non-Thai Migrants (TB-RAM) Project: A Quick Snapshot

WHAT IS THIS PROJECT?

The TB Reduction Among Migrant (TB-RAM) project is a 5-year project that began in October 2007. It is funded by Global Fund to fight AIDS, TB, and Malaria (GFATM), a grant-making organization based in Geneva, Switzerland created in January 2002 that aims to dramatically increase resources available to fight these three killer diseases in the world. Now on its 4th year, the TB-RAM project continues to work on its goal of reducing TB morbidity among non-Thai migrants in six provinces in Thailand.

WHAT ARE ITS INTENTIONS?

It aims to deliver the following services: (1) Increase case detection and treatment success rate among non-Thai migrants by expanding quality TB services which includes (a) providing patient support, and (b) doing community TB care; (2) Empower non-Thai communities to reduce their TB burden through public awareness; (3) Ensure coordinated TB/HIV care for non-Thai migrants by developing a service delivery system; and (4) Increase the capacity of implementing agencies among non-Thai migrants on project monitoring and evaluation, and program management and supervision.

WHO ARE THE BENEFICIARIES?

The project works closely with border communities, with particular focus on those in the Thailand-Myanmar border, their local community leaders, and others with influence to educate and encourage them to take part in anti-TB efforts. It targets non-Thai communities since they are seen as the TB vulnerable population, especially those undocumented migrant workers who do not have access to basic healthcare and free TB treatment due to the illegality of their migration status.

WHERE DOES IT OPERATE?

It covers six provinces namely Ranong, Phang Nga, Phuket, Chumporn, Kanchanaburi, and Tak, which covers a total of 14 districts. High concentration of migrants is located in these provinces sharing border with Myanmar. The project serves an estimated total of 235,000 migrants living in these areas.

Province	Districts					Migrant Population	
	WVFT		ARC		KRCH		
	Phase I	Phase II	Phase I	Phase II	Phase II	Phase I	Phase II
Ranong	Muang	Muang	Kraburi	Kraburi		21,000	29,805
Phang Nga	Muang	Kraburi	Takuatung	Takuatung		12,800	23,982
	Takuapa	Takuapa					
	Taimuang	Taimuang					
Phuket	Muang	Muang				20,000	7,472
	Kathu	Kathu					
		Thalang					
Chumporn	Muang	Muang	Thasae	Thasae		12,800	24,138
	Lang Suan	Lang Suan					
		Tako					
Kanchana-buri			Sangkla-buri	Sangkla-buri	Sangkla-buri	35,400	65,180
			Tongpa-poom	Tongpa-poom			
				Sai Yoke			
				Tamaka			
Tak	Maesot	Maesot				33,000	85,307
TOTAL POPULATION COVERAGE						**135,000**	**235,884**

Table Showing Estimated Migrant Population Covered by the Project.

WHO LEADS THE PROJECT IMPLEMENTATION?

World Vision Foundation of Thailand (WVFT), was designated as both the principal recipient (PR) and sub-recipient (SR) for this project. As a PR along with Thailand's Department of Disease Control – Ministry of Public Health, WVFT is responsible for disbursing the project funds and monitoring the project implementation. As an SR, it will be doing the actual implementation of the project in the field. Collaborating with WVFT as SR is the American Refugee Committee (ARC) and the Kwai River Christian Hospital (KRCH).

Get to Know the Implementers!

World Vision Foundation of Thailand (WVFT): A Christian humanitarian organization that has a long history of working with migrant communities in the borders of Cambodia, Laos, and Myanmar, allowing it to foster the relationship and expertise needed to handle the sensitivities arising from working with migrant communities.

American Refugee Committee (ARC): A non-profit, non-sectarian, international humanitarian organization providing opportunities and expertise to refugees, displaced people, and communities. It has been providing assistance to refugees and migrants in Thailand since 1979.

Kwai River Christian Hospital (KRCH): A private hospital under the administration of the Church of Christ in Thailand (CCT). For over 50 years, it has been serving the community living in the district of Sankhlaburi, an area where almost 50% of its population are non-Thai migrants. The hospital is composed of staff who can speak Karen, Mon, Burmese, and Thai attracting many non-Thai speaking migrants to access their health services, and it is strategically located 15km from the Three Pagodas Pass, a major border crossing serving as an important entry point for refugees coming from Myanmar.

WHAT IS ITS STRATEGY?

Advocacy, Communication, and Social Mobilization (ACSM) is the main strategy in this TB prevention and control project among migrants. The TB-RAM project collaborates with government organizations (GOs), non-government organizations (NGOs), public health staff, hospitals, village leaders, and business owners in providing a healthy and enabling environment for migrants with TB – this means having migrant-friendly services and migrant health-care financing for all migrant workers irrespective of their legal status. It mobilizes communities by recruiting and building the capacity of migrant workers as community health volunteers, who are called Migrant Health Volunteers (MHVs), in educating the community on TB and available TB care and services, in referring TB suspects to health facilities, and in acting as DOTS treatment partners to TB patients. It provides health information and counseling to TB patients through established health posts, and also provides them financial support for TB diagnosis and treatment, nutrition, and transportation in visiting health facilities. The project also develops behavior change communication (BCC) materials, mostly in written in Myanmar, to complement the community education sessions. Lastly, it also builds the technical capacity of its staff, MHVs, and public health staff in effectively managing TB care.

What's the Score for Year 4? The TB RAM Project Scorecard at a Glance

By the end of the TB-RAM Project's 4th year implementation, the Global Fund to Fight AIDS, TB, and Malaria (GFATM) awarded the project with a grade of A1– the highest grade that can be given to a grant project. Getting an A1 grade means the project has "exceeded expectations".

Achieving this grade is not easy. Behind the numbers written in the reports are stories of hard work, struggles, and challenges. This is in addition to undergoing the donor's comprehensive assessment of the project's performance in terms of the following criteria: (1) achievement of long-term outcomes and impact results related to the Millennium Development Goals (MDGs); (2) degree in which the program provides good value for money and delivers aid in an economic, efficient, and effective manner to populations in need; (3) achieving results against set targets; and (4) over-all management of grant, which includes monitoring and evaluation, procurement of health commodities, financial management, and program management (Global Fund to Fight AIDS, Tuberculosis, and Malaria, 2012). If a project achieves a high mark on each of these criteria, then it will be categorized under "exceeded expectations"

So how did the TB-RAM Project scored on program and finance management for Year 4?

PROGRAMMATIC SCORE CARD

The following table highlights the project's achievements in relation to its key objectives for Year 4 and in comparison to the project's achievements in the previous years.

TB-RAM Project Indicators	YEAR 1		YEAR 2		YEAR 3		YEAR 4	
	Targets	Achievement	Targets	Achievement	Targets	Achievement	Targets	Achievement
No. TB Suspects refered	1,170	1,172	5,016	3,880	6,600	6,996	7,100	7,150*
No. new sm+ cases detected	59	106	250	343	400	347	430	376
No. of new sm+ cases enrolled	38	106	208	298	360	316	385	343
No. of enrolled TB patients among migrants recieving PITC and results of HIV test**	N/A	N/A	N/A	N/A	450	497	500	507
Treatments success rate	58%	86%	80%	84%	80%	89%	80%	81%***
No. of health posts developed	39	81	73	61	95	74	22	39
Training of MHVs	2,550	2,487	1,480	2,800	1,950	3,760	2,310	2,666

**This figure refers to non-cumulative number of TB suspects*
***All TB cases, and not only new smear positive TB cases, receives PITC and the results of their HIV test.*
****This figure is recorded and reported in Year 4 but take note that this is the treatment success rate of TB patients enrolled for treatment in the previous year*

With a total of 7,150 TB suspects referred for sputum smear examination[1], the project achieved more than 100% of its target for referrals. Out of these TB suspects, 376 were notified to be new smear positive[2] TB patients. Although the notification rate[3] is 13% shy from the target of 430, the number of TB patients diagnosed to be new smear positive has been increasing through the years if compared to the previous years.

The increase in referrals could be attributed to the inclusion of co-workers and neighbors, in addition to family members, as household contacts of TB suspects that should also be referred. Also, various active TB case finding activities were done such as joint community TB campaigns with the community hospitals, outreach activities with government staff in hard to reach areas to do TB screening, and having mobile clinics to screen migrant workers for TB near the Three Pagodas Pass – a major border crossing serving an important entry point for migrants coming from Myanmar.

1 **Sputum** is a matter coughed up and usually ejected from the mouth, including saliva, foreign material, and substances such as mucus or phlegm, from the respiratory tract (2009 The American Heritage Dictionary of the English Language 4th Ed.). **Sputum smear examination** is a process wherein a sample from a TB patient's sputum is spread on glass slide and stained for cytologic examination and diagnosis under a microscope.
2 **New Smear positive patient** refers to the one who has never taken anti TB treatment or who has taken TB drugs for less than a month and with confirmed findings of bacilli in the sputum when examined under the microscope
3 **Notification rate** refers to the number of TB cases reported to the National TB Program per 100,000 population

The project was also able to enroll more TB patients for TB treatment from the new smear TB positive cases notified (343 out of 376 or an enrollment rate of 90%) than the target it has set for year 4 (385 out of 430). The good news is most of these enrolled TB patients were cured. The treatment success rate in this mobile migrant population is at 81%[4], exceeding the target by 1%. This is a remarkable performance given that the World Health Organization's (WHO) recommended success rate for the general population is at 85%. However, despite having a good treatment success rate, the project still needs to minimize the failure rate[5] which was at 8% during Year 4, way beyond the average failure rate among member states belonging to WHO's South East Asia Region which is less than 2% (World Health Organization Regional Office for South East Asia, 2011).

PROFILING THE TB PATIENT DEFAULTER

How would you know if a TB patient is a possible candidate for defaulting or not completing the TB treatment? Interestingly, the TB RAM Project's Operations Research study shows that defaulting TB patients, in a migrant context, have unique and common characteristics. What are these characteristics?

- Lives alone, without a family or any close friends who understands him or her
- Has a low pay and tough jobs
- Has insecure housing because either they cannot afford to pay the rent while sick or because the house owner forced him or her to move out upon learning that he or she has TB.

All of these characteristics can be placed under one word: the patient's socio-economic status.

So if you meet a migrant TB patient with these characteristics, think of creative ways to make sure he or she completes treatment.

4 This refers to the treatment success rate of new smear positive TB patients enrolled in the previous year.
5 Failure rate refers to number of new smear positive TB patients which remains to be TB positive even after 6 months of treatment

To sustain the TB-HIV coordination done in the previous year, mandatory HIV testing and counseling were given to all TB patients. As a result, a total of 507 TB patients were counseled and tested on HIV, 11% of which were found to be HIV positive.

Although this is an alarmingly high percentage, it means that the project was able identify the accurate number of TB patients co-infected with HIV since the project's HIV positivity rate is close to Myanmar's HIV positivity rate of 10.4% among new TB patients (Myanmar National TB Program Annual Report, 2010). Also, the collaboration among various Global Fund-funded projects – the TB project and the HIV project, such as doing cross-referrals for TB or HIV screening and facilitating joint community education activities, has contributed to efficient TB-HIV case detection. Unfortunately, it is beyond the current project's Monitoring and Evaluation (M&E) system to follow-up or document if these TB/HIV co-infected patients have full access to antiretroviral (ARV) treatment.

Health posts, which have become important places within the migrant community where TB screening, sputum collection, and TB education are conducted, continue to flourish. A total of 39 health posts were established which is 77% more than the intended target of 22. Such health posts are not merely being built but its functionality is also being regularly assessed by the project based on a checklist that was created outlining the criteria of a functioning health post.

The migrant health volunteers (MHVs), being an important key in doing the most important initial step in TB prevention and control – finding TB cases, were continuously being trained on TB case detection, TB signs and symptoms, referral process, treatment compliance, and handling side-effects of TB drugs in patients. At the end of Year 4, the skills of a total of 2,666 MHVs were built to ensure the quality of TB cases to be referred to health facilities.

Over-all, the project has delivered its promise, achieving beyond the targets it has set for Year 4.

TB RAM Project's Financial Report Card

The project funded has continued to work on the reduction of TB morbidity among non-Thai migrants in 6 provinces in Thailand with a total consolidated expenditure of **$ 1,510,203** for Year 4 of its implementation. Fifty-two percent of this represents Human Resource costs. The project has 110 staff for both PR and SRs committed in making a difference through collaboration with government organizations (GOs), non-government organizations (NGOs), public health staff, hospitals, village leaders, and business owners in providing a healthy and enabling environment for migrants with TB. Language barrier, difficult terrains reaching TB migrants and mobility of migrants have been some of the challenges that our staff faced. Adequate number of human resources (government health staff, project staff, and migrant health volunteers) must be in place and available to be able to accommodate the possible increase in demand created by the project through mobilization.

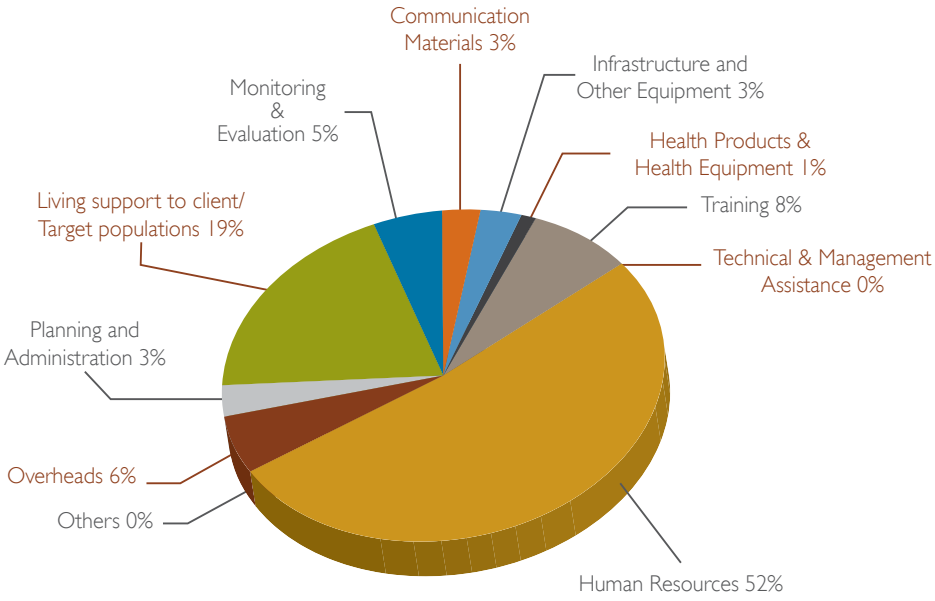

Figure shows the Financial Utilization of the project

Living support to clients and target populations has the second largest share of the total project expenditures, representing 19%. This project works with the migrants, through the community health volunteers called the Migrant Health Volunteers (MHVs), in educating the community on TB and available TB care and services, in referring TB suspects to health facilities, and in acting as DOTS treatment partners to TB patients. It provides health information and counseling to TB patients through established health posts, and also provides them financial support for TB diagnosis and treatment, nutrition, and transportation in visiting health facilities. The project serves an estimated 236,000 migrants living in six provinces namely Ranong, Phang Nga, Phuket, Chumporn, Kanchanaburi, and Tak.

There were also 2 important initiatives implemented during for Year 4 of the project: the Operations Research (OR) and the Knowledge, Attitude & Practice (KAP) Survey. Other investment of the project has been used for the capacity & skills building of both staff & MHVs, who were continuously trained on TB case detection, TB signs and symptoms, referral process, treatment compliance, and handling side-effects of TB drugs in patients. At the end of Year 4, the skills of a total of 2,666 MHVs were built to ensure the quality of TB cases to be referred to health facilities. The project has established a total of 39 health and has developed behavior change communication (BCC) materials, mostly in written in Myanmar, to complement the community education sessions.

Over-all, the project has delivered its promise, achieving beyond the targets it has set for Year 4.

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TB RAM Project: under close observation

In Year 4, the project initiated two studies to look at its progress in reducing TB among non-Thai migrants

The TB RAM Project's 4th year of implementing a TB prevention and control program for non-Thai migrants was marked with two important initiatives – conducting an Operations Research (OR) and a Knowledge, Attitude, and Practices (KAP) survey[6], which are means to assess and evaluate its progress vis-à-vis its over-all plans and targets since it began in October 2007, and to improve its future programming. Let us take a look at the following brief overview and summary of results of each study.

STUDY #1: THE OPERATIONS RESEARCH (OR)

WHY DO THIS?

This study aims to determine the key factors that contribute to TB treatment outcomes of migrants and the challenges faced by the project.

HOW WAS IT DONE?

It used both quantitative and qualitative methods of doing data collection and analysis, using both primary and secondary data. Quantitative method includes reviewing and analyzing the existing TB case notification and TB treatment outcomes data in the six project sites. On the other hand, qualitative

HOW LONG WAS IT DONE?

Nine weeks from 26 July to 30 September 2011.

6 This KAP survey conducted in Year 4 is an end-line survey. This was done to compare the results of the project's baseline KAP survey which was conducted during the start of the project.

WHAT WERE THE RESULTS?

- Treatment success rate stood at 85% which is more than the WHO recommended success rate of 80% for a migrant population.
- 15 key factors affecting the favorable or unfavorable TB treatment outcomes were identified:

1. Size of the target population: Having a low ratio of project staff and migrant volunteers to TB patients exceeds the staff's and volunteers' capacity to provide adequate TB services leading to a probable provision of different standards of TB care to TB patients.

2. Location of the patient's house: Migrant patients who cross borders have lower treatment success rate and has higher probability of defaulting and dying as compared to migrant patients staying within Thailand.

3. Patient's intention or motivation to be cured: Most patients believed that no one can help them get cured but their own self and that one is responsible for one's self.

4. Support of families and friends: Strong relationship with families and friends, and the will to survive to support and protect their families encourage patients to complete their treatment

5. The type of doctor serving the patients: Having a positive doctor-patient relationship and having a doctor who can speak Myanmar encourages patients to access TB services

6. Spiritual and religious beliefs: Praying, regular meditation, and observing religious teachings have helped patients to cope with their illness.

7. Support of the patient self-help groups: The monthly meeting of the patient's self-help support group, which involves sharing of treatment experiences, provided psychosocial support to patients and encourages them to complete treatment despite experiencing side-effects.

8. TB knowledge and perception: The patient's awareness, knowledge, and perception on TB affect his or her health seeking behavior and TB treatment compliance.

9. Presence or absence of stigma and discrimination: Most patients interviewed did not experience stigma and discrimination from families or communities but it still remains as an issue that affects TB treatment compliance of patients.

10. TB treatment partner: Most patients positively viewed treatment partners as someone helping them to take their medicines on time, making them influential to patients in completing treatment.

11. Patient's socio-economic status: Patients who live alone without family or close friends, who have low-paying and tough jobs, and who does not have a stable home would have a higher chances of discontinuing TB treatment and disappearing from the community.

12. Patient's mobility: Interestingly, most migrant patients are not as mobile as expected. On average, most have been living in their current location for a decade. However, some expressed moving out given certain conditions such as security issues and having enough money to go back in their own country and this can affect completion of TB treatment

13. Access to health services and information: Access to free TB medication and Myanmar-speaking doctors and knowledge on where to get the available TB services helped patients in continuing their treatment.

14. HIV co-infection and other underlying health problems: Having HIV co-infection and other serious health problems such as diabetes mellitus, hypertension, kidney disease, and lung cancer affects the patient's adherence to TB treatment

15. The patient's employer: A kind and supportive employer increases the chances of the migrant patients to complete treatment and be cured.

WHAT WERE THE RECOMMENDATIONS?

- Strengthen monitoring of the project's outputs to improve data use.
- Enhance the target migrants' access to healthcare services by increasing their knowledge on how to avail and use public health schemes such as the Compulsory Migrant Health Insurance Scheme (CMHIS) or the Social Security Scheme (SSS), and by advocating to implement alternative solutions to provide TB care to migrants such as the following: (1) allowing provincial health offices to provide health insurance at full cost to irregular migrants and (2) encouraging employers to purchase CMHIS on behalf of the migrants.
- The project should have a systematic recruitment and capacity building strategy for migrant health volunteers to ensure improvement of their competencies over time and continuity of their service.
- Develop strategic behavior change interventions.
- Establish patient self-help groups in all the project sites but to be provided with well-organized approaches, standard tools and materials, defined schedules, and highly-skilled facilitators. This is to ensure enhanced TB treatment literacy and psychosocial support to migrant patients.
- Create innovative means to follow-up TB cases among migrants such as adopting a community surveillance and rapid response system to easily monitor patients' movements thus, reducing the chances of patients not completing their TB treatment.
- Facility-based TB services must always be complemented by a strong community intervention and TB case follow-up.
- Create a balance between demand and supply. Creating demand for TB services must have a corresponding supply of human resources to be able provide quality TB care.

STUDY #2: THE KNOWLEDGE, ATTITUDE, AND PRACTICE (KAP) SURVEY

WHY DO THIS?

This study aims to assess the changes in TB knowledge, attitude, and practices (KAP) among the target migrant population as a result of the advocacy, communication, and social mobilization (ACSM) activities done by the project, comparing it to the KAP baseline survey results conducted at the start of the project.

HOW WAS IT DONE?

It used a cross-sectional survey using a multi-stage sampling method to select the migrant respondents in the 14 target districts within the six provincial project sites. A total of 1,142 migrants aged 18 years old and above were interviewed using a survey questionnaire, which included questions in the KAP baseline survey questionnaire to ensure data to be gathered are comparable.

HOW LONG WAS IT DONE?

Six months from October 2011 to March 2012.

WHAT WERE THE KEY RESULTS?

ON TB KNOWLEDGE

- Almost 90% of the respondents know that TB is an infectious disease.
- There was increase in knowledge about coughing for 2 or more weeks as a key TB sign and symptom (76%) as compared to only 50% of the respondents knowing about it during the baseline survey.
- Most of the respondents knew that TB is transmitted through air (82%) yet a lower percentage knew how to prevent TB (76%).
- At present, more migrants know that TB is curable (90%).
- Although Directly Observed Treatment (DOT) is the recognized strategy for TB treatment, majority of them had never heard about it (72%).
- Proportion of those who knew that anybody could get TB increased slightly from 40% to 60%.

ON PERCEPTION

- Only 8% of the respondents perceive TB as a very serious issue in their community - a big drop from the 69% of respondents perceiving TB as serious during the KAP baseline survey. It was discovered that there was an inverse correlation between perceived seriousness of TB with their knowledge on TB transmission and prevention, and available TB services - the more they know about TB, the less they perceive TB as a serious issue.
- They perceive their community as supportive to TB patients, a significant increase from 56% to 70%. Their perception of their community rejecting TB patients also decreased by 10%.

ON ATTITUDE AND PRACTICES

- Observing basic hygiene practices is still low among migrants which could still increase their susceptibility to TB.
- Although their perception on their community as being supportive to TB patients has improved, 18% of those respondents who experience TB reported facing stigma and discrimination, specifically friends and neighbors staying away from them and avoiding talking to them.
- Only 23% of the respondents reported participating in TB education activities, most of which being done in the communities. TB education in the workplace is also minimal at 8% given that most of these migrants are workers.
- During TB education activities, majority of them said they could understand more than half of the contents but not all since they are busy and could not concentrate during the session.
- Overall, those who participate in TB education activities were more likely to have accurate knowledge on TB. However, having such knowledge does not automatically translate to doing the right health behavior.
- Respondents reported that they will inform the government health staff if they experience TB symptoms – this is 30% higher than the baseline survey giving the same response. Also, proportion of the respondents from the follow-up survey would inform NGOs if they experience TB symptoms – this is four times higher than that of the baseline survey. NGO and the government health facility ranked 1st and 2nd respectively as a place where migrants would go for TB diagnosis and treatment. This shows the trust gained by government and NGO health staff among target migrants.

ON SOURCES OF TB INFORMATION

- Non-government organizations (NGOs) ranked first as the migrant's source of TB-related information which was not the case during the KAP baseline survey wherein families, friends, neighbors, and co-workers used to be the major source of TB information. Also, respondents see NGO health workers as the most effective source of TB information and regard them as the most effective way to share TB information to migrant communities. These results show the presumed stronger presence of NGOs in providing TB education.
- Mass media ranks low as source of TB information probably because it can only reach a small proportion of the target population.

WHAT WERE THE RECOMMENDATIONS?

- Fill-in the existing gaps on TB-related knowledge, attitudes and practices
- On knowledge: Equally emphasize how TB is transmitted and how TB can be prevented. Also, the curable nature of TB should be promoted along with the concept of DOT.
- On perception: Ensure to emphasize that although TB is curable and free TB services are available, TB infection is still a serious issue that needs to be addressed. The benefits of practicing preventive behaviors over accessing TB treatment should also be emphasized.
- On practices: Find creative and strategic ways on how to encourage migrants to do basic hygienic practices and to observe health lifestyle to decrease their chances of getting TB.
- Improve TB education coverage. Expand the coverage, such as having more TB education in the workplace, to be able to reach more migrants.
- Strengthen strategic interventions for behavior change communication (BCC)
  - ♦ Have shorter but targeted and focused sessions.
  - ♦ Highlight key messages that need to be emphasized during BCC sessions.
  - ♦ Session contents should always include the current TB situation, TB signs and symptoms, cause, mode of transmission, and prevention.
  - ♦ Apply entertainment-education methods to attract and maintain the participants' attention.
  - ♦ To make BCC sessions attractive and holistic, incorporate other topics that would be helpful to migrants such basic hygiene, legal and rights issues, and occupational health to name a few.
  - ♦ Use various ethnic languages, such as Kayin and Mon, when conducting BCC activities and developing materials.
  - ♦ Ensure that the venue for the BCC session is quiet, spacious, and can be accessed conveniently by migrants. Further, the time of the session should be able to accommodate the irregular working hours of migrants.
- Enhance capacity of project staff and migrant health volunteers in developing, planning, and delivering strategic interventions for BCC
- Sustain and further improve access to TB and other healthcare services to migrants
- An enabling environment has to be in place to be able to translate accurate knowledge into appropriate practices. Spreading information on available health insurance scheme for migrants should be done, with emphasis on being able to get free TB diagnosis and treatment under the scheme to encourage accessing health facilities for TB diagnosis and treatment.

Note to readers: *If you are interested to know more detailed information about these two studies, please contact Dr Nang Sarm Phong (sarmphong_nang@wvi.org) or Sawapa Tangswapak (sawapa_tangsawapak@wvi.org) of World Vision Foundation of Thailand's TB RAM Project's Global Fund Compliance Team.*

Investigating TB RAM project's better practices

Better practices are defined as practices that have been proven successful in particular circumstances. These are used to demonstrate what works and what does not and to accumulate and apply knowledge about how and why they work in different situations and contexts. After 4 years of implementing a TB project, facing unique challenges given a mobile population as its target beneficiaries, the TB RAM Project continues to achieve its targets. What practices did the project observed to be able to reach its targets? What worked well? What did not work well? What can other similar TB projects learn from reaching out to migrants?

A MENU OF OPTIONS TO ENSURE TREATMENT COMPLIANCE

TB treatment compliance has always been a challenge when working with a mobile population such as migrants who usually leave an area to seek better job opportunities, escape arrest and deportation, or return back to Myanmar. This mobility has led some migrant TB patients not to complete their TB treatment. To ensure treatment compliance, the TB RAM Project established facility-based treatment, community-based treatment, and even mobile clinics. Options for the patients include the following:

- stay at a TB house for 6 months provided by the Kwai River Christian Hospital (KRCH),
- go home within Thailand and the project will provide a DOTS partner or volunteer who can speak their language and who will visit them to ensure they drink their medicines,
- go home within Thailand and just go the clinic established by WV Thailand, which is usually located near the migrants' homes, to take their TB drugs daily, and;
- return to Myanmar and the project will be sending a mobile clinic at the end of every month to follow-up patients in the Three Pagodas Pass, a major border crossing serving as an entry point for migrants coming from Myanmar.

As such, it is no wonder that the project, though targeting a migrant population, has achieved a treatment success rate close to the WHO's recommended success rate of 85% for a general population.

DOING THINGS TOGETHER IS BETTER

Increase in referrals of migrants suspected of having TB may be attributed to the active case finding being done through joint conduct of TB campaigns and outreach activities with the government, particularly at the district level, the community hospitals and even with the business owners. In Kanchanaburi, the project conducted an outreach activity together with the district health hospital, health center, and the business owners wherein TB patient treatment follow-up, giving of nutritional support to TB patients, psychological support, and screening of household contacts were done. This has resulted to increase in referrals and case detection especially in hard to reach areas.

The coordination and collaboration among different Global Fund-funded projects for migrants in Thailand – HIV, TB, and Malaria, has also led to efficient TB case referrals and detection among the three diseases. This has contributed to good case management of TB-HIV. For Year 4, almost 10% of all enrolled TB patients was found to be HIV positive as well. This is a win-win situation for both projects and patients: the projects save time and resources for case detection while the patients get educated on and can access services on TB, HIV, and Malaria.

Having this coordinated response to TB care builds the project's credibility to the community and shows sincerity in providing holistic TB care to target migrant population.

"MY EMPLOYER HELPED ME IN COMPLETING MY TB TREATMENT"

It is true that there are stories of business owners firing their employees, who are mostly migrants, once they are diagnosed with TB. This has resulted to migrants keeping their illness to themselves for fear of losing their job.

However, not all business owners are created equal – there are those who are compassionate and ensure the welfare of their migrant employees.

In the recent 2011 Operations Research study conducted on the TB RAM Project, many patients who were interviewed affirmed that their employers are very kind and supportive. Some shared that it was their employer who took them to the hospital while others said that their employers gave them money and provide them with food. Some patients expressed that their employers even allowed them to stay and live in the worksite and has provided them with a dormitory at the back of the workplace.

Employers providing such comfortable atmosphere to migrant workers with TB can definitely positively influence the patient's treatment outcomes.

With the migrants contributing to Thailand's economic prosperity through low-skilled labor in various sectors – fishing, manufacturing, construction to agricultural industries, it is but right to provide them with protection and access to basic health services such as TB care. As one business owner in Ranong province shared, "If Myanmar laborers were to leave altogether, the businesses dependent on them would collapse in no time."

BRINGING PATIENTS TOGETHER TO SUPPORT EACH OTHER

The project has established self-help groups (SHGs), a peer support strategy which aims to provide psychosocial support and TB treatment literacy to TB patients. During the monthly SHG gathering, TB patients share their TB knowledge and their experience in undergoing TB treatment. TB patients acknowledge SHG gatherings as a good place to learn more about TB and to release their stress as a TB patient, and it creates a sense of belongingness and acceptance for them. The establishment of the SHGs motivates treatment compliance and provides emotional support to TB patients. Although it has been established under the project, the SHG concept has not been implemented in all sites. It is essential that this concept of having a monthly SHG gathering be expanded in all sites with a standardized approach, tools, and materials, and highly-skilled facilitators to make it enriching and beneficial for patients.

USING LOCALS TO REACH TO THE LOCALS

The project has been recruiting and harnessing Myanmar doctors to attend to the needs of TB migrant patients in Thailand. One of the project implementers, the Kwai River Christian Hospital has hospital staff who can speak Karen, Mon, and Burmese – the same languages spoken by the migrants, attracting many migrant patients to access their health services. Meanwhile, another project implementer, WV Thailand, operates a clinic that consist of 2-3 Myanmar doctors who can provide initial diagnosis and treatment for general health issues and unwanted side-effects of the TB-drugs. An Operational Research study on the project showed that TB migrant patients prefers seeking TB care from the project's clinics over the government hospital because they feel more comfortable talking to Myanmar doctors who speak and understand their language.

KNOWLEDGE SHARING: KEY TO PROGRAM FINE-TUNING

Regular and intentional meetings among project staff, among the principal recipient (PR) and the sub recipients (SRs), and between the project and Ministry of Health facilitate open and honest discussions on issue and problems arising from implementing the project. Not only are challenges discussed but achievements are also celebrated in these meetings. To date, weekly and monthly meetings are being done among project staff while quarterly and annual meetings are being conducted among PR, SRs, and the Ministry of Health. Having regular and intentional sharing of experiences, and exchanging of ideas and technical support assist in efficiently doing problem solving to improve project performance.

BEHAVIOR CHANGE COMMUNICATION (BCC) MATERIALS: DEVELOPED BY MIGRANTS FOR MIGRANTS

Based on the end line KAP survey done for the TB-RAM project, there was increase in knowledge on correct TB signs and symptoms, mode of TB transmission and prevention, TB treatment, and available TB services over the last 3 years. The report also showed improved attitude of respondents toward TB patients. One key factor that can be attributed to improvement in KAP is how the project developed its BCC materials together with the migrants thus, making the materials easily understood and accepted by migrants as well. The variety of communication channels used to reach the migrants such as print materials, videos, NGO health workers, community health volunteers, health education sessions, and even peers have also been instrumental in the improved KAP. Strong collaboration was also made with migrant health volunteers and the community leaders to be able to effectively reach the target population, who are usually mobile or have irregular working hours, with the correct TB knowledge and practices.

CONSTANTLY IMPROVING THE MONITORING AND EVALUATION (M&E) SYSTEM

The project faced so many challenges in doing M&E, especially since it is being done in a migrant setting. At the beginning of the project, there is very little epidemiological and social data on TB at the national and local level on migrants. Given such scenario, the project needs to collect more data compared to other regular TB projects since the migrant population is mobile. But through the years, with constant revisions being done in the M&E system based on increased experience working on TB with migrants, the quality of TB data on migrants became more comprehensive and complete. Routine data quality assessment and other data quality control activities were done to ensure good quality data. Regular M&E workshops were done to improve skills of project staff in doing quality M&E. To date, the project was able to establish an M&E system that is a reliable source for TB data on migrants.

Having migrants as a target population for a TB prevention and control program is not easy but this list of better practices can help future similar projects in avoiding pitfalls in implementing a TB project reaching out to migrants.

Check it out: patients and partners speak!

Let us take a look as patient and partners share their wisdom, experience, and lessons through quotes as they embarked on a journey with the TB RAM Project in TB prevention and control for the past years.

*"**Prevention is better than treatment** – this is the lesson that I learned from this experience."* -- Kyaw Tan Tun, TB patient

◆

*"The thing that I like the most in my work is that I love to see the patients taking their medicine regularly. This seems like a little thing but I am very **happy to see them getting better every day**."* -- Kue Htoo, TB treatment partner

◆

*"Sometimes I could not recognize the patients when they come for follow-up because they looked much healthier and happy. **I feel that I have my reward when I see their smiles**."* -- Lalida Murray, Nurse, Kwai River Christian Hospital

◆

"My most unforgettable experience as a project staff is the happiness knowing that I was able to support a better life for a disadvantaged population." – Pee Nui, Migrant Liaison Officer

◆

*"Some of the patients lived in remote areas and it was difficult for me to travel but I am still willing to go and visit them. When I saw the patient recovered, it made me very proud and happy because **I was part of helping him or her to be cured.**"* – Yeesaw, Migrant Health Volunteer

◆

*"**I saw the importance ...of doing TB identification and supporting migrant workers in our village. It also [keeps] Thai people safe from TB**."* -- Khun Yutthanakorn Chonchenkit, community leader

◆

"Aside from the food that the staff gave us every week, we heard the word of God. Someone teaches us Bible stories and we study the bible." -- San San Yee, TB patient

◆

*"Finding TB suspects or visiting TB patients in some areas is challenging. Travelling to houses of migrants and camps in remote areas is not easy because the road during rainy season is more difficult and dangerous to travel by motorcycle and then [we] to walk barefoot because of mud. **Many times, I feel frustrated, but when I think of helping people as a good thing, it encourages me to work.**"* -- Suthep Thangman, Migrant Liaison Officer.

THE LIGHTER SIDE OF LIFE: LOVE IN A TIME OF TB

Rachanee is working as a Migrant Liaison Officer (MLO) for the TB RAM Project, overseeing several migrant villages near the Mynamar-Thailand border. As an MLO, she is responsible for sending and bringing TB patients to hospitals via border check points and for coordinating with various government officials on referrals of TB migrant patients.

Although a migrant herself, settling in Thailand when she was 7 years old and taking various jobs while growing up from housemaid, factory worker, to a social worker, dealing and working with migrants remains a challenge.

"I met some hard-headed patients who are very difficult to convince and show no interests to any of our advice. I was very frustrated at first but later on, I tried to understand that they also have their own difficulties themselves by living in a hostile foreign country," shared Rachanee.

In her day-to-day work, she saw how hard life is for the migrants such as being excluded in the healthcare system.

"In spite of many challenges [at] my work…I am proud of myself and pleased for being involved in TB control, especially when I see patients complete their treatment and they have a healthy life with their family," said Rachanee.

But another challenging part of her work is dealing with the frequent changing of government staff in the hospital, the border check points, the border coordination unit, and the immigration office. This means having to rebuild relationships again to be able to start the coordination process.

Nevertheless, it is through this constant coordination at the border check point that one of the happiest moment in her life happened – she get to meet the love of her life, a Thai soldier stationed at the check point where she needs to always pass by to be able to refer patients.

"Though I met my husband at that checkpoint only a few times when I have to bring a patient to the hospital by motorcycle, some attachment grew between us little by little," she shyly said.

Rachanee is happily married to the Thai soldier and now has a 2-year-old daughter named Khao Puen.

Indeed, love can be found even in the most challenging times.

Lessons Learned

Four years have passed since the TB RAM project began its voyage through the challenging seas of reaching out to migrants, with the goal of improving their health particularly from TB infection. Despite achieving program targets as planned, challenges remain – language barrier between patient ad healthcare provider, difficult terrains in reaching migrant TB patients, mobility of migrants affecting compliance to TB treatment and retention of migrant health volunteers, rise of TB-HIV co-infection, the changing migration policy, and the remaining large number of undocumented migrants not being able to access free TB treatment. But it is through experiencing these challenges that the project gained valuable lessons that can help in improving future implementation of a TB project focusing on migrant populations.

Make behavior change communication (BCC) sessions short and simple yet focused, attractive, and holistic.

It is a known fact that a patient having TB knowledge would not automatically do the right health behavior for TB prevention and control. As such, a strategic behavior change communication plan must be in place in every TB project to ensure that negative behaviors are changed and not only knowledge or awareness is increased. It also important to contextualize the BCC sessions to the migrants' level of understanding, better if it include key, simple TB messages and done in their own language. Making the session both entertaining and educational will retain their attention and promote better understanding of TB concepts. Integrating other concepts within a BCC session, such as hygiene, healthy lifestyle, and legal and migrants' rights issues; will provide a variety of topics that can hold the interest of migrants. Having a quiet, spacious, and accessible venue, and a schedule accommodating the irregular working hours of migrants will provide an enabling environment for active participation and learning.

Creating demand for TB services requires sufficient supply of human resources.

Mobilizing migrants to seek proper TB care if experiencing TB symptoms will definitely increase the demand for TB services. Adequate number of human resources (government health staff, project staff, and migrant health volunteers) must be in place and available to be able to accommodate the possible increase in demand created through mobilization. An imbalance in the demand and supply will overstretch the capacity of the health staff and volunteers, leading to work overload and inability to cope with the increasing demands of the project implementation. Consequently, achievement of project targets would be adversely affected.

Establish self-help groups for patients in all sites and create a system for its effective operation.

Self-help groups provided psychosocial support and enhanced patients' literacy on TB treatment of TB migrant patients. It provided a sense of belonging and a venue for patients to share experiences as they undergo TB treatment enabling them to understand and cope with side-effects. However, such self-help groups are only benefitting a few patients since it is not being implemented in all project sites. There is a need to expand this peer-support strategy but with well-organized approaches, standard tools and materials, defined schedules, and highly skilled facilitators to ensure sense of belonging among migrant TB patients are maintained, consistent and correct TB information are shared and discussed, and TB treatment compliance are positively promoted.

Strengthen the capacity of both project staff and volunteers on BCC and advocacy, and not only on technical skills related to TB prevention and control.

There is no doubt that being knowledgeable on TB concepts and technically competent on TB case management is essential when working in a highly technical project such as a TB prevention and control. However, equally essential is learning the skills in doing effective advocacy and in developing and implementing a strategic BCC plan, especially if a project is tasked to be a key player to do advocacy, communication, and social mobilization on TB prevention and control. It is easy to underestimate the importance of BCC and advocacy with the project rigorously emphasizing on achieving project targets, compliance, and doing monitoring and evaluation, but advocacy and BCC are keys to sustaining the initiatives started by a project – both ensure changes in behaviors, policies, and health systems that are necessary for an enabling environment to reduce TB incidence among migrants in the long term.

Intensify advocacy efforts to save more lives.

Doing advocacy is not merely generating support for a healthy and enabling environment for migrant TB patients but also finding and initiating alternative solutions to ensure more lives are saved and suffering of patients are minimized. Advocacy issues that need to be intensified include promoting to migrants the benefits of getting and using the healthcare coverage scheme for migrants, encouraging employers to buy Compulsory Migrant Health Insurance Scheme or National Universal Health Coverage Scheme card for their migrant workers, and encouraging provincial health offices to provide health insurance at full cost even to irregular migrants. Further, it is also essential to intensify efforts in establishing a strong referral network among TB service providers, both the government and non-government organization, to ensure a collective response in supporting migrant TB patients. There is also a need to mobilize existing community-based organizations within the communities to extend their role in taking care of their own health (including TB) and their community members.

The project may have been implementing for the past four years but it is still continuously learning. Some of the lessons may have been learned the hard way but these have helped in enriching the body of knowledge of how to work with a migrant population, particularly on health.

TB PATIENT TURNED TB ADVOCATE

Maung Chit is called by the village as a ***sayar*** – a senior, respectful person, a mentor or a teacher in the Myanmar language, as he works as a project community staff educating villagers on TB and helping TB patients.

"Some of them even say that I definitely sure to go to heaven because of the good deeds I am doing," Maung Chit cheerfully explained.

But starting a living in Thailand was never easy for Maung Chit. He first arrived in Thailand to look for his father who left the family to migrate to Thailand but he eventually became a victim of human trafficking in Thongphaphum and Boh Ploy districts. He was able to escape to Saen Tor district but luck was not on his side – he was arrested by the police because of his illegal status. He was saved by a Myanmar lady but it took him half a year working in a factory to pay his debts to his savior.

With his wife, they moved to a factory in Bangkok for better opportunities. It was during this time that his wife started coughing. To cure the coughing, his wife drank some herbal medicines and antibiotics. It was soon discovered that his wife had TB. They had to move back to Saen Tor after facing difficulties to make ends meet in Bangkok.

Not long after, Maung Chit was also diagnosed with TB. Luckily, even as a migrant, he and his wife were covered with a health insurance scheme making their TB treatment in Thailand free.

"I have to take 11-12 tablets for the first 2 months and it was really difficult to swallow but I have no choice. I want myself to recover and to be healthy for my family," shared Maung Chit.

After going through such experience, Maung Chit now helps his fellow Myanmar migrants about TB as a disease and the importance of getting cured from TB.

"They are luckier now because their treatment cost is being paid and they are provided with nutrition packages which I did not receive during my time," he said, "I am pleased that I can help my fellow Myanmar."

Maung Chit, being a former TB patient himself, is very satisfied of being able to help TB patients. However, he still had one wish.

"The project could have been implemented earlier because more migrants could have been assisted since most of them do not possess a registration card or even a health insurance," he confessed.

Probably, his next advocacy is on increasing awareness on getting and using the health insurance for migrants. Keep up the fight against TB Maung Chit!

Sustaining healthcare initiatives for migrants: an investment and not an expense

Migrant workers' contribution to Thailand's economy cannot be underestimated. According to the 2011 Thailand Migration Report by the International Organization for Migration (IOM), the availability of migrants in labor-intensive industries has contributed to the country's gross domestic product (GDP) growth and profits, helped employers and producers to keep prices of their goods low due to cheap labor, and supplied the needed labor to fill low-skilled jobs unwanted by Thais. Even the Royal Thailand Government (RTG) has acknowledged the need for migrant workers to be able to maintain its labor-intensive, export-oriented economy. Inevitably, migrants would be a permanent feature of Thai society for a long time (International Organization for Migration [IOM], 2011).

For these labor-intensive industries such as fishing, manufacturing, construction, and agriculture to thrive and maintain its economic prosperity, a healthy workforce must be in place. The RTG had initiated mechanisms to ensure migrant workers being hired are healthy and free from disease. With Myanmar having the highest number of registered migrant workers based on the 2010 data of Thailand's Ministry of Labor, the RTG began implementing the bilateral agreement on migration management with Myanmar requiring compulsory medical check-up and obtaining official visa and work permit for Myanmar migrants (Jitthai, 2012). With this compulsory medical check-up, migrant workers entering Thailand are healthy but it has been reported that the problem arises when they start working and living in the country – their poor working conditions provided by the employers make them more susceptible to infectious and parasitic diseases (IOM, 2011), such as TB, malaria, and dengue just to name a few. As such, access to healthcare must be provided to these migrant workers if labor productivity is to be maintained within these industries. But do the migrants have access to the needed and deserved healthcare?

According to a recently conducted Operations Research (OR) on World Vision Foundation of Thailand's TB-RAM project, the RTG, being a WHO member state that endorsed the World Health Resolution on the Health of Migrants in 2008, has developed and implemented strategies to improve non-Thai migrants' access to health services. One such strategy is allowing regular labor migrants to join the Compulsory Migrant Health Insurance Scheme (CMHIS) wherein upon payment of THB 1,300 annual fee, they would be able seek health care services either in a Thai government clinic or hospital for little or no cost (Jitthai, 2012). However, most migrants are irregular or undocumented making them ineligible for health insurance coverage. They can still access the public health services but they need to pay for each service they want to avail. But with these low-skilled migrants only receiving minimum wage, most of them do not have the financial resource to purchase either a health care coverage or pay for every service in a health facility.

Interestingly, various reports have noted that among registered migrants under CMHIS, there is still low usage of the CMHIS benefits (Jitthai, 2012; IOM/World Health Organization [WHO], 2009). According to Pearson, "during 2004-2006 more than half of the regular migrants did not collect their health cards which would have entitled them access to the health system" (as cited in IOM, 2011, p. 86). Reasons for non-use of the CMHIS benefits by registered migrants include no understanding of the benefits of the cards, no knowledge on how to use the cards, and no knowledge on how to proceed in accessing hospital services (Jitthai, 2011). Worse, there are some employers who keep their cards to prevent them from running away and changing jobs (Limanonda & Peungposop, 2009). It seems that being a registered migrant is not a guarantee to having and maintaining a robust health, and to have access to public health services in Thailand.

The situation is bleaker for undocumented migrants. Even though they are allowed to access public healthcare facilities, most are hesitant to do it due to a variety of factors such as "language barriers, perceived and real discrimination, fear of arrest for not having proper documents, and an inability to pay the fees" (IOM, 2011, p. 86). Consequently, labor migrants, whether registered or undocumented, would prefer to self-medicate and will not seek healthcare unless their illness is already in the critical stage (Jitthai, 2012).

Given such situation, and with migrants being inherently mobile, there is a higher probability for most migrants to acquire diseases and transmit it to the community, putting both Thais and migrants at risk. Also, having a sickly migrant workforce would entail fast turnover of workers and higher cost for employers and businessmen to recruit, train, and maintain migrant workers (Burns, 2010).

With the government's 30-day migrant registration event, giving undocumented migrant workers a chance to regularize their status and eventually be entitled to healthcare, apparently being an ineffective process based on the decreasing registration figures through the years (IOM, 2011), and with the CHMIS seemingly still needing improvement, alternative solutions can be considered to ensure that migrants, who have greatly contributed to growing Thailand's economy, have access to even basic health care services. In the context of accessing TB services, Jitthai (2011) suggested possible solutions that included the following:

- Establishing a local mutual fund or trust fund, either by securing resources from the private sector or a combined contribution from the local health facilities, employers of migrants, and the migrants; to support the migrants' healthcare cost either partially or in full.
- Encourage employers to buy CMHIS on behalf of their migrant workers who cannot afford the premiums
- Allow NGOs and community-based organizations to buy CHMIS for the migrants within their project coverage area
- Allow NGO clinics to be part of the designated health service providers under the scheme since most migrants prefer going to NGO clinics due to the presence of Myanmar doctors whom they can talk to in their own language
- Create a campaign targeted to migrants actively promoting the benefits of the health care coverage scheme and how to use it
- Create service providers networks among government health facilities and NGOs that would help facilitate easier follow-up of migrant TB patients under treatment, who are constantly moving from one area to another
- Use the health prevention and promotion budget allocated from CMHIS to hire migrant health workers thus, encouraging more migrants to seek healthcare services knowing they can talk to someone speaking the same language

Such alternatives do not want to create dependency of migrants to other's assistance for their healthcare cost. Migrant workers have to be encouraged to be responsible for their own health thus, fully subsidizing their healthcare is not a viable and effective option. Integrating the migrants into the public health system is the more sustainable alternative. As Jitthai (2011) remarked, "the more migrants are brought into the public health system, the more sustainable the health development of migrants would be" (p. 40). IOM (2011) also emphasized that "providing preventive and promotive health activities plus addressing the working and living conditions of the migrants can be more cost-effective than treating migrants with advanced health conditions" (p. 91).

With the growing global economic demands, migrant workers are here to stay to fill the jobs available in labor-intensive industries that are pumping in profits for Thailand. As IOM (2011) puts it, a paradigm shift must occur – it is about time that ensuring the health needs of migrants is seen by the country as an investment rather than as an expense.

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TB-RAM Project
Principal Recipient Office

World Vision Foundation of Thailand
582/18-22 Sukhumvit 63 Klongtoey
Wattana Bangkok 10110 Thailand
Tel. +66 2 381 8863 to 5
www.worldvision.or.th
National Director: Chitra Thumborisuth