

Healthy Migrant, Healthy Thailand

HEALTHY MIGRANTS, HEALTHY THAILAND:
A Migrant Health Program Model



IOM International Organization for Migration



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List of Implementing Partners of MOPH-IOM Migrant Health Program

International Organization for Migration

Thailand Mission

Ministry of Public Health:

Central level

Cluster of Health Services Support,
Permanent Secretary Office
Bureau of Inspection and Evaluation,
Permanent Secretary Office
Bureau of Policy and Strategy,
Permanent Secretary Office
Department of Health Service Support

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Chiang Rai Provincial Health Office
Chiang Saen District Health Office
Mae Fah Luang District Health Office
Mae Sai District Health Office
Muang District Health Office
Chiang Rai Hospital
Chiang Saen Hospital
Mae Fah Luang Hospital
Mae Sai Hospital
Ban Saeo Health Center
Paya Prai Health Center
Huai Mu Health Center
Ko Chang Health Center
Lao Lew Health Center
Mae Ngoen Health Center
Mae Sai Health Center
Pang Mahan Health Center
Pa Sak Health Center
Pong Ngam Health Center
Pong Pha Health Center
Sob Roug Health Center
Sri Don Mun Health Center
Terd Thai Health Center
Wiang Health Center

Phang Nga Province

Phang Nga Provincial Health Office
Kuraburi District Health Office
Takuapa District Health Office
Takuatung District Health Office
Thai Muang District Health Office
Takuapa Hospital
Lam Kaen Health Center
Namkem Health Center
Tanoon Health Center
Takuapa Health Center
Tream Health Center

Ranong Province

Ranong Provincial Health Office
Ranong Hospital
Bangrin Health Center
Bangnon Health Center
Mittrapab Health Center
Pak Nam Health Center
Hin Chang Health Center
Had Som Pan Health Center
Muang Municipal Health Service Unit

Samutsakorn Province

Samutsakorn Provincial Health Office
Samutsakorn Hospital

Tak Province

Tak Provincial Health Office
Mae Ramad District Health Center
Mae Sot District Health Center
Tha Song Yang District Health Center
Mae Ramad Hospital

Mae Sot Hospital
Tha Song Yang Hospital
Ban Mae Ta Wo Health Center
Huai Hin Fon Health Center
Huai Ka Lhok Health Center
Huak Mite Pan Health Center
Ja Dee Kho Health Center
Mae Ku Health Center
Mae Ok Pha Ru Health Center
Mae Pa Health Center
Mae Song Health Center
Mat Tao Health Center
Nong Boa Health Center
Phra That Pha Daeng Health Center
Phu To Health Center
Tha Sai Laud Health Center
Wong Takaein Health Center

Foreword

The study of migrant health program in Thailand was conducted under the collaboration among the Ministry of Public Health (MoPH) of Thailand, World Health Organization (WHO) and International Organization for Migration (IOM) with the objective to improve efficiency of the program. The working group reviewed the principle and strategies of works including the overall efficiency and effectiveness of the program planning, framework, framework management and process management. The study revealed that achievement of management, technical support, networking and communication among IOM, MoPH, and on-site team are achievement factors to strengthen knowledge and improve capacity of migrant workers. The recommendations acquired from the study will lead to improvement of efficient services and be applicable in other areas. This will ultimately raise the level of access to health services, health improvement and well-being of migrants in Thailand.

The Ministry of Public Health realized that the design of migrant health activities should consider innovative, challenged and cost-effective activities to be a good model of migrant health program. Expanding the target areas to cover unregistered migrants and those who cannot access to health services should also be considered. Health Services should be provided actively and appropriately in line with epidemiological surveillance data in all areas. A plan should be formulated for concrete and constant development of migrant health workers and volunteers' network.

The Ministry of Public Health would like to thank the IOM, WHO, working group and all involved personnel, both in central and provincial offices, including migrant health workers and volunteers in all areas for their contribution to the achievements of migrant health program. We hope that this lesson learnt will benefit not only migrants' health in Thailand but in other countries as an experience to share among countries that have migrant workers.



Dr. Prat Boonyawongvirot
Permanent Secretary
Ministry of Public Health

Foreword

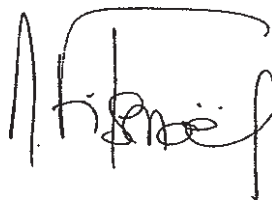
Incoming migration has been a fact of life in Thailand for some time now. The gap of socioeconomic development between Thailand and its neighboring countries, otherwise known as the push and pull factors of migration, has made Thailand an attractive destination for migrants, particularly from Myanmar, Lao PDR, and Cambodia. The challenges are vast and complex with 1.2 million labour migrants and their families, as well as an equal number of unregistered migrants thought to be residing in Thailand.

The root causes of migration into Thailand are here to stay: considering the situations in neighboring countries, it is unlikely that the push and pull factors will cease to exist in the near future. Accordingly, the Thai government has had to adapt its economic, security, and social policy with the understanding that the migration issue is a permanent one. The failure to do so would mean a nation with several million marginalized people, potentially leading to deep social problems. There is a connection between the wellbeing of migrants and the wellbeing of the general Thai population.

Health is no exception to this connectivity. Despite Thailand's strong record of public health standards, migrant populations remain vulnerable to various health risks, often lacking the economic means or social safety nets to access adequate health services. This is a concern from a public health standpoint, as sustained health problems in a concentrated demographic often translate to issues among the wider population. In other words, the broader Thai population has a large stake in the health of migrants.

The strong partnership between the International Organization for Migration (IOM), The Ministry of Public Health (MOPH) and the World Health Organisation (WHO) have been a logical response to these public health concerns. With IOM's expertise in migrant health the MOPH's far reaching and successful public health care system and WHO's role with developing a migrant health information system, the three organizations have always been in good strategic positions to address the issue of migrant health. Since its official inception in 2003 the IOM-MOPH Migrant Health Program has been utilizing the knowledge and experience of both organizations to protect the welfare of both the Thai public and migrant population with the basic understanding that one benefits the other.

As it is evident in this report, the partnership has been a great success. The MHP has been growing steadily in Thailand to more provinces and as a result, more migrants have better access to public health services. It is also clear that there is always room for improvement. There are challenges that lie ahead: from improving migrant health information systems to better cooperation amongst all relevant government agencies. Our hope is that this report will serve both as a model and lesson for migrant public health projects, and that these lessons will foster more projects to strengthen migrant health in the future.



Ms. Monique Filsnoel

Chief of Mission

International Organization for Migration

Abbreviation

AHI	Avian and Human Influenza
AIDS	Acquired Immunodeficiency Syndromes
BCC	Behavior Change Communication
BCG	Bacillus Calmette-Guerin Vaccine
CCMH	Collaborating Center for Migrant Health
DNA	Deoxyribonucleic Acid
EC	European Commission
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
IDC	Immigration Detention Center
IEC	Information, Education and Communication
IOM	International Organization for Migration
IRC	International Rescue Committee
KAP	Knowledge, Attitude and Practice
Lao PDR	Lao People's Democratic Republic
MCHW	Migrant Community Health Worker
MCHV	Migrant Community Health Volunteer
MHP	Migrant Health Program (of MOPH and IOM)
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
MSF	Medicin Sans Frontier
NGO	Non-government Organizations
PATH	Program for Appropriate Technology in Health
PTSD	Post-trauma Stress Syndrome
SRRT	Surveillance and Rapid Response Team
TTVI	Thailand Tsunami Victim Identification
UN	United Nations
UNICEF	United Nations Children's Fund
UNOCHA	United Nations Office for Coordination of Humanitarian Affairs
UNTFHS	United Nations Trust Funds for Human Security
USAID	United States Agency for International Development
USD	United States Dollar
WHO	World Health Organization
WVFT	World Vision Foundation of Thailand

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Executive Summary

This report provides an overview and analysis of the development of the Ministry of Public Health (MOPH) - International Organization for Migration (IOM) Migrant Health Program model, its strategies, progress, challenges, key results and recommendations. The purpose of the report is to document how the Migrant Health Program addressed issues and barriers impacting on the health of migrants, and to highlight the benefits of a migrant health system that is embedded within the existing national and peripheral levels of the public health system. It will also consider the significant implications this has for public health security in Thailand.

A range of structural and cultural factors operating at the individual and community level are closely linked to the limited access that approximately 2.5 million migrants residing and working in Thailand have to health facilities. These factors are major constraints to improving and enhancing the health behaviors and health conditions of both registered and unregistered migrants and their host communities. Recognizing the multi-dimensional aspect of personal and community health requires a collaborative response to ensure marginalized communities and underserved migrants have access to basic health services that meet their specific needs. Since 2003, the MOPH and IOM have been partnering closely with Provincial and District Health Offices and relevant public health facilities to develop innovative and sustainable means of basic health provision for registered and unregistered migrants and their dependents who are residing in migrant-rich communities. The MOPH-IOM Migrant Health Program is implemented among diverse population groups, physical environments and local communities requiring targeted approaches that respond to the context of each setting.

The ultimate goal of the Program is to contribute to the Healthy Thailand policies of the Royal Thai Government. The Program's overall objective is to assist and support the government to improve health knowledge, awareness, practices and access among migrants and host communities by integrating comprehensive, participatory, sustainable, and cost-effective migrant health services into the primary health care system of Thailand. The Program works to increase understanding, cooperation and advocacy about migrant health rights among stakeholders at the field level to ensure the provision of migrant-friendly services. In addition, migrant community health posts, health/information corners and outreach health services build rapport and ensure strong referral and transfer networks between the community, public health facilities and non-governmental organizations' services. Essential to this process is the incorporation of paid, full-time Migrant Community Health Workers (MCHWs) who operate as interlockers between target migrants, communities and government health systems.

IOM's experience has identified a need for planners and implementers of primary health care programs to recognize the "hidden" nature of issues among migrant populations. They face the double challenge of being illegal residents while harboring a burden of health conditions which often carry significant social stigma. Accordingly, the Program does not assume that improved awareness about health conditions, knowledge about available services, an ability to pay for the services and/or to access free services is sufficient to lead to an increased utilization of services. Evidence from the Program implementation has in fact identified that both registered migrants with insurance under the Compulsory Migrant Health Insurance Scheme and unregistered migrants who in principle are required to pay out of pocket expenses for care both have, in reality, limited access to available

health services. Therefore, the Program has continuously focused on multi-sectoral advocacy and collaboration to achieve an increased level of service utilization that is acceptable and appropriate to migrant communities through various community-driven activities in an enabling environment.

Diverse project timelines, project settings and population groups have made it difficult to standardize combined key results of the Program. However, it has encouraged greater capacity and advocated recognition of the importance of delivering culturally acceptable health services in diverse languages and increased awareness at the district and provincial levels of government; this is demonstrated by the ongoing employment of MCHWs in some sites. Although this commends the impact and potential of the Program being adopted elsewhere, there are a number of considerations that should be contemplated to ensure an adequate response to the significant gaps between health rights and migrants working and residing in Thailand.

Recommendations

Development of a Long-term Policy and Mechanism for the management of International Labour Migrants:

- Develop an appropriate, efficient and affordable migrant management policy with long-term vision for a balance of national, economic and health security for migrants and the Kingdom of Thailand in general.
- Recognize the significant contribution that migrants make to the Thai economy by developing a sound labour migration policy.
- Encourage and support all labour migrants and dependents to register with the government.

Development of an Official Migrant Health Policy, Migrant Health Service, and Migrant Health Information System:

- The development of an official migrant health framework/policy within the MOPH as a foundation mechanism to effectively respond to migrant health needs.
- Advocate and maintain a separation of issues relating to legal status and registration processes from the human and health rights of migrants to access the health service system.
- Develop and integrate a systematic migrant health service system into the standard structure of all MOPH departments at the central and peripheral levels to support front line public health personnel and to promote long-term systemic self-reliance.
- Establish a Migrant Health Unit at the central level within the MOPH to ensure more effective coordination within and outside the MOPH.
- Establish a Migrant Health Information System to bridge information gaps and inform future program development as well as to justify additional supports in order to effectively address issues.

Demonstration of the Transparency of the Program at all Levels:

- Raise the profile of the positive contributions of labour migrants to Thai society and sensitize communities and society in general to provide non-judgmental, non-discriminatory health services.
- Advocate the provision of health services to migrants by demonstrating the transparency of the Program to the public health sector and other sectors that involve national security such as the National Security Council, the Governor, Local Administration Organization, Military and Police divisions at all levels.

Scaling-up Migrant Health Services by Promoting Good Practices and effective Strategies:

- ❑ Expand the scope and scale of migrant health services to ensure increased access to essential health services to improve the health condition and health security of society as a whole.
- ❑ Capacity building and greater insight into the social determinants that influence migrant health, awareness and behavior among all public health stakeholders across communities and society.
- ❑ Official recognition and certification of MCHWs and Volunteers by the MOPH as skilled workers and integration into the existing Thai Village Health Volunteers network to ensure a collective response to community health issues.
- ❑ Innovative solutions that take into consideration the mobile characteristics and nature of migrant populations and an adjustment of health service protocols to respond to these characteristics.
- ❑ Promote and develop strategic communications with migrant communities to enable behavior change that educates and empowers migrants to take charge of their self and community health.
- ❑ Develop creative and innovative population-based approaches to expand the Program to engage hard to reach population groups including seafarers.
- ❑ Streamline/restructure financing of migrant healthcare options to enable a more balanced, equitable and efficient financing mechanisms and cost recovery including the securing of private sector resources.
- ❑ Promote low or no cost health prevention and promotion by ensuring that a skillful health workforce, primarily MCHWs and Volunteers, are maintained within the public health system to deliver basic health prevention strategies to their communities.
- ❑ Promote community participation and responsibility in self and community care to raise ownership of community health and wellbeing and to promote the concept of a good citizen who is aware of their responsibility to maintain health security of their host community.
- ❑ Utilize MCHW networks to address other social issues that impact on health such as awareness raising on preventive measures to reduce human trafficking.

Strengthening Cross-border Collaboration:

- ❑ Revitalize and review the Joint Action Plan for cross-border collaboration between Thailand and Myanmar to include joint problem solving, trouble-shooting and sharing of education materials and epidemiological data and tools where possible.
- ❑ Continue to review the Joint Action Plan between Thailand and Cambodia and Thailand and Lao PDR to ensure ongoing achievements and effective responses.
- ❑ Encourage local authorities and community organizations in source communities to raise efforts on pre-departure activities to educate about safe mobility, migration and related health risks including the consideration of involving families at source communities and a national level campaign.
- ❑ Encourage the development of health infrastructure in neighboring countries and the bridging of services gaps to improve the situation using Thailand and this MOPH-IOM Migrant Health Program as guide to meeting health needs of marginalized population groups.

I. Background

Migration into Thailand

The Kingdom of Thailand's economy represents a significant proportion of regional GDP. Thailand's per capita GDP was approximately seven times that of Cambodia, Lao People's Democratic Republic (Lao PDR) and Myanmar. [1] The Kingdom's sustained economic growth and relative social stability attracts millions of migrant workers to Thailand with the majority coming from three neighboring countries, namely: Myanmar, Cambodia and the Lao PDR. An analysis of migrant registration in 2004, carried out by the Royal Thai Government, identified there were 1.2 million labour migrants and family members living in Thailand. However, the International Organization for Migration (IOM) estimates that there are likely as many unregistered migrants in Thailand. In addition to economic migrants, Thailand has accommodated a large number of displaced persons from neighboring countries for many decades.

Ongoing political instability in Myanmar has and continues to cause mass movement of displaced populations into Thailand. At present in 2009, while there are more than 140,000 displaced persons from Myanmar living in any of the nine temporary shelters along the Thai-Myanmar border, many more displaced persons from Myanmar are estimated to be living along border areas in the vicinity of the shelters as well as in large urban city areas such as Bangkok and Samutsakorn. In addition, there are several thousand ethnic Hmong from Lao PDR residing in shelters in the upper central province of Petchaboon.

According to IOM's experience, regardless of the cause, whether there is a marked disparity in underlying environmental conditions and economic status, a prevalence of violence or socio-political instability, population movement produces a direct impact on personal and community health. [2]

The health condition of irregular migrants is often significantly below the Thai standard. This is due to the fact that many migrants receive limited or no perinatal care, essential vaccinations and frequently live in environments with poor basic hygiene and sanitation. Many are also consequently at risk of contracting communicable diseases including Filariasis, Mumps, and Meningococcal Meningitis. These communicable diseases were previously adequately controlled or eliminated among Thai populations. Furthermore, many migrants have been in Thailand for over a decade making it difficult to trace the epidemiology of infection. In light of this, given the generally lower levels of public health development in neighboring countries, it is a concern for both Thai public health authorities and the community in general that migrants may carry diseases into Thailand. However, regardless of the source, Thailand is unlikely to achieve national health security in the absence of equitable access to primary health care for marginalized populations including registered and unregistered migrants, in addition to Thais living in remote host communities.

Early identification and management of health issues among migrants reduces the long-term economic and social impact of illness. Equally important is improved access to health services that are culturally appropriate, which will ultimately lead to more efficient and effective preventative and therapeutic outcomes among migrants. [3] A common concern for policy makers is that improved health services for unregistered migrants may attract more

migrants into Thailand. However, an assessment jointly conducted by IOM and the Thai Ministry of Public health (MOPH) suggests otherwise. The flow of migrants is more likely to be influenced by overall push and pull factors. The push factor refers to political and economic factors in each migrants' country of origin, and the pull factor refers to a demand for low-skilled and low-wage labour forces in Thailand. [4]

The Thai Ministry of Public Health’s Strategies Related to Health of Migrants

To date, the Ministry of Public Health (MOPH) has developed three key strategies that aim to directly and indirectly address the health of migrants. Officially launched in 2007 by the Bureau of Policy and Strategy of the Permanent Secretary Office, the Border Health Development Master Plan 2007-2011 aims to improve the quality of life of border populations, including migrants (Annex 1). The Department of Disease Control also developed a HIV/AIDS Master Plan which is inclusive of migrants and mobile populations in 2007 (Annex 2). Finally, in collaboration with relevant government and non-government agencies, the Migrant Health Strategy was drafted in 2006-2007 by the Department of Health Service Support (Annex 3). Although not yet officially endorsed, elements of the Migrant Health Strategy are being implemented by related government and non-government agencies. Despite the fact that each of the three strategies were developed based on different approaches; namely area based, disease based, and population based, they share core values or contexts as summarized in the table below.

Table 1. The Ministry of Public Health’s Strategies in relation to the Health of Migrants

Border Health Development Master Plan, 2007-2011	Migrant Health Strategy (draft)	HIV/AIDS Master Plan, 2007-2011
<ul style="list-style-type: none"> ❑ International cooperation with neighbouring countries 	<ul style="list-style-type: none"> ❑ Migrant health service system development ❑ Universal migrant health insurance 	<ul style="list-style-type: none"> ❑ Risk and vulnerability reduction ❑ HIV prevention in large infrastructure sectors ❑ International cooperation with neighbouring countries
<p style="text-align: center;">Shared Values of the Three Strategies</p> <ul style="list-style-type: none"> ❑ Improving health service access among target populations ❑ Enhancing meaningful participation of target communities ❑ Establishing and strengthening coordination and collaboration among relevant stakeholders ❑ Developing and improving relevant health information systems ❑ Establishing and strengthening effective administrative and management systems ❑ Supporting positive policy development and implementation 		

- Sources :
1. Bureau of Policy and Strategy, Permanent Secretary Office, MOPH
 2. Department of Health Service Support, MOPH
 3. Department of Disease Control, MOPH

Note : See details of the three strategies in Annex 1-3.

Development of MOPH-IOM Migrant Health Program

In December 1999 during an IOM Council in Geneva, the Royal Thai Government formally requested IOM to assist with addressing the health needs of migrants in Thailand, particularly those from Myanmar, regardless of their legal status. It was encouraging to receive a strong and well-conceived appeal by the Ministry of Foreign Affairs and the MOPH to adopt and develop migrant inclusive policies and strategies. Such an appeal identified a commitment to protect the welfare of both the Thai public and migrant populations on the basis of sound public health principles and humanitarian considerations, despite the many competing demands and challenges faced by the government. The initial appeal for support resulted in a joint assessment by IOM and MOPH technical staff which took place at the central level and in a few provinces along Thai-Myanmar border areas between 7 November and 4 December 2000. [4]

The joint assessment involved a series of consultative meetings with central and local level MOPH staff as well as various non-government organizations (NGOs) working with migrants in Thailand. The assessment resulted in an agreement that the migrant health program should focus on migrants, in particular unregistered migrants, who are living and/or working outside the temporary shelters located along the border. This is primarily because the shelter populations have received health services from various NGO-providers for some time, while on the other hand, many migrants residing outside the shelters have limited or no access to primary health care. Major barriers for these migrant population groups include fear of arrest and deportation due to their illegal status, inability to pay for health services and related costs, and remoteness of residence. Several other factors also influence accessibility to health services including language and cultural barriers, high mobility among some migrant populations, and a lack of cooperation and support from their employers. These obstacles are further compounded by health service providers who hold negative perceptions and attitudes toward migrants. Such stigma obstructs health communication, and client-provider relationships, further fostering distrust and social tension between migrants and the Thai communities in which they live. Common health problems identified among migrants include key primary health care issues such as reproductive health, maternal and child health, infectious disease control and prevention, and personal hygiene and community sanitation. Employed migrants often also face additional health risks as a result of occupational hazards such as chemical use and accidents in the workplace.

IOM and the MOPH have been partnering closely with Provincial/District Health Offices and relevant public health facilities to develop innovative and sustainable means for providing basic health services to migrants, particularly those who are marginalized and underserved. The IOM-MOPH Migrant Health Program (MHP) was officially launched in late 2003, on receipt of the Program's first financial support from the United States Agency for International Development (USAID) for implementation in the priority Provinces of Chiang Rai and Tak. In the past few years, the MHP has evolved from a single project to multiple projects implemented in several priority provinces of Thailand. As of December 2008, the MHP has projects underway in the migrant-populated areas of Chiang Rai, Tak, Samutsakorn, Ranong, and Phang Nga provinces. Migrant health related research projects are also being conducted by IOM and MOPH at the central level as well as the provision of technical support with migrant health policy and programming to the MOPH and relevant organizations at the national level. In addition to funding received from USAID, several other donors finance different components or sub-projects of the MHP. Key MHP donors include the European Commission (EC), the Government of Japan through the United Nations Trust Fund for Human Security (UNTFHS) and the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the World Bank.

II. Program Description

The ultimate goal of the MHP is to contribute to the *Health for All* and later the *Healthy Thailand* policies of the Royal Thai Government. Although the MOPH has developed several mechanisms and schemes to ensure equity of access to various health services for all Thais, it is impossible for the country to achieve the Healthy Thailand goal when the health needs of some 2.5 million migrants in Thailand remain unmet. In order to assist the government to achieve these goals, the MHP's *overall objective* is to support the government to improve health knowledge, awareness, practices and access among migrants, registered and unregistered, as well as their Thai host communities in priority areas of Thailand through the provision of a *comprehensive, participatory, sustainable* and *cost-effective* migrant health service. The MHP's focus is grounded in the following six *strategies* :

1. Strengthening the capacity of relevant counterparts at all levels;
2. Increasing access to migrant-friendly health services;
3. Developing a sustainable MHP model that can be replicated elsewhere;
4. Strengthening collaboration among key stakeholders;
5. Facilitating the development and supporting the implementation of positive migrant health policies; and
6. Strengthening community preparedness and response to potential disaster and/or disease pandemics.

Since the MHP's inception in late 2003, the Program has been implementing a wide range of activities under each strategy. Key activities are outlined below.

Strategy 1 : Strengthening Human Capacity

Purpose : To strengthen the capacity of relevant counterparts in the planning, design and provision of primary health care services to migrants and their communities. Counterparts include government and non-government agencies as well as health and non-health sectors who play a key role in improving community health and well-being. Migrants themselves are also key stakeholders of the MHP.

Key Activities : A series of formal training was provided to the "Migrant Health Team" in each target district. The training consisted of representatives from local government health personnel, Migrant Community Health Worker (MCHWs) and Migrant Community Health Volunteers (MCHVs) from target migrant communities themselves, and local Thai host communities, particularly community leaders and Thai Village Health Volunteers. Other means for capacity building included regular team meetings, mentoring and on-the-job training for MCHWs and MCHVs by IOM and public health staff, annual participatory project review and workplan development, annual cross-fertilization workshops and field exchange visits.

Strategy 2 : Increasing Primary Health Care Access

Purpose : To improve health related knowledge, awareness and behavior as well as to improve access to health information and services among migrants and host communities through community participation and strategies that target behavior change.

Key Activities : The MHP provides both community and facility-based health services to target communities. Community outreach is conducted by public health personnel with assistance from MCHWs and MCHVs through mobile clinics, home visits, and campaigns in order to provide health information; health prevention and promotion; and health care, treatment and referral to target populations. The MHP also promotes access to migrant-friendly health services at public health facilities, i.e. Public Health Centers and District/Provincial Hospitals close to target communities. In addition, the MHP established community health posts and health corners in migrant communities and workplaces which are administered by trained MCHWs who also serve as frontline service in target populations.

Strategy 3 : Migrant Health Program Model Development

Purpose : To monitor, document and evaluate Program achievements, lessons learned and recommendations for future programming

Key Activities : In order to develop appropriate MHP models and approaches, a series of consultative meetings were conducted among representatives from the MOPH, the local MHP teams and IOM to come to an agreement on MHP implementation structure, roles and responsibilities of relevant parties and management flow. In addition, team members also organized, co-organized and participated in various events to share experiences and learn from other team members as well as other agencies working on similar issues. Different MHP models/approaches in different settings were monitored and evaluated internally and externally to review for ongoing appropriateness and necessary modifications. This document is a key output of this strategy which attempts to describe good practices, to identify potential for replicating and or expanding the model/approaches elsewhere, as well as to identify the challenges and recommendations for future migrant health programming.

Strategy 4 : Strengthening Multi-stakeholder Collaboration and Reduction of Stigma and Discrimination

Purpose : To reduce stigma and discrimination and encourage a harmonious co-existence between migrants and their host communities through multi-stakeholder collaboration, community participation, and information, education and communication (IEC) strategies. It is anticipated that increased harmony in any multi-cultural society will assist with paving the way for a more holistic approach to community health programming, and therefore, less exclusion of any sub-populations.

Key Activities : Several stakeholder meetings and training sessions were conducted at the district, provincial and national levels to enhance mutual understanding about international migration and health, basic human rights and migrant rights, and health security as a component of national and human security. To encourage involvement and ownership of the MHP, several stakeholders were also invited to participate in MHP activity planning and implementation.

Strategy 5 : Support and Implementation of Migrant Health Policy

Purpose : To support existing public health policy, further development of the policy, and implementation of the policy in order to attain equitable access to primary health care services among migrants and host communities. This in turn will contribute to the government's Healthy Thailand governance agenda.

Key Activities : Both top-down and bottom-up approaches were used to support this strategy. Several meetings/workshops/conferences were held, in addition to monitoring field visits by MOPH and IOM representatives. Policy updates were presented to local teams as required. Guidance and assistance were provided to local teams in order to appropriately and effectively translate and implement existing policies. These forums also provided an opportunity for field implementers to share information and concerns as well as advocate for policy change.

Strategy 6 : Community Preparedness and Response to Disaster/Pandemic

Purpose : To ensure migrants and host communities are prepared, protected and assisted before, during and after a disaster, whether natural or human-made, as well as during a disease outbreak and pandemic.

Key Activities : The MHP facilitates and promotes community disaster and disease pandemic preparedness planning that includes both registered and unregistered mobile and migrant populations. In the aftermath of a disaster, the MHP provides basic essentials during a humanitarian emergency, in addition to health information and services including mental health and psychosocial support to affected migrants, their families and communities. The MHP also provides assistance to the government on other related issues as required.¹

¹For example, the MHP in Pang Nga conducted community mapping and assisted the Royal Thai Police to collect identification information and DNA samples to help identify migrant Tsunami victims.

Program Site

Based on initial findings of the joint assessment by IOM and the MOPH in 2000, it was agreed that the MHP should prioritize geographic areas with the greatest needs. Accordingly, the following key characteristics were agreed as the primary criteria for Program site selection.

- 1) Presence of high concentration of migrant populations, particularly unregistered migrants including their dependents.
- 2) Presence of additional stress on health conditions among migrants and host communities.
- 3) Limited access and accessibility to public health services among migrants and host communities.
- 4) Political commitment by the Governor and strong collaboration from the local health authority and care providers to implement the Program in addition to maintaining regular, positive and constructive dialogue with private sectors in selected provinces to ensure their contribution and collaboration.
- 5) Willingness of local health and other authorities to contribute staff time, some level of financial commitment or some form of health expenditure to the Program, especially for public utility services that directly benefit the community at large (and therefore are politically justifiable) for example child immunization, highly infectious disease diagnosis and treatment.
- 6) Acceptance by provincial authorities of the pilot nature of the Program, particularly in relation to the sharing of data and information on international migration and health issues.

The above stated criteria assisted with identifying priority provinces for program implementation in addition to the eight provinces already prioritized by MOPH. It was agreed that program implementation should be limited to one or two provinces for the first three years of the Program, in order to learn from implementation challenges and subsequently identify how best to replicate and expand the Program in a manner that reinforces its political, technical and financial benefits. From the perspective of a pilot approach, the selected province(s) would represent others facing similar challenges with migration.

According to site selection criteria, the Program was officially launched at the end of 2003 in selected priority districts of Tak and Chiang Rai Provinces with financial support from USAID as mentioned above. Although Tak Province has five border districts adjacent to Myanmar, the Program was only piloted in the three districts of Mae Sot, Mae Ramad and Tha Song Yang where large clusters of migrants from Myanmar live and work. Most of these migrants are unregistered and work in both rural agricultural and urban manufacturing sectors. Chiang Rai is a large province that consists of 16 districts. The Program was first launched in three districts including Mae Sai and Chiang Saen which are adjacent to Myanmar and Lao PDR and Muang which is the provincial capital. Similar to Tak Province, migrants residing in urban areas in Chiang Rai mostly work in the manufacturing sector whereas rural residing migrants work in the agricultural sector.

Experiences and lessons learned from implementation in the first two provinces were later on used as a basis to modify program approaches to suit other settings with diverse characteristics. In 2004, with funding support from

the EC, the MHP in Chiang Rai was expanded to include Mae Fah Luang District. Mae Fah Luang District boasts a large number of indigenous populations from more than 10 highland ethnicities who work in the agricultural sector. In addition, in 2005 the Government of Japan, through the United Nations Trust Fund for Human Security and WHO, provided funding support to further modify and pilot test the Program in Ranong and Samutsakorn Provinces.

Ranong is the southern most province of Thailand that is adjacent to the Myanmar border. The vast majority of migrants are from Myanmar and are concentrated in the outskirts of the capital District of Muang. Many Myanmar migrants have been in Ranong for over a decade and mostly work in fishing and fishing related business such as sorting and seafood processing. Some also work in agricultural and livestock businesses such as chicken farms.

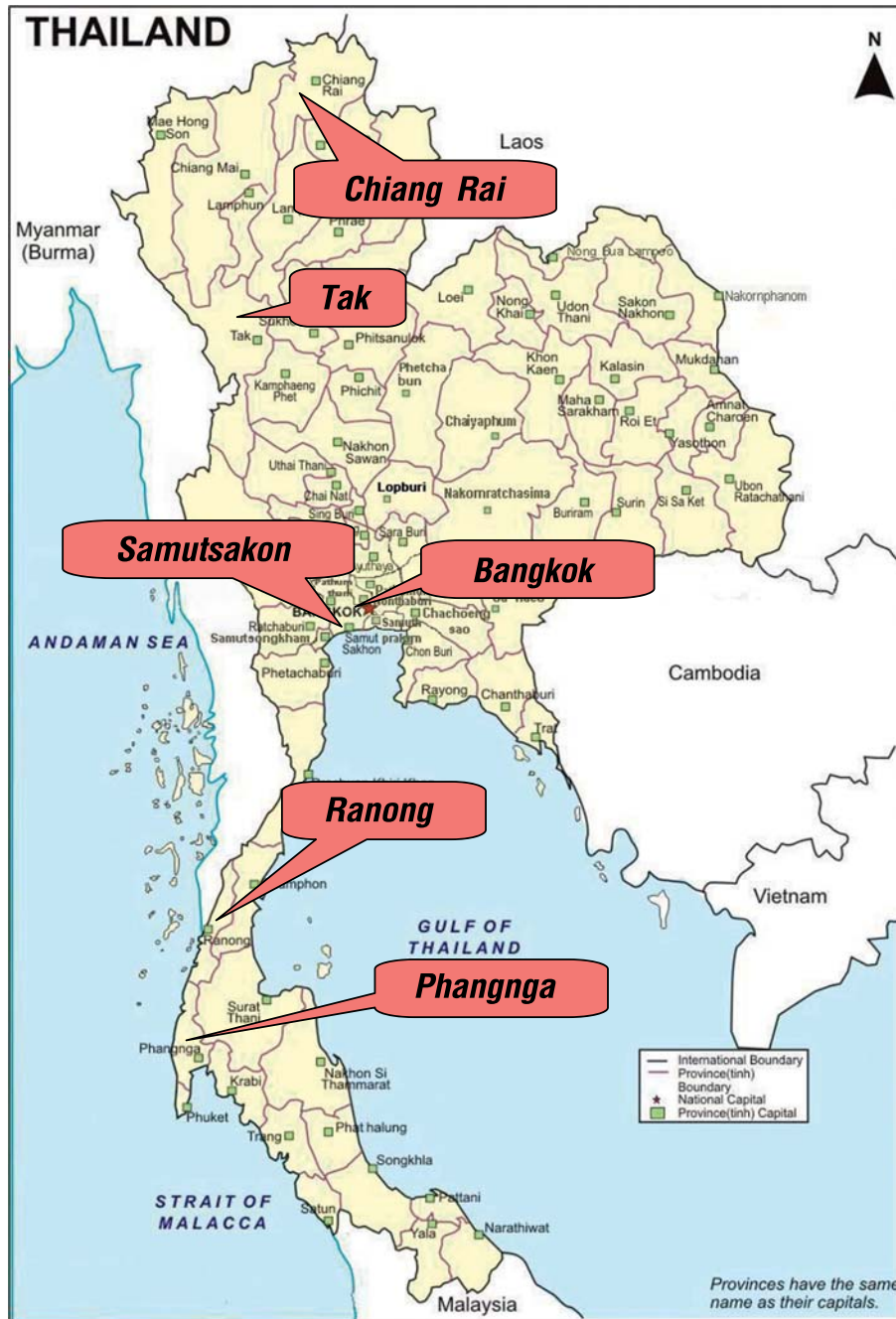
Although geographically Samutsakorn is a very small province with only three districts, it is recognized the Province is well-known as the largest seafood producer in Thailand. The vast majority of migrants in Samutsakorn Province reside in municipality areas and work in fishing and fishing related businesses. Located just 50 kilometers from Bangkok, Samutsakorn is classified as an urbanized area with a very high density population.

To reduce impacts of the 2004 Tsunami that affected provinces on the Andaman Sea, in 2005 the MHP set up local teams and sub-offices to provide humanitarian, mental health, psychosocial and other assistance to local authorities and migrants in Ranong and Pang Nga Provinces. Funded by the Irish Government, the World Bank and WHO, the infrastructure of the Tsunami relief project later on served as a fundamental MHP modality in Ranong and Pang Nga, in a similar manner to the Program in Tak and Chiang Rai Provinces.

To date the Program is mostly focused on areas along the Thai-Myanmar border, with technical and managerial support from IOM and MOPH in Bangkok. In particular, these include selected communities/villages in the following geographic areas:

- ❑ Chiang Rai Province; four districts of Muang, Mae Sai, Chiang Saen and Mae Fah Luang
- ❑ Tak Province; three districts of Mae Sot, Mae Ramad and Tha Song Yang
- ❑ Ranong Province; Muang District
- ❑ Samutsakorn Province; Muang Municipality
- ❑ Pang Nga Province; four districts of Kuraburi, Takua Thung, Takua Pa and Thaay Muang

Figure 1. Location of Migrant Health Program implementation sites



Target Populations

The MHP benefits various population groups in Thailand and beyond however the primary beneficiary group of the MHP is the migrant populations from Myanmar. The mix of population groups include displaced persons residing outside of the temporary shelters along the Thai-Myanmar border, indigenous persons who were born or have long been in Thailand but have not yet obtained Thai citizenship, and economic migrants. Since most MHP implementation sites are spread throughout the provinces of Thailand which border Myanmar by land and sea, the sub-populations of the target beneficiaries vary widely. While a majority of the target populations in Chiang Rai are from the Shan and Lahu ethnic groups, most of the target populations in Tak are Karen or Mon. The urbanized

setting of Samutsakorn attracts migrants from all over Myanmar but the vast majority are Burmese. Many migrants in Ranong and Pang Nga are from Tavoy in Myanmar, which neighbors the border of Ranong.

Tak and Chiang Rai are the very first pilot projects implemented in Thailand that provided a broad range of primary health care services to migrants. Being a pilot project, it was agreed by all stakeholders that the Project should ensure a manageable caseload. The estimated target population during the pilot phase was no more than 30,000 individuals, specifically those living in geographic areas limited to one or two districts in each of the selected provinces. However, the Program had the capacity to extend its coverage to approximately 60,000 individuals who lived and/or worked in seven districts of the first two piloted provinces as listed above.

The secondary beneficiary group is a large number of Thais living and/or working in the same catchment areas of Program sites. These Thai populations are often as marginalized as migrants, particularly those in the remote and hard-to-reach locations. Furthermore, although the Program does not intend to conduct cross-border activities, some populations residing along border areas in Myanmar also benefit from the MHP, especially those living close enough to cross the border to receive services in Thailand. This demonstrates the non-discriminative approach of the Program which strives to provide services to those who really need them for the benefit of the whole of society.

Another beneficiary group is the government and non-government counterparts who are either directly or indirectly involved with migrant health issues. They benefit from the MHP through various forums including formal training and/or workshops provided and/or organized by IOM alone and/or through collaboration between the United Nations, government and non-government partners.

III. Program Model

The Program's implementation structure was developed through a joint collaboration between IOM and the MOPH. The structure was first developed for the Migrant Health Project in Tak and Chiang Rai Provinces in 2003. A modified version was applied to respond to the particular characteristics and settings of migrants and communities in Samutsakorn and Ranong Provinces in 2005, and then in Pang Nga in 2006.

Since the majority (approximately 80% on average) of migrants in Thailand are from Myanmar, many reside in communities along the Thai-Myanmar border and, thus as mentioned earlier, the Program to date mostly focuses on Thai-Myanmar border areas. However, as many more migrants are moving towards the inner provinces in search of better job opportunities, it is important that both border health and migrant health strategies are incorporated into the Program. The joint assessment and Program development process confirmed that the well established Thai primary health care system should be employed and extended to meet the particular health needs of migrants. By integrating migrant health services into the primary health care system of Thailand, the MHP's overall objective to assist the government to improve migrant health and well-being can be realized.

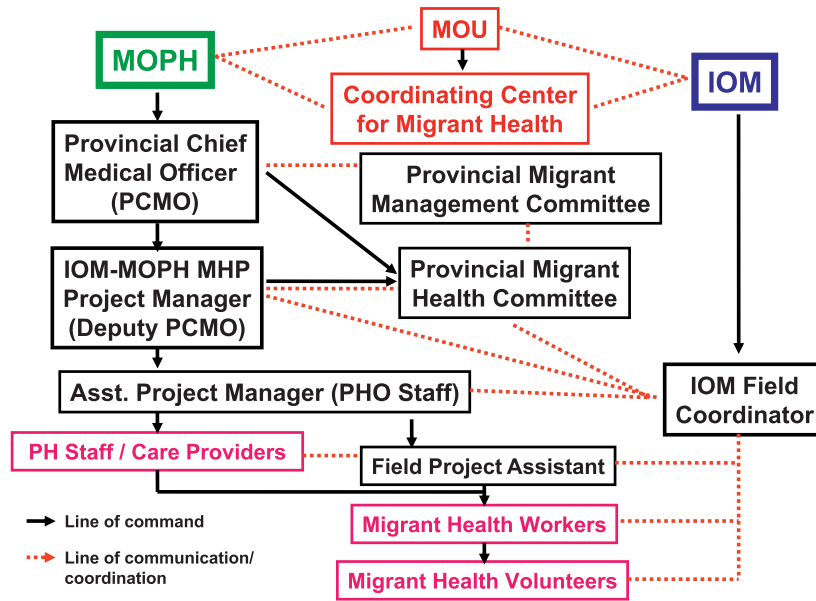
Program Structure and Operational Management

IOM's experience with delivering health services to migrants has confirmed how crucial it is to avoid establishing separate health service systems which are exclusively dedicated to migrants outside of the existing public health system. Facilities and services that are accessible to both host communities and migrants have the potential to prevent double standards in quality and to reduce stigma, discrimination and conflict among different populations. All information, case management, capacity building opportunity and human resources need to be consistent with Thailand's MOPH standards as far as possible, while the needs of the target population must also be maintained to ensure appropriate services. Therefore, the MHP is embedded within the MOPH structure and operates inside MOPH affiliated health facilities. It is important to note that the sharing of the MOPH's health facilities and their staff should not interfere with the regular programs they implement and should not create unnecessary additional workloads. The bottom line is to ensure that diverse population groups have equal access to quality basic health services while ensuring there is no parallel system introduced.

A Memorandum of Understanding (MOU) was developed at the beginning of the Program between IOM and the MOPH to define the specific roles, responsibilities and timelines of each party. The key roles and responsibilities of IOM are resource mobilization, technical and financial management and assistance, and monitoring and evaluation of the Program. In addition to a substantial contribution toward the planning and implementation of the Program at the field level, the MOPH at central level play a key role in policy support, technical assistance, monitoring and evaluation along existing MOPH internal monitoring and evaluation lines, and coordination among relevant departments within the Ministry as well as with the local health offices and other line ministries.

The key components of the Program model are embedded at all levels into the existing primary health care structure of the MOPH health infrastructure as illustrated in Figure 2.

Figure 2. MOPH-IOM Migrant Health Program Structure



The MHP implementation in all target sites follows the same structure which consists of three key elements: coordination bodies, human resources and management flow.

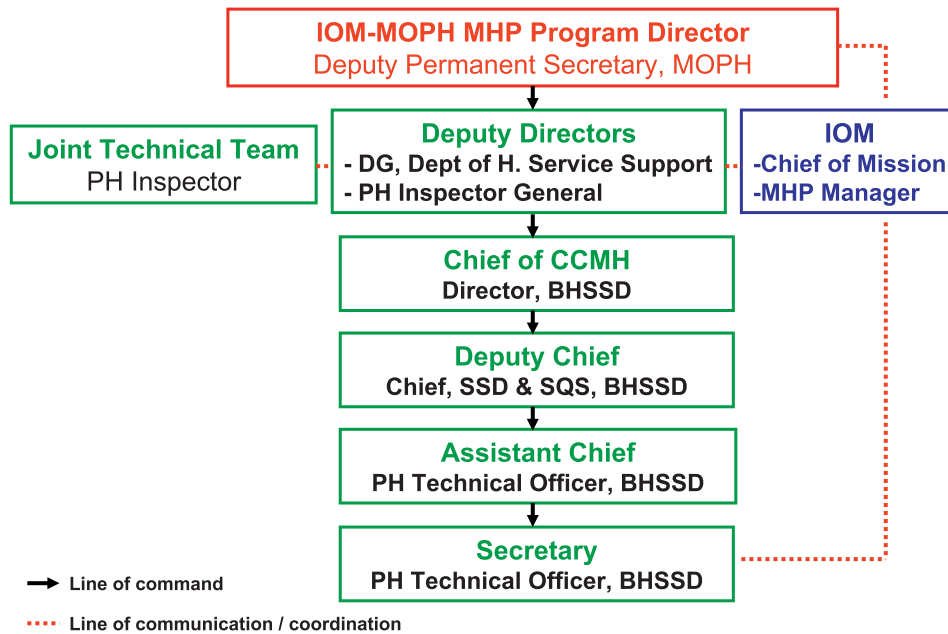
1. Coordination Bodies

The establishment of the MHP’s coordination bodies at all levels helps strengthen collaboration and communication which in turn enhances program results and outcomes. The coordination bodies are established at central, provincial and district levels.

1.1 Collaborating Center for Migrant Health (CCMH)

As illustrated in the Figure 2 and 3, the MHP is directed by the Deputy Permanent Secretary of the MOPH. As an inter-departmental body operating within the Department of Health Service Support of the MOPH, the Center serves as the program secretariat in coordinating and providing policy and technical support to local MHP teams from various departments at the MOPH and other line ministries/ organizations. While the Department of Health Service Support of the MOPH involves the management and coordination of the Program, the Public Health Inspector serves as the Joint Technical Team leader at the central level. The Center also coordinates the MOPH’s regular monitoring visits to the field by the Public Health Inspector and other relevant senior officials to provide policy, technical and management support to local MHP teams, as well as for the joint program review and/or evaluation with IOM. In addition, the Center co-organizes the annual Joint Technical Team Meetings with IOM to convene key stakeholders from relevant ministries, NGOs who work with migrants, academic institutions/ organizations, as well as migrants themselves to discuss key concerns and to strengthen migrant health systems. IOM at the central level fulfills the role on external coordination, donor relations, regular liaison with the Department of Health Service Support of the MOPH, as well as providing technical and management support to Program implementation and policy development as appropriate.

Figure 3. Collaborating Center for Migrant Health (CCMH)



1.2 Provincial Migrant Health Committee

The Provincial Migrant Health Committee was integrated into the existing Provincial Health Committee chaired by the Provincial Chief Medical Officer in all target provinces. The Committee usually meets quarterly to share information and concerns as well as to provide policy support and advice to the overall management of migrant health issues in the province. The Committee also coordinates migrant health projects implemented by the MHP as well as relevant projects implemented by NGOs who are collaborating with government health authorities in the province. The membership mainly includes heads of relevant Provincial Health Office units in all target provinces. The Provincial Migrant Health Committee is expanded to include other key stakeholders as determined by the local context. For example, in Tak, Ranong and Pang Nga Provinces, the committee also includes representatives from District Migrant Health Teams (see below) and Chiefs of Public Health Centers since the Program is implemented in multiple sub-districts in the provinces. In Samutsakorn, representatives from the Provincial Hospital, who is key implementer of the MHP, as well as from NGOs working on migrant health and migrant rights issues are also invited to be a committee member, in addition to key staff from the Provincial Health Office. In Chiang Rai, the Committee also involves representatives from the District Migrant Health Teams, Offices of the Governor and other line ministries as well as the entrepreneur association. IOM’s Field Coordinators, the only IOM staff at the field level, are Committee participants in all target provinces. The teams usually meet on a quarterly or semi-annual basis as determined by local context and need.

1.3 District Migrant Health Team

The Team in each district consists of representatives from the District Health Office and participating Public Health Centers and/or Public Hospitals, the MHP project-based Field Assistant, and the MCHWs employed by the Program. The Migrant Health Team in each district usually meets on a monthly basis to discuss achievements and challenges from the previous month as well as to develop detailed workplans for the following month and to discuss overcoming any challenges.

2. Human Resources

The Program is embedded within the government public health structure and implemented by existing human resources within all levels of the MOPH. However, some adjustments were made to the terms of reference of public health personnel involved in the Program. A few positions, particularly at the field level, were created to suit operational requirements. The key human resources of the MHP and their roles and responsibilities are as summarized below.

2.1 Central level

As shown in Figure 3, the Program's central level human resources exist within the CCHM. The MOPH contributes a considerable amount of staff time to work on the Program as its in-kind contribution. The Deputy Permanent Secretary acts as the MHP Director, providing guidance and support to overall migrant health policy at the national level. Two senior officials from the Department of Health Service Support and the Office of Inspector General serve as the Program Deputy Director. They follow up policy implementation in the field as well as providing technical guidance to the local health authorities and care providers. The CCHM Chief, Deputy Chief and Assistant Chief are senior and mid-level staff of the Bureau of Health Service System Development. Enlisting the Bureau of Health Service System Development as key coordinator of the CCHM was specifically for migrant health system development as an addition to their existing mandate for Thai population. The day-to-day coordination and communication between IOM and MOPH is conducted through a technical officer of the Bureau of Health Service System Development who serves as secretary of the CCHM.

In addition to the day-to-day management structure of the Program and the CCMH, the Office of Inspector General contributes the services of a pool of Public Health Inspectors who are responsible for monitoring and providing technical and management support to local health authorities in target provinces. They lead the Joint Technical Team by jointly conduct monitoring visits to implementation field with technical staff from IOM Bangkok. They also chair and/or participate in the annual Joint Technical Team Meeting to review achievements and discuss areas of improvement, as well as discuss appropriate local and national strategies for migrant health programming.

On the IOM side, the Chief of Mission to Thailand is responsible for the overall management of the Program, external and donor relations and the promotion of the IOM-MOPH collaboration at national and global levels. The IOM's MHP Manager is primarily responsible for day-to-day management of the Program at all sites including Bangkok; resource mobilization; liaison with donors and the CCMH; technical and management assistance to implementing partners at both central and peripheral levels; supervision of Program staff; liaison with IOM headquarters and IOM Missions in other countries as well as national and international key stakeholders in order to share good practices and lessons learnt on effective internal and external migrant health strategies.

2.2 Provincial level

The MHP is embedded into the Provincial Migrant Health Committee chaired by the Provincial Chief Medical Officer as described above. Under the overall supervision of the Provincial Chief Medical Officer, several health personnel at the provincial level manage and coordinate the overall implementation of the project. IOM's Field Coordinator roles and responsibilities are established as follows.

MHP Project Manager

In general, the Deputy Provincial Chief Medical Officer serves as the Project Manager of IOM-MOPH MHP at the provincial level. S/he leads the development of the project implementation framework and collaborates partnerships with various provincial departments, MOPH and IOM. S/he also endorses work and budget plans submitted by the implementing partners i.e. relevant unit(s) of the Provincial Health Office, Public Hospitals and Public Health Centers. The Project Manager also oversees the overall management of project operations to ensure that planned activities are implemented in a timely and technically sound manner.

MHP Project Coordinator

One senior public health technical officer from the Provincial Health Office is appointed as the MHP Project Coordinator at the provincial level. The key role of the Project Coordinator is to coordinate with the IOM Field Coordinator, various departments/units within the Provincial Health Office, implementing partners as well as with other local authorities, NGOs and community-based organizations supporting the day-to-day management of the MHP activities. S/he also assists the Project Manager to oversee project management through field monitoring visits, participating in selected MHP team meetings and regularly providing project updates to the Project Manager.

Field Assistant

The Field Assistant supports the Project Coordinator and collaborates with IOM Field Coordinator by providing regular technical and/or administrative support to the MHP team, particularly to the MCHWs/MCHVs to prepare for the implementation of day-to-day activities. S/he also coordinates input from different MHP teams for the IOM Field Coordinator, who in turn develops and submits monthly activity reports to IOM Bangkok.

IOM Field Coordinator

The IOM Field Coordinator facilitates project startup which involves several tasks such as the development of project implementation planning; recruitment and training of project staff, particularly Field Assistants and MCHWs; and setup of field offices, in close consultation and collaboration with the Project Manager, the Project Coordinator and the MHP team. S/he also supports the MHP Project Coordinator in providing technical and management assistance to MHP teams in participating districts; preparing and implementing project activities as agreed in the workplan; ensuring implementation is in line with Program goals and objectives; as well as providing feedback to and/or consulting with IOM Bangkok as required. In addition, the IOM Field Coordinator is responsible for incorporating implementation results from different MHP teams to develop and submit monthly provincial reports to IOM Bangkok for further submission to donors.

The Project Manager, Project Coordinator and the IOM's Field Coordinator form a Provincial Team. As required, the Project Manager and the Project Coordinator are backed up by the Provincial Chief Medical Officer and/or other senior relevant Provincial Health Office staff while the Field Coordinator is backed up by IOM's Bangkok based MHP Manager. Accounting and financial reporting responsibilities rest with Provincial Health Office financial staff in most participating provinces. However, there is a need in some provinces to employ project-based Finance Assistance to handle this issue or to transfer accounting responsibility to the Field Assistant.

2.3 Service provider level

The District Health Office plays a key role in project implementation management in most participating provinces, particularly where implementation sites are outside municipality areas. Although they are neither first line service providers nor the administrator of government health budgets, they are responsible for the overall health of the public and the provision of technical support to healthcare providers, especially investigation and control of infectious disease outbreak. The mandate of the District Health Office ensures coordination and management support to first line district care providers in the provision of healthcare to migrants and host communities in target areas.

Public Healthcare Provider

Public Health Centers and/or Public Hospital care providers provide health prevention, promotion, care, treatment and referral to migrants in target communities. Planned and implemented as a component of their regular work schedule, they provide migrants, registered and unregistered, with outreach healthcare services through regular mobile clinic services and/or facility-based services at the Primary Care Units of Public Health Centers or Public Hospitals (see more detail in the program approach section below). They are assisted by MCHWs and MCHVs as described below. They also provide on-the-job training and mentoring to MCHWs and MCHVs.

Migrant Community Health Workers

Migrant Community Health Workers are employed fulltime by the Provincial/ District Health Offices and/or Public Health Facilities involved in the project with financial support from the MHP. They are consistently trained and retrained on a quarterly basis on various public health and related issues, mostly by public health personnel with technical and financial support from IOM. They are stationed at community health posts (see more details below), Public Health Centers and/or Public Hospitals in target areas and play a central role in bridging gaps between migrant populations and available public health services. For more information on the qualifications, capacity building and primary tasks of the MCHWs, please refer to Annex 4.

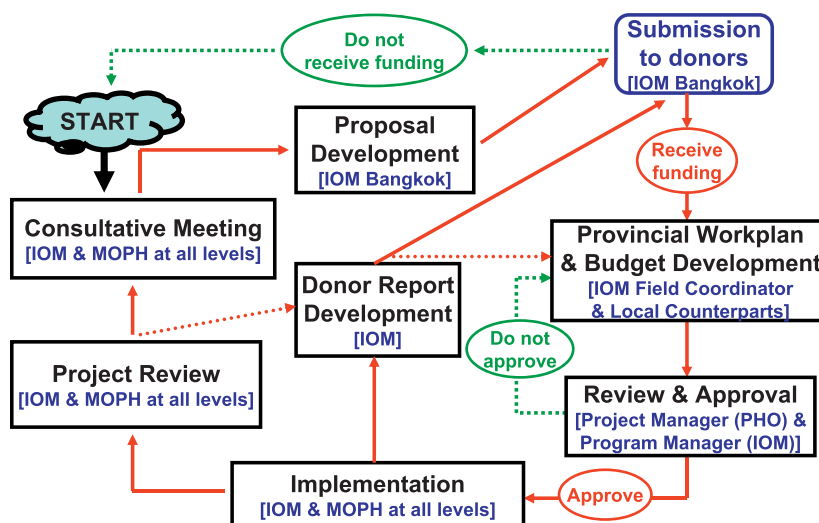
Migrant Community Health Volunteers

Migrant Community Health Volunteers are migrants who live and/or work in target communities. They receive training from public health personnel a couple of times per year on basic health issues relevant to their communities. IOM provides technical and financial support. They assist MCHWs and public health personnel in the provision of health information and basic health prevention to peers as required on an ad-hoc basis. Some also play a key role in providing health information and health referral to peers in the workplace (see more details in the program approach section below and the Annex 5).

3. Management Flow and Operational Procedures

The MOU between IOM and MOPH ensures the MHP is co-managed by IOM and relevant departments/ offices within the MOPH. As shown below in Figure 4, the project involves a variety of staff and offices from all levels of the MOPH throughout management of the project cycle.

Figure 4. Project Cycle Management of MOPH-IOM Migrant Health Program



3.1 Project Development

Before launching the Program, IOM and the MOPH conducted a joint assessment of potential field operation sites to collect demographic data of migrant populations as well as to discuss implementation and management modalities with local health authorities. The consultation not only helps all partners to gain a mutual understanding on the purpose of the overall Program and operational procedures, but also to gain ownership of the Program. For subsequent project development under the IOM-MOPH MHP Collaboration, IOM Field Coordinators facilitate input from local partners on changing circumstances and needs in their responsible areas. IOM's Bangkok based MHP Manager then takes the lead in developing project proposals with background information obtained from the field and additional input and agreement from the MOPH. On behalf of the IOM-MOPH MHP, IOM submits the proposals to donors and follows through with the process of grant negotiation, signing donor agreements as well as grant management.

3.2 Operational Procedures

IOM and MOPH jointly develop planning for activities implemented at central level, while responsibility for financial management rests with IOM as the grant manager. For field activities, IOM and MOPH co-organize project startup meetings to inform and clarify project agreements, expected results, timeline and overall budget with local partners. The IOM Field Coordinator and the MHP Project Coordinator then coordinate and incorporate input from implementing partners into one provincial work and budget plan and submit to both the MHP Project Manager at the Provincial Health Office and IOM's MHP Manager in Bangkok for review and endorsement. The work and budget plans are revised where appropriate and the final version endorsed by both the MHP Project Manager and the IOM MHP Manager to be used as a reference for field implementation.

On a quarterly basis, each implementing partner develops a detailed quarterly workplan and budget according to the master workplan described above. Some modifications can be made as deemed appropriate and quarterly workplan and budgets are then submitted to the provincial team for compilation. Once approved by the MHP Project Manager, the IOM Field Coordinator is responsible for submission of the quarterly workplan and budget to

IOM's MHP Manager in Bangkok for final review and approval to ensure the plans are in line with objectives and donor requirements. Once endorsed, IOM Bangkok provides quarterly funding to the provincial team through the joint Provincial Health Office-IOM bank account in each province. The funds transferred to the province are co-managed by the IOM Field Coordinator, with the IOM MHP Manager in Bangkok as an alternate, and by the MHP Project Manager, with the Provincial Chief Medical Officer or the Project Coordinator from the Provincial Health Office as an alternate. The implementing partners receive cash advances and report activities and expenditure to the Provincial Team each month. Monthly progress and financial reports from each province are consolidated, reviewed, revised and submitted to donors by IOM Bangkok.

The district level MHP teams meet each month to review achievements and lessons learned from the previous month and to plan activities for the subsequent month. Selected health topics are also discussed at the monthly meeting and it is a good opportunity for public health staff to provide refresher training to MCHWs.

Representatives from district/ sub-district level implementing partners meet quarterly with the Provincial Team to review achievements and lessons learned from the previous quarter and plan for subsequent quarter activities. Requests for an adjustment to the workplan are also discussed and agreed upon, as well as discussion about MHP team training requirements, particularly for MCHWs and MCHVs. In addition, an internal project review is conducted annually by team members each province for the same purpose. As deemed appropriate, the provincial team may invite staff from IOM Bangkok and MOPH to participate in the annual project review, particularly during the first few years of project implementation.

3.3 Technical Assistant and Monitoring and Evaluation

On a day-to-day basis, MCHWs and MCHVs receive technical guidance and support from public health staff. In addition, they also receive formal training from the Program delivered to them periodically by local public health staff, IOM staff and/or specialist consultants who are engaged by the MHP.

The implementation team is requested to submit activity progress and financial reports on a monthly basis. Since there was no migrant health reporting system that the Program could utilize, the MHP developed a reporting format in order to track health services provided to migrants. The format was based on an adaptation of the existing Health Information System being used by the public health sector among Thai populations.² Some case definitions and standardized measurements were revised to fit the diverse circumstances of migrant health. For example, basic child immunization records were extended to migrant children under 15, instead of five years old as commonly recorded among Thai children since the majority of migrant children do not receive vaccinations according to the national protocol. The field reports are sent to IOM for review and compiled for submission to donors. Simultaneously, the service records are also submitted to the MOPH according to routine reporting lines and specific requests from the MOPH.

² The Program later collaborated with the World Health Organization (WHO) to develop Migrant Health Information System that built upon the existing system in place for the Thai population. For more detail on Migrant Health Information System Development, please contact WHO Thailand Office.

Technical input and support is provided to MHP teams at the field level via regular joint monitoring visits by IOM and the MOPH. IOM visits for technical assistance are mainly conducted by the MHP Manager while the MOPH involves staff visits from the Department of Health Service Support and Public Health Inspector Office, along the normal monitoring line of the MOPH. Virtual technical guidance and support are also provided to local teams. IOM Bangkok staff also provide technical assistance on accounting and financial management to local teams according to donor regulations.



A joint field monitoring visit by senior staff from the MOPH, IOM, WHO and a board member of the UNTFHS

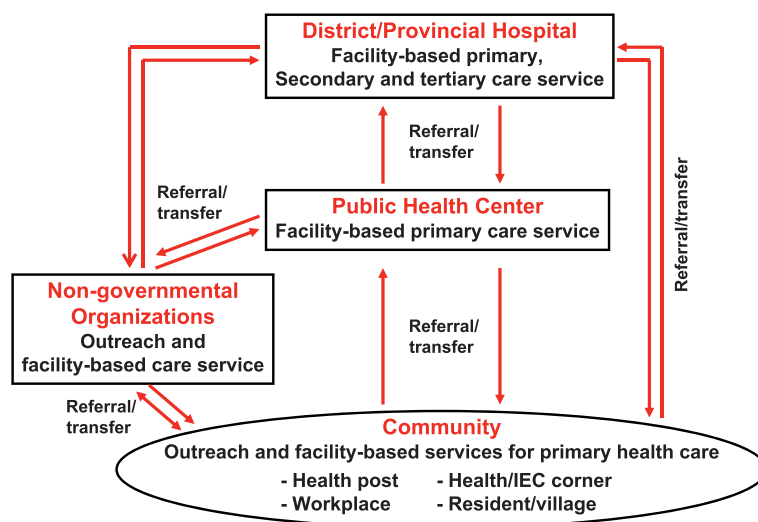
Midterm reviews are conducted for projects of three or more years of implementation. Although an external review is preferred, most project midterm reviews are conducted internally due to limited funding. The joint review team consists of representatives from IOM and the MOPH as well as relevant partner agencies. The main purpose of the midterm review is to assess whether the technical design, operational management and initial assumptions are still valid. Implementation strategies and plans are revised based on review findings. Towards the last semester of projects, final evaluation of project achievements, challenges, lessons learned and recommendations are conducted in all sites by one external review team to ensure reliability and consistency.

Program Implementation Approaches and Good Practices

MHP implementation sites are dispersed along the Thai-Myanmar border, except in Samutsakorn; all with diverse population groups, physical environments and local communities requiring approaches that meet the context of each setting. As illustrated in Figure 5, the MHP adopted the MOPH's existing structure to reach migrants in target areas, with an additional emphasis at the community level. Migrant community health posts, health/IEC corners and outreach health services in workplaces were extended to village or household level outreach activities normally implemented within the local Thai population. Medical referrals and transfers between community and public health facilities are conducted through the regular procedures of the MOPH that were established for Thai citizens. Referral and transfer networks between the community, public health facilities, and NGOs services have been established and/or enhanced through the MHP. The MHP has also worked to ensure services are not duplicated but rather compliment one another to maximize resources.

In summary, target communities and populations in the five provinces can be grouped by geographical setting and **good practices** for different settings can be summarized as below.

Figure 5: Migrant health service system operated under MOPH-IOM Migrant Health program



1. Remote and Isolated Communities

Most target communities in Tak Province and in Mae Fah Luang District of Chiang Rai Province are remote communities in isolated areas along the border. Many of these remote communities have limited access to health and social services due to an absence of proper roads and/or public transport. Although fees for basic health care at public health facilities are not high³ and migrants who cannot afford to pay often have health care costs waived⁴, living in remote communities results in high transport costs⁵ that affect time lost attending to farms and families and/or loss of daily wages for those who rely on cash income to maintain a livelihood. These factors impact on access to primary care services and the subsequent delay in receiving appropriate care which could ultimately lead to chronic conditions and death. Although many approaches have been trialled in these areas, two key approaches have been emphasized in this setting.

Approach 1.1 Community health post

As a result of national healthcare reforms to introduce the Universal Health Coverage Scheme, Public Health Centers became the grass root level of care. Community health posts previously established to provide primary health care services in remote communities under supervision from Public Health Center and/or District Health Office were closed down. In addition, the reform placed a greater emphasis on curative treatment thereby limiting the budget for health prevention and promotion and ultimately discouraging local health authorities from providing community health services. Populations in several villages in MHP target areas reported having no access to health services following the closure of community health posts and prior to the launch of the MHP.

³ Thai citizens can receive services free of charge according to the National Universal Health Coverage Scheme. Registered migrants are requested to pay about USD 1 per visit. Unregistered persons are required to pay the actual cost for the service(s) they receive. For example, it usually costs about USD 10 for natural child delivery while basic vaccines are available free-of-charge for all children in Thailand.

⁴ For more information, please refer to IOM/MOPH/WHO joint publication entitled “Financing Healthcare for Migrants: A case study from Thailand” published in 2009.

⁵ Between USD 6-10 for one round trip which are about two times higher than the standard daily wage in these areas.

The MHP operates five community health posts in Tha Song Yang District of Tak Province and three in Mae Fah Luang District of Chiang Rai Province. The community health posts are located in highly remote and hard-to-reach areas, particularly in the big village “twin-city” areas⁶ on the Thai side. The MHP either renovates abandoned community health posts or establishes new posts with contribution and involvement from community members. To promote local participation and ownership, the MHP provides the cost for materials and the community leaders and members contribute their land and/or labour to construct the posts.

Each community health post is equipped with basic household medicines including paracetamol, cough medicine, oral rehydration solution and first-aid kits. The health post is administered by trained and qualified MCHWs with regular monitoring and supervision from public healthcare providers from the nearby Public Health Center. The assigned MCHW provides basic health screening, prevention, consultation and care to community members, both migrants and Thais. Some community health posts also perform rapid testing and treatment for endemic diseases such as Malaria. This is particularly the case when MCHWs have Thai nationality and are recognized as having capacity to conduct additional tasks as assigned by local health authorities. The MCHW consults with the closest Public Health Center via short-wave radio or other means when attending to difficult and/or emergency cases, and can refer patients to public health facilities for further diagnosis and care as required. All patient data and services provided at community health posts is recorded into a log book and the MCHW who administers the post must summarize information and report to their supervisor on a monthly basis. Community health posts result in early detection and early warning signs which enables an effective and rapid response to disease outbreaks along the border.

The MCHWs also conduct home visits or remind patients who need treatment to follow up and receive services from the community health post as required. As much as possible, the MCHWs are selected from the communities where health posts are located to enhance the possibility that services are sustained when donor funding ceases.



A rural Community Health Post

[Approach 1.2 Mobile clinic](#)

As a supplement to the services of the community health post, the MHP team regularly delivers a mobile clinic service in remote communities. The MCHWs and/or MCHVs pre-advise communities of the mobile clinic schedule to maximize service utilization. During mobile clinic sessions, MCHWs help register patients, measure vital signs,

⁶ The area where villages located right at the border or very close to the border on both Thai and Myanmar sides.

and record patient information on their out-patient cards. They also conduct health IEC for patients while waiting for diagnosis. Patients are diagnosed by public healthcare providers and receive care and treatment as required. Basic medicine can be prescribed by public health personnel as required. MCHWs perform medical translation during diagnosis and treatment as well as explain medication details in the appropriate native language. The mobile clinic services mainly covers cross-cutting basic health issues such as child immunization and growth monitoring, family planning, perinatal care, rapid testing and treatment for Malaria, and first aid. Severe cases are referred to the closest public hospital. The teams often use community health posts as the mobile clinic venue when available. Where there is no community health post, other public community gathering spaces are used. The teams also conduct home visits for treatment follow up as well as to facilitate group discussions with community members on community health needs and to develop community-driven solutions to address local health problems.



Migrant Community Health Workers assist public healthcare providers with measuring vital signs and translation at the mobile clinic.

2. Urban Community

[Approach 2.1 Promoting access to public health facilities](#)

In the urban/semi-urban areas where physical access to public health facilities is not a primary concern, the MHP focus is to promote migrants' access to public health facilities closest to them. The Program employs several strategies to ensure public health services are migrant-friendly, which in turn helps increase access.

The MHP equips catchment area Public Health Centers and Public Hospitals with one or more MCHW, depending on the volume of migrant clients. Trained MCHWs provide health IEC and medical interpretation services. They also assist public healthcare providers to perform basic services such as screening, medical history and monitoring vital signs (such as blood pressure and body temperature) as required. They also assist with explaining how to administer prescribed medicines in appropriate migrant languages.

MCHWs are trained and supervised by public health personnel and IOM staff to conduct community mapping in all sites at the beginning of field implementation. The mapping provides informative evidence such as the location and distance between migrant communities and public health facilities, available public transport, and preferred transport options in order to determine whether service utilization at existing public health facilities should be promoted rather than active community outreach services such as the mobile clinics.

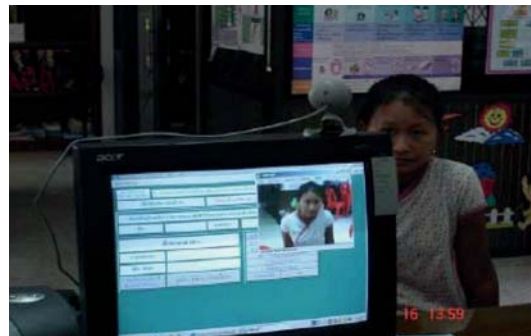


A migrant community map produced by Migrant Community Health Workers

Another activity that resulted from the community mapping exercises is the development of family health folders by trained MCHWs for migrants living in catchment areas for longer than six months. The activity involves one MCHW per group of up to 250 migrant families to develop the health folders. The folders are filed at relevant Public Health Centers responsible for target migrant communities. When migrants visit, MCHWs retrieve the folders for care providers to record details of health issues and services provided, in the same fashion that the care providers undertake for Thai patients. In Ranong, the records are entered into the Migrant Health Information System as a pilot project with technical and financial support from WHO.



Migrant (blue) and Thai (green) Family Health Folders



A pilot Migrant Health Information System at a public health center

In addition to the provision of services and assistance by peers who are culturally aware and able to provide services in migrant languages, the attitude of public health care providers is another magnet for migrant-friendly services. The MHP in collaboration with IOM's Labour Migration Unit and Thailand's Ministry of Labour and Social Welfare deliver a series of training and workshops on globalization, international migration, basic human rights, migrant rights and migrants' contribution to Thailand. The training specifically targets all levels of public health personnel in order to enhance and fine tune their insight into international migration.

MCHWs and other MHP team members conduct outreach IEC activities at the same time as promoting an increase to primary care utilization at public primary care facilities near migrant communities. An enabling and friendly environment is essential to increasing service utilization at public facilities.



A public healthcare provider vaccinates a child at the public health center.

[Approach 2.2 Community health post and mobile clinic](#)

Community health posts assist with reducing public health facility caseloads in urban or semi-urban areas with large migrant communities or a huge influx of migrant populations. The MHP established one community health post in Mae Sot District of Tak Province, one in the Municipality of Samutsakorn Province, and two in large fishing villages in Pang Nga Provinces for this purpose.

The setup, administration, and functions of urban setting community health posts are the same as those in remote areas of Tak and Chiang Rai Provinces described earlier. The MHP allows for the community health post spaces to be available for other activities implemented by other organizations targeting the same areas, for instance, to organize group discussions among migrants on HIV/AIDS.

Similarly to those in remote areas, and in addition to community health posts, the teams in Mae Sot District, Samutsakorn Municipality, and those in Pang Nga also regularly deliver mobile clinic services at community health posts. They particularly target primary and perinatal care to reduce overcrowding at public hospitals.



An urban Community Health Post

3. Workplace Intervention

The MHP applies several approaches in both rural and urban settings to reach large clusters of migrants working in established settings such as manufacturing, seafood processing factories and agricultural farms. Key approaches considered to be good practices for this type of setting are summarized below.

[Approach 3.1 Migrant health corners](#)

In each target district, approximately 200 MCHVs are recruited from migrant communities and workplaces. They receive at least two training sessions each year from the MHP on priority health issues relevant to their communities. Through a series of consistent discussions in Samutsakorn and Ranong Provinces, business owners and employers of migrants agree to provide a space in their workplace for the MHP teams to establish migrant health corners. Health IEC materials are placed and replaced at 39 migrant health corners established in migrant workplaces in the two provinces. One to two MCHVs from each participating workplace are recruited and provided with extra training from MHP teams, particularly on family planning and first aid. They provide basic care, consultation and medical referral to their peers. Some also receive a first aid kit from the MHP to provide first aid to peers as required, in addition to distributing condoms and the contraceptive pill under the supervision of public healthcare providers.



A Migrant Community Health Worker contributes a corner of her rental room as a health corner for migrants in the community.



A workplace health information corner

[Approach 3.2 Mobile clinic](#)

In Samutsakorn, staff from the Migrant Health Unit of the Provincial Hospital, that is, the MHPs implementing partner, also deliver mobile clinics at migrant workplaces in municipality areas. Although physical access to the hospital is not much of a concern in an urban setting like Samutsakorn, many migrants, especially unregistered migrants and their dependents, avoid accessing services at the hospital because of a fear of being arrested by police and due to a lack of understanding about their rights to basic healthcare. The MHP team in Samutsakorn delivered regular mobile clinic services to several migrant workplaces in the first two years of project implementation, mainly to provide health education and information as well as to develop rapport and trust with migrants, registered and unregistered. As time passes, migrants gain enough confidence and the team therefore reduces the frequency of mobile clinic services as migrants are more willing and able to utilize services at the hospital where a number of MCHWs are available to assist them. The mobile clinic service is then maintained for special occasions only such as during immunization campaigns.



A mobile clinic for tuberculosis screening in the workplace

4. Cross-cutting Approaches

In addition to approaches that are considered good practices for specific settings with specific physical characteristics, there are some generic approaches that can be applied in all settings that can contribute greatly to the success of a Program.

Approach 4.1 Community outreach

Regardless of target areas, migrant ethnicities and the type of work in which they are involved, community outreach is an approach that has several positive effects on the Program. In fact, mobile clinic services, home visits, community or workplace health IEC as well as large-scale community campaigns are all part of community outreach. In addition to direct service provision, community outreach is also important for delivering information campaigns; not only health related but also for other issues such as annual labour migrant registration announcements, the introduction of the MHP team and advice about available services that all individuals in Thailand can access regardless of their nationality.

In addition to the 39 migrant health corners established in migrant workplaces in Ranong and Samutsakorn, 17 migrant health corners were also established in migrant communities in Ranong and Pang Nga Provinces. Selected MCHWs and MCHVs in Ranong and Samutsakorn offer a corner of their residence to be used as health corners. Because of limited government and Program budgets, basic medicines cannot be provided to migrant health corners after donor funding has ceased. However, MCHWs and MCHVs can sustain some services for their peers, particularly services that do not involve budgets such as health IEC and referral.



A mobile clinic service and a home visit to a migrant community



Hand wash training for migrant children in the community



A community health awareness campaign



Migrant Community Health Workers conduct workplace health education sessions.



Approach 4.2 Comprehensive programming

One of the key philosophies of the MHP is to ensure equity in access to available health services. To achieve this, it is important that the Program addresses the health and related needs of diverse population groups in society, whether male or female, child or adult, Thai or migrant.

Although the MHP focuses its efforts on migrant-rich communities, the Program implementation emphasizes a need to provide the same services to both migrants

and Thais in host communities. In addition, the Program employs a community health development approach by providing a comprehensive health service to target communities. The primary health care system that the MHP adopts to address the health needs of individuals of all age and gender groups is a good approach to ensure service comprehensiveness. It addresses all basic health needs such as primary care, family planning, maternal and child health. While covering a broad range of services and various health issues on a daily basis, priorities can also be given to selected health issues according to local needs such as seasonal and endemic diseases like Dengue Hemorrhagic Fever and Malaria.

Comprehensive Programming

Many Thai citizens in Samutsakorn Province express their appreciation to the MHP mobile clinic service. They often visit the clinic and receive healthcare from the mobile team. This not only helps to reduce negative perceptions that health authorities care more for or provide better services to migrants, or that migrants are sources of disease that require special concentration, but also helps promote a harmonious co-existence of Thai and non-Thai populations in society.

Recognizing the multi-sectoral dimension of health and human welfare, it is important to offer separate but related non-health services in the target areas of the Program. The MHP aims to address legal, socio-economic and cultural barriers preventing access to health care among migrants and their dependents. In IOM’s experience, there is a constant need for planners and implementers of primary health care programs to recognize the “hidden” nature of issues among migrant populations. Migrants face the double challenge of being illegal residents while harboring a burden of health conditions which carry significant social stigma such as Tuberculosis and Filariasis. Accordingly, the MHP does not assume that the mere existence of improved levels of awareness about health conditions, knowledge about available services, ability to pay for the services and/or to access the free services is sufficient to lead to an increased utilization of services. In fact, it is evident from the implementation of the MHP that both registered migrants with insurance under the Compulsory Migrant Health Insurance Scheme and unregistered migrants who in principle have to pay out of pocket expenses for care both have, in reality, limited access to available health services. Therefore, the MHP is continuously focused on achieving an increased level of service utilization in an enabling environment.

At the healthcare facility level, no effort is spared to ensure that linguistic, legal and political barriers are removed or minimized to alleviate perceived fears among migrants of being mistreated or neglected at primary health care facilities or of being deported. Services are migrant-friendly through the provision of medical interpretation/translation by MCHWs as well as improving attitudes of care providers toward illegal migrants. During the annual medical examination for registered migrants, when healthcare providers have to perform thousands of examinations within one-two months time, in addition to their routine services to other patients, the MCHWs also provide interpretation/ translation services. The MCHWs also provide health IEC to migrants during the registration pipeline. This helps improve the effectiveness of the diagnosis as well as treatment outcomes. On the other hand, the MOPH provide several policy guidelines to local health authorities and public healthcare providers, while IOM assists the MHP teams in translating the policies into practice. At implementation level, this assures healthcare providers that the provision of health services to illegal residents is for humanitarian purposes and that they will not be charged against the government’s code of conduct.

Complimentary Actions

The Thai cabinet has allowed unregistered migrants already living/working in Thailand to register and obtain an annual government work permit within announced timeframes. In doing so, migrants are required to undergo a medical checkup and join the national health insurance scheme before they can obtain a work permit. The MHP teams take this opportunity to conduct information campaigns to promote the benefits of labor migrant registration. It is possible this contributes to a relatively stabilized number of registered migrants in Target provinces when overall national registration trends are declining.



A billboard produced by the MHP to promote labour migrant registration

[Approach 4.3 Multi-sectoral collaboration](#)

As mentioned earlier, health and human services are multi-dimensional in nature. It is unlikely that public health issues can be solved purely by medical and health intervention alone. This is particularly true with migrant health issues since there are various sub-populations who are of concern to different authorities such as the Immigration Bureau, Military, Ministry of Interior, Ministry of Labour and Social Welfare, and the MOPH, just to name a few. Strengthening multi-sectoral coordination and collaboration is a key to Program success in addition to the long term sustainability of the Program.

Collaboration with Local Administrative Authority and Employer of Migrants

The MHP in Pang Nga collaborates with various stakeholders outside of the health arena to enhance the impact of Program activities. In particular, they periodically collaborate with Local Administrative Organizations responsible for community sanitation to organize a “large cleaning day” in migrant-rich communities. The Thai Village Health Volunteers, community leaders and members work side by side with migrants to improve community sanitation. This kind of joint activity among different authorities and populations demonstrates a harmonious and healthy society.

To date, Pang Nga is the only MHP site, and perhaps only place in Thailand, where Local Administrative Organizations and business owners who employ migrants provide both financial and in-kind contributions to the MHP team to implement migrant health activities.

Multi-sectoral Collaboration with Various Stakeholders

The MHP in Chiang Rai initiated the very first activity in Thailand that involved a large scale collaboration between health and non-health sectors, government and non-government agencies, and Thai and non-Thai communities. The team piloted a sub-project on influenza pandemic preparedness in four districts involving over 100 representatives from 45 organizations from various sectors and communities. The Chiang Rai model is being replicated by relevant authorities and non-government partners in other provinces and outside of Thailand through IOM.

The MHP, even prior to the inception of the Program, has been putting great effort into establishing and strengthening multi-sectoral collaboration at national and field levels. At the national level, the Collaborating Center for Migrant Health established by IOM and MOPH has been expanding to collaborate with other organizations who work directly on health issues for migrants; for example, with UNICEF on behavior change communication (BCC) to prevent Avian and Human Influenza (AHI), with Raks Thai Foundation on HIV/AIDS prevention, and with Medicin Sans Frontier (MSF) for HIV/AIDS care and treatment. In addition, the annual Joint Technical Team meeting co-organized by IOM and MOPH involves counterparts from various line ministries, United Nations (UN) agencies as well as NGOs.



Thais and migrants work hand in hand to improve community sanitation through a collaboration between the MHP, the Local Administration Organization and employers.

At the field level, a multi-sectoral network and collaboration was initiated prior to field implementation. Led by IOM and MOPH technical staff, the MHP teams in each province organized a consultative meeting with various stakeholders before the development of the provincial master workplan. The meeting aimed to map out existing health services implemented by both government and NGOs in the same geographic areas. Based on meeting results, the MHP teams designed the provincial master workplan with strong consideration to avoid a duplication of health services. In addition, they looked at the establishment of and/or strengthening of implementation and referral networks. For example, the MHP teams in Ranong and Samutsakorn Provinces excluded HIV/AIDS and tuberculosis from workplans since there are already NGOs working on these issues in the same target communities. To this date the MHP teams have established good referral networks for migrants to access services from relevant NGOs.

As described in the Program Structure, the MHP establishes and/or re-establishes and strengthens multi-sectoral networks and collaboration in all target provinces and districts through the Provincial/ District Migrant Health Committees. In some target sites, in addition to government and non-government agencies, the committees also involve business associations and/or entrepreneurs that employ migrants. Where appropriate, non-health sectors are also invited to participate in relevant coordination meetings and direct service delivery.

In some target areas with large communities of migrant populations, the MHP collaborates with “migrant learning centers” (migrant schools) run by NGOs to conduct child and school health program for migrant children. In addition to general health issues, the team can also provide health services that are particularly important for children and teenagers such as periodontal care and sex education.



A health education session at a migrant learning center

IV. Program Cost

It is important to note that the MOPH at all levels have been providing a great amount of complementary staff time to support planning, implementation and monitoring and evaluation of the MHP. In addition, the MOPH also provides other contributions to the Program, particularly in expanding the existing national policy for health prevention and promotion to include registered and unregistered migrants. For instance, the MHP's target populations receive free basic essential vaccines from the MOPH according to the national "Immunization for All" policy, as well as free temporary contraception methods including the oral pill, injection and condoms. As the MHP is funded by various donors in different locations, different donor rules and regulations must be applied accordingly. In some target areas where donor funding does not allow for certain costs, the local health offices and facilities contribute to Program implementation. For example, the medicine used at community health posts and mobile clinic sessions in Tak Province are supplied by the Provincial Health Office.

Although the MHP has only been established over the past five years and requires further investment in Program infrastructure and effort to further develop human capacity, the Program is able to minimize costs while maximizing the benefit and results of the Program. Several innovative management and operational means are used to reduce costs (see more details in the Program's strengths in the section below). Overall, the total cost for implementing the MHP in 12 districts of five target provinces over five years of the Program was USD 3,648,739. A detailed costing analysis of the program has not yet been conducted due to several limitations including significant contributions made by various stakeholders as mentioned above. However, considering that some 100,000 migrants, and a large number of Thais in host communities, receive health information, prevention, promotion, care, treatment, and referral services from the Program each year, the rough estimated unit cost of this Program is about USD 7 per migrant per year⁷. Note that this estimate does not include a costing for the MOPH's in-kind contribution such as medical supplies in selected target areas.

Table 2: Summary of Program costs between 2004-2008

Cost category	Amount (in USD)						%
	USAID (Tak and Chiang Rai)	EC (Chiang Rai)	World Bank (Pang Nga)	UNTFHS (Ranong and Samutsakorn)	UNICEF (Ranong and Pang Nga)	Total	
Technical and management staff cost	468,846	172,573	-	148,480	69,445	859,344	24
Office cost	58,067	42,450	1,782	19,547	9,316	131,161	4
Operational cost	812,767	400,498	58,082	851,717	371,720	2,494,784	68
Indirect / program support cost	60,320	38,940	4,271	37,395	22,524	163,450	4
Total cost	1,400,000	654,461	64,135	1,057,139	473,005	3,648,739	100

Source : MOPH-IOM Migrant Health Program Record

⁷USD 3,648,739 / 5 years / 100,000 migrants = USD 7.30

V. Key Program Results

Based on program modalities and the good practices described above, the Program has achieved outcomes that have both short and long-term implications to the migrant health system and community. In addition to quantifiable outputs resulting from direct service delivery, the MHP has achieved several outcomes which are difficult to quantify but still considered key successes of the Program.

Strategy 1 : Strengthening the capacity of relevant counterparts at all levels

Key Result 1.1 Government and non-government counterparts

The MHP works to increase understanding and cooperation among various stakeholders at the field level, particularly among public health personnel. These efforts ensure the provision of migrant-friendly services through a series of formal and informal capacity building activities such as training and sensitization workshops. The workshops not only include Southeast Asia regional migration and migrant health dialogues and workshops organized by IOM's Labour Migration Program, but also other forums in which IOM collaborates and/or provides technical support, for example, events such as Thailand's bi-annual National Migrant Health Conference. The MHP also supports local and national partners as well as selected MCHWs to participate in conferences and various formal/informal forums about legal and policy issues. In addition, the Program provides opportunities to government counterparts at the central and local levels to encourage increased exposure to current migration and migrant health issues and services through field exchange visits, learning by doing, and cross fertilization workshops among MHP teams from different districts and provinces. Consequently, public health personnel have an increased understanding about international migration and migration health, and are more familiar with responding to migrant populations.

Why a service for migrants?

“When IOM and MOPH staff from Bangkok first approached us, I told them that I wasn't interested. Why we need to get out of our ways to take care of illegal migrants while we are already so stretched? But little by little, we have learned to realize the importance of international health and glad that our province has an opportunity to be a part of the Program.”

Ms. Ratchanee Buranakitpaiboon
Policy and Planning Officer
Chiang Rai Provincial Health Office

Key Result 1.2 Migrant communities

Embedded into the government public health structure, the MHP is the first program in Thailand to establish networks of paid, full-time MCHWs who serve as interlockers between target migrants/communities and government health systems. The MHP and partners developed a standard training curriculum and also assist government health personnel to supervise and provide ongoing training for MCHWs. Trained MCHWs have been supporting public health personnel in the provision of culturally appropriate health services to migrants of diverse background and ethnicities in the five target provinces.

One-hundred and eleven (111) MCHWs with limited educational background and health experience have been engaged within the public health system. Many are primary school graduates who have been given the opportunity

to increase their skills to support their communities to recognize health issues and access appropriate healthcare. In addition to quarterly training on various public health topics, healthcare providers also provide daily on-the-job training and mentoring to MCHWs. MCHWs report that the MHP mentoring system is very useful as it equips them with greater skills and confidence to provide support and services to their peers rather than just receiving

Migrant Community Health Workers are crucial.

“Migrant Community Health Workers are crucial to migrant health services. With support from IOM, our hospital hires 11 Migrant Community Health Workers to assist our staff at the out-patient and inpatient units and at the Community Medicine Unit for community outreach... besides taking care of migrant patients, the translation service they provide helps relieve stress due to communication barriers among our staff and this also helps improve the effectiveness of our services.”

Dr. Molee Wanichsuwan
Deputy Director
Samutsakorn General Hospital

formal training alone. Many MCHWs apply participatory approaches to empower target migrants and communities to take charge of their communities’ own health prevention strategies. They also develop and strengthen their presentation skills in order to lead group discussions, present their work and express their opinion to the public. This is evident at national level presentations to the National Migrant Health Conference hosted by the MOPH and co-organized by IOM and key NGOs working with migrants including the Program for Appropriate Technology in Health (PATH), International Rescue Committee (IRC), Medicin Sans Frontier (MSF), World Vision Foundation of Thailand and Raks Thai Foundation.

Although MCHWs are key drivers behind increased access to health services, there were initial challenges to achieving this result. In the preliminary phase of the Program, MCHWs found it difficult to gain the trust of their communities even though they were recruited from the same target communities. This is because some migrants had been arrested by local authorities after receiving services from the MHP team, and therefore, it was believed the MHP were linked to authorities. The distrust was also accompanied by the fact that services were provided by new teams who did not previously exist and the view of the community that MCHWs did not have adequate knowledge and skills to provide services. It took time and effort to develop rapport within migrant communities and to have their skills and roles recognized as MCHWs. Many migrants were more willing to utilize services towards the second year of Program implementation.

In addition to MCHWs, the MHP established networks of more than 1,300 MCHVs in each target province to support public health personnel and MCHWs with the provision of health services and health related information.

Table 3: Number of trained Migrant Community Health Workers and Migrant Community Health Volunteers by province

	Tak	Chiang Rai	Phang Nga	Ranong	Samut-sakorn	Total
Migrant Community Health Workers	22	32	13	28	16	111
Migrant Community Health Volunteers	483	429	60	250	99	1,321

Source : MOPH-IOM Migrant Health Program Record



A series of training for Migrant Community Health Workers
 (Clockwise from upper left: emergency child delivery; facilitation and presentation skills;
 IEC material development; teamwork skills)



Ready to take off: each trained Migrant Community Health Worker
 is equipped with a first aid kit and household medicines

Strategy 2 : Increasing access to migrant-friendly public health services among migrants

According to the results of external evaluation, the Program successfully provides a comprehensive health service, both in terms of health issues as well as a continuum of prevention, care, support and treatment. The Program also expands beyond national standards and targets, for example, advocating the provision of basic essential vaccines to migrant children aged below 15 years old instead of the national standard age of up to five years. Although Program service records show an increasing trend of service provision to migrants, it is very difficult for the Program to analyze service coverage since target migrants are highly mobile and it is, therefore, challenging to obtain an overall denominator of coverage. An exception is witnessed in Mae Fah Luang District of Chiang Rai Province where target populations are stateless indigenous persons from diverse ethnic highland groups. These

population groups are more static and less mobile and, therefore, it is feasible for the team to calculate service coverage. However, to subsidize the limitation on population data, the MHP managed to conduct “enhanced” KAP surveys during the final Program evaluation to estimate Program reach⁸.

Evaluation results also demonstrate that the MHP can reach a large proportion of undocumented migrants who are not eligible for government health coverage. Due to limited funding, there were occasions where the MHP could not provide sufficient medicine to target populations. However, target migrants have expressed an understanding about the limitation and still communicate satisfaction with the services they receive from the Program. With effective and culturally acceptable referral mechanisms - whereby MCHWs are recognized by public healthcare providers, speak Thai and migrant languages, and can support/accompany migrant patients to the health facilities as required - clients report being very satisfied with services and willing to pay healthcare costs to receive effective diagnosis and treatment.

As mentioned earlier, the MHP is highly operational in nature and involves a broad range of health services according to the principles of the primary health care system. The Program’s service areas can be categorized into five areas and selected key results are as summarized below.

Key Result 2.1 Introduction to the concept of “migrant-friendly” health services

The MHP successfully introduced the concept of “migrant-friendly” health services in target areas. Ensuring the introduction and provision of a friendly service does not only improve access but also emphasises the importance of services that are appropriate and acceptable to target communities.

An example of this is demonstrated in the fact that all IEC materials produced by the MHP team are bilingual using Thai and the local languages in each target site. With technical support from IOM, local MHP teams including MCHWs received training on IEC material development. Following training sessions, each team locally developed materials and conducted pretests with target populations to ensure appropriateness prior to actual production. A majority of migrants have primary education or below and because there are more than 10 languages/dialects and a minimal understanding of Thai language, communication is a key barrier for both clients and service providers. Strategies to reach low-literacy audiences are adopted to ensure effectiveness. Such an approach demonstrates the Program’s transparency to local authorities as well as equity by communicating to both Thai and migrant populations whom can equally benefit from these materials. Furthermore, the MHP also adopts the MOPH’s Maternal and Child Health Handbook by revising, updating and reproducing it in bilingual format and distributing it to migrant mothers to record growth and vaccination schedules of their children. This demonstrates an inclusive approach that recognizes the rights of all children to health regardless of their legal status and the role of MCHWs in maintaining links between migrant families and the public health system.

⁸ As of June 2009, the survey results are being analyzed and will be published separately



Bilingual (Thai and migrant languages) IEC materials developed by Migrant Community Health Workers with technical support from public health officers and IOM



Bilingual signs at the public hospital



A Migrant Community Health Worker provides translation service at the public hospital.

In addition, as mentioned earlier, the provision of proactive health services through various forms of community outreach is a further means to ensure a migrant-friendly service.

The MHP operates a total of 10 community health posts in migrant-rich communities along the border provinces of Tak and Chiang Rai, as well as in the coastal province of Pang Nga. These community health posts are administered by qualified MCHWs who provide a front-line service to both Thais and migrants in the communities. Since these areas have several natural border crossing points, the MCHWs at the community health posts also help monitor the health situation and population mobility in catchment areas. They refer patients from these “buffer zones” to public health facilities and/or inform local health authorities should they suspect a case of emerging or re-emerging infectious disease. Local health authorities report this to facilitate a more timely and effective investigation of infectious disease outbreak and control. Furthermore, the community health posts work to strengthen rapport between migrant communities and the public health system itself.

In Ranong and Samutsakorn Provinces, 39 migrant health corners have been established at migrant workplaces. Seventeen (17) MCHWs and MCHVs in Ranong and Pang Nga Provinces offer a small corner of their accommodation to function as additional migrant health corners in their communities. Similar to the community health post, the MCHWs and MCHVs are able to provide basic health consultation and care to their neighborhood peers whenever necessary. Because of limited government budgets, basic medicines cannot be provided to migrant health corners once donor funding has ceased. However MCHWs can sustain some services for their peers, particularly services that do not involve money, for example, health IEC and referrals.

The MHP has encouraged greater capacity to deliver health services in diverse migrant languages and increased recognition at the district and provincial levels of government as demonstrated by the ongoing employment of 84 MCHWs despite the end of several donor funding agreements. This fact demonstrates an increased understanding and response from government agencies as evidenced by consistent and increasing rapport, collaboration, communication and cooperation throughout project implementation cycles. In addition, the MHP has promoted and provided over 200 government partners from health and non-health sectors to receive formal and informal training related to international migration, migrant rights and migrant health issues. These combined efforts have significantly raised the profile of basic human rights among both registered and unregistered migrants and the need to acknowledge migrants’ contribution to the overall benefit of Thailand. The MHP has worked consistently with numerous levels of government to introduce the concept of migrant-friendly health services in order to create greater acceptance of migrants as part of the extended Thai community.

Key Result 2.2 : Primary care and health IEC

Migrant-friendly primary care services and health IEC were effectively achieved in target areas despite the diversity of challenges across sites. As already identified in this document, each priority target province has a different set of circumstances that have effectively involved a different set of responses. An example of these differences is demonstrated by a diversity of employment characteristics. Chiang Rai province is a good example of different circumstances facing migrants in each district of the province. For example, Muang District attracts workers in manufacturing and construction, Mae Sai attracts work in manufacturing and agriculture, Chiang Saen in the tobacco factory and entertainment sector, and Mae Fah Luang District mostly has more of a fixed population of unregistered hill tribe persons who are employed in agriculture. The Chiang Rai example is quite different to other provinces which attract more seasonal workers who are more likely to return to their native communities or to other work elsewhere in the Kingdom. These factors are important to consider when presenting key results for primary care and health IEC as they reflect two key challenges; one is the difficulty with actually pinpointing results

in mobile populations and in particular in relation to the provision of an effective and acceptable primary care service, and the other is the need for different health IEC strategies to reach migrant population groups across the provinces.

Reach of IEC to One-one and Small Group Discussions, and Large Scale Campaigns

Community mapping exercises in each province facilitated greater reach to target population groups as evidenced by the fact that over 55,000 migrants were reached annually for health awareness raising and education via one-one and small group discussions. An increased awareness about specific health issues, knowledge and preventative health practices among target populations is demonstrated by results of several KAP (knowledge, attitude, and practice) surveys conducted in each province. These results are attributed to effective communication between communities and MCHWs and MCHVs in addition to the bi-lingual IEC materials distributed to over 90,000 migrants across all provinces. A good example of innovative communication solutions was observed in Ranong Province. The MCHWs developed and delivered a bilingual puppet show to raise awareness about specific health issues and concerns with an evidently successful response of over 50,000 participants over three years. This communication approach used dramatization to convey health messages and learning via entertainment, and has been an effective and popular strategy to internalize and disseminate from person to person in an alternative way that attracts significant attention as demonstrated by the number of participants. Another example of innovative communication techniques is the application of animated cartoons and cartoon books as means for health IEC among migrants, as was found in the results of several surveys conducted by the MHP.



Migrant children enjoy reading a comic book on avian and human influenza prevention (left) and a health exhibition in the community (right).



Migrant Community Health Workers use puppet shows as a means to deliver health IEC to migrants.



Animated cartoon about HIV and safe mobility produced with inputs from migrants

Reach of Primary Care

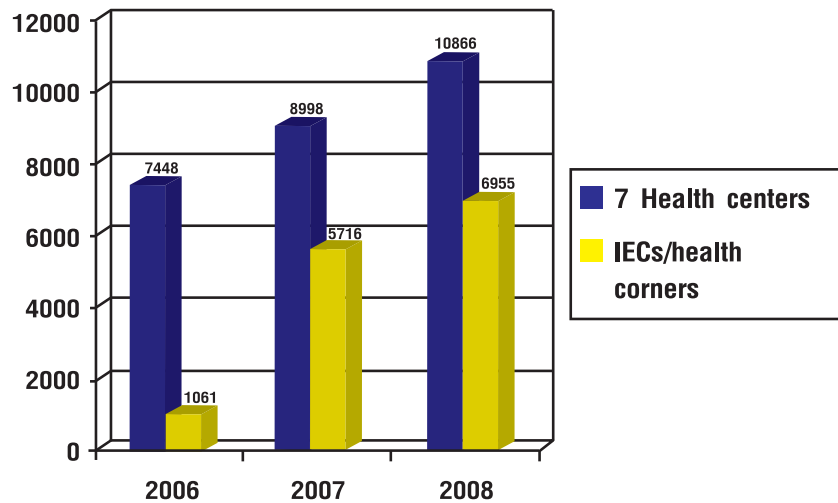
As already identified, the reach of primary care via community outreach of mobile clinics, home visits, health promotion, and health IEC campaigns is difficult to refine due to mobile populations and their constant movement throughout the Kingdom and across borders. However, there are other examples of the physical impact of the MHP which can identify the reach of the Program. In the remote location target communities, a relatively large population and a limited number of public healthcare providers at Public Health Centers in catchment areas, resulted in an innovative response from the team at Mae Fah Luang District. In order to leverage limited human resources, they maximized the impact of their mobile clinic service by pooling two or three staff from each Public Health Center to deliver mobile clinic services to different communities on a quarterly basis. In communities with large numbers of target populations, the team stayed overnight to ensure coverage of most, if not all of the individuals requiring services. They also used the opportunity to raise dialogue with various population groups in the community such as youth, women, and aging persons to highlight their specific health needs. In addition, since there are over 10 ethnic population groups in Mae Fah Luang, the team often required three to four interpreters in order to ensure they understood individual patients. Accordingly, school students were invited to assist the mobile clinic team by supporting patients with appropriate translation to public healthcare providers. This is a further example of valuable and collaborative community participation.

Table 4: Number of mobile clinics conducted in four target districts of Chiang Rai Province 2004-2006

Muang District		Chiang Saen District		Mae Sai District		Mae Fah Luang District		Total	
No. of clinic session	No. of clients	No. of clinic session	No. of clients	No. of clinic session	No. of clients	No. of clinic session	No. of clients	No. of clinic session	No. of clients
128	5,577	113	3,184	131	10,195	145	11,255	517	30,211

Source : MOPH-IOM Migrant Health Program Record

Figure 6 : Number of migrants who received health information and services from the MHP affiliated public health centers and migrant health/IEC corners in Ranong



Source : MOPH-IOM Migrant Health Program Record

Health Services Responding to Specific Local Context, Needs and National Policy

The MHP has also been able to respond to isolated issues impacting on migrant communities. In Mae Sot District of Tak Province, an average of 300 adults and children, male and female undocumented migrants and dependents are being deported back to Myanmar on a daily basis. It is very likely that sooner or later, most if not all of these deported migrants will return to Thailand to seek jobs and a better livelihood. Since the beginning of 2007, the MHP has been collaborating with Mae Sot Immigration Office to establish a health IEC corner at the Immigration Detention Center (IDC), where MCHWs provide health education and IEC materials on various relevant health topics to the detainees awaiting the deportation process. As of December 2008, the MHP has provided health IEC to 35,469 migrant detainees at Mae Sot IDC.

In Ranong Province in 2008, the MHP, in consultation with Ranong Immigration Office, provided mental health and psychosocial support services to 64 smuggled Myanmar migrants who had been trapped and almost suffocated in a container. The MHP was able to initiate group counseling, mental health assessment and subsequently identify levels of Post-trauma Stress Syndrome (PTSD). This enabled a platform for advocacy to enable these migrants to access appropriate psychological/distress support services. Detainees reported being pleased to have an external person outside the IDC to whom they could express their fears, concerns and stress. The services continued on a regular basis for one month, until the migrants were repatriated back to their hometowns, with support from IOM Mission and the World Vision Foundation in Myanmar.

Another example of incidental health campaigns in response to an ad hoc mobilization of migrant populations is the extension of the National Hypertension Prevention Campaign Day to include migrants in Samutsakorn. The MOPH launched the campaign throughout Thailand in 2007. The MHP helped to extend this campaign in Samutsakorn reaching up to 2,000 migrant workers who agreed to have their blood pressure measured. This is a further positive angle to the ongoing presence of the MHP, MCHWs and their role in linking migrant communities, both registered and unregistered, to Thailand’s national public health campaigns.

In addition, the MHP teams in all target sites extended national immunization campaigns, particularly on the National Polio Eradication Day, to all migrant children identified during the campaign period in catchment areas (see more details below).

Key Result 2.3: Reproductive health including maternal and child health

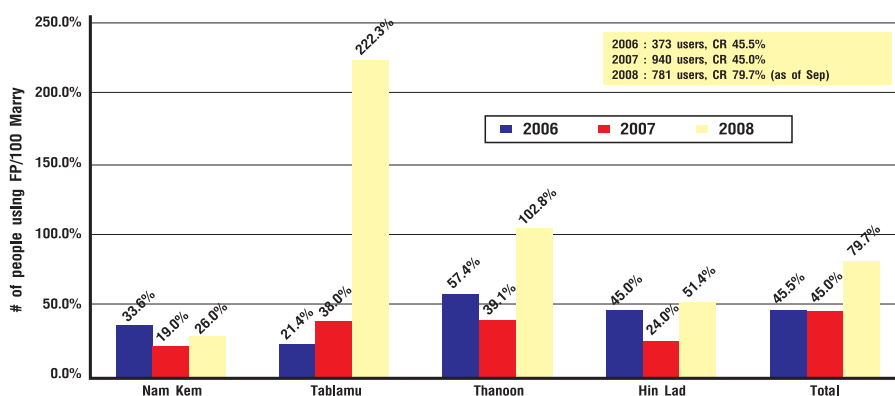
Women of reproductive age (15-44 years old) make up a large proportion of migrants and dependents of male migrant workers. They often experience difficulties with travel when accessing appropriate healthcare [5] due to non-cooperative employers or heightened risk of arrest and deportation. Furthermore, migrant women are more likely to be undocumented than migrant men [6] increasing their vulnerability to authorities. Many migrant women of reproductive age have had a general lack of access to reproductive healthcare and information on sexually-transmitted infections. [5]

A key factor driving success in relation to reproductive health rests on the continuing service systems and coordination between hospital and health centre networks, home visits and case follow-up activity by MCHWs/MCHVs. National Sentinel Surveillance targets currently focus on female sex workers and HIV positive women who are undertaking antenatal care. The MHP assists public health authorities to conduct annual surveillance surveys involving migrants, and ensuring appropriate referrals are made for respondents in these target population groups. MCHWs are a pivotal link that bridge issues of access, fear and misunderstanding between migrant communities and the public health system.

Increase in Contraception

The MHP helped to increase contraceptive use amongst female migrants of reproductive age who had been living with a partner in the target areas for over six months. Contraceptive rates increased from 59% to 77% in Tak Province and 31% to 54% in Chiang Rai Province. Ranong identified over 100% coverage amongst women in the target group of reproductive age with the coverage increasing from 95% in 2006 to 244% in 2008, demonstrating how the MHP benefits both host and migrant communities. Phang Nga reported an increase in contraceptive use as demonstrated in the table below. The preferred contraceptive choice across MHP sites was contraceptive injection followed by birth control pills and condoms.

Figure 7: Contraceptive rates among married female migrants in 4 target areas of Phang Nga Province, 2006-2008



Source : MOPH-IOM Migrant Health Program Record

Note that the MHP team in Chiang Rai Province also regularly collaborates with the Planned Parenthood Association of Thailand to provide contraceptive implants to migrant women due to the lack of qualified personnel in the public sector.



Migrant Community Health Worker teaches females about the use of the contraceptive pill.



Contraceptive implant (Norplant) is gaining popularity among female migrants.

Increase in Perinatal Care

Trends across MHP sites indicate an overall increase in **antenatal care** from 497 to 1,515 migrant cases in Chiang Rai Province; 5,021 to 5,799 in Ranong Province; 199 to 367 in Tak Province, and Samutsakorn as demonstrated in Table 5 below:

The MHP aimed to support an overall increase in the number of **births attended by a trained professional**, particularly government health staff. Trends reported across Program sites indicated that pregnant women were gradually favoring assisted delivery by government health staff or Trained Birth Assistants. This is demonstrated by the table below.

Table 5 : Perinatal care services provided to migrant women by the MHP in Samutsakorn Province, 2006-2008

Type of Service / Year	2006	2007	2008
Antenatal cases / visits	2,482 / 5,122	2,870 / 3,269	2,831 / 4,785
Total delivery	745	883	812
- Delivery by trained professionals	734	883	737
- Delivery by traditional birth attendants	Data not available	Data not available	177
Postnatal cases (2 times)	157 (21%)*	288 (33%)*	529 (65%)*

Source : MOPH-IOM Migrant Health Program Record

Note : * Number of migrant mothers who received postnatal follow-up / number of delivery

Due to complexities closely linked to the frequent mobility of migrant populations, ongoing **postnatal care** was a greater challenge to the MHP. This is demonstrated above in Table 5, whereby follow up of postnatal care was a greater challenge compared to antenatal cases and total public health supported deliveries. Similarly in Chiang Rai and Tak Provinces, loss to follow up, as reported in the project evaluation was commonly due to migrants relocating to original birth countries or further migrating for work in other provinces. Some areas of Chiang Rai Province reported a consistently high coverage (80-100%) of postnatal care, which is reflective of some of these districts comprising indigenous populations who are less likely to move around for employment. Ranong province reported a slight increase of postnatal care cases from 241 to 317 over the project period. When compared with the number of migrant children delivered at the hospital or by traditional birth attendants (208 and 277 cases on average) this may reflect the success of MCHWs maintaining strong links between their communities and postnatal care services.

The MHP teams conduct regular child growth monitoring and underweight children are referred to local NGOs to receive supplementary foods.



A migrant girl shows her maternal and child health handbook originally developed by the MOPH for Thai children and reproduced in bilingual (Thai and migrant languages) by the Migrant Health Program for use with migrant children.



A home visit for postnatal and child care by a public health nurse and a Migrant Community Health Worker



Migrant Community Health Workers conduct child growth monitoring at the community health post (left) and in the community.

Increase in Vaccination

The MHP assisted with an increase in child vaccination from 941 to 1,410 in Pang Nga Province; 1,060 to 1,700 in Ranong Province; and 34 to 399 in Samutsakorn Province over the course of the projects. BCG vaccinations at birth increased among infants born in all target sites with some districts reporting increases as high as 99%, clearly a result of the increased delivery by trained professionals at public health facilities. In Samutsakorn Province, new parents advised that they often send their babies back to Myanmar between 1-10 months of age and then the child usually returns to them in Thailand at age three years or older. This identifies challenges to ensuring that migrant newborns and children receive their full essential basic vaccinations.

As mentioned earlier, the MHP teams extend immunization campaigns, particularly on annual National Polio Eradication Day, to all migrant children in target areas. The MHP's Polio Campaign in Phang Nga Province had a good response among 0-15 year old migrant children, reporting an increase from 74% to 92% coverage in target populations over the project period. Similarly, in Samutsakorn Province, the same campaign for the period of December 2007 - January 2008 achieved 98% (1,621) of total migrant children surveyed in target areas right before the launch of the campaign, with an additional response from parents of local Thai children (217). Ranong MHP undertook the campaign among Thai and migrant children reaching 89% and 97% between 2006 and 2007.



Migrant Community Health Workers conduct Polio Eradication Campaign among migrant children.



Over 300 migrant children who live along the border queue for vaccinations.



A public health nurse provides vaccination to migrant children.

Key Result 2.4 : Communicable disease control and prevention

Another key health concern of the MHP among migrants is communicable disease control and prevention, particularly Acute and Severe Diarrhea, Malaria, Tuberculosis and Dengue Hemorrhagic Fever all of which are common across all target sites as shown in Table 6. Emerging infectious diseases such as Avian and Novel Human Influenza are also of concern since many migrants raise backyard poultry in somewhat unhygienic conditions for their own food security and/or work/live in substandard livestock farms and slaughterhouses. The MHP has worked to focus on strengthening referral networks and developing a system that is able to respond to key communicable diseases across districts. However, all communicable disease control and prevention approaches are localized according to local endemic and outbreak circumstances; and therefore, it is difficult to obtain a complete data set to present as key results across target sites.

Table 6 : Top three infectious diseases reported among migrants in the target provinces

Tak (2004-2006)	Chiang Rai (2004-2006)	Ranong (2006-2008)	Samutsakorn (2006-2008)	Phang Nga (2003-2007)
Acute and Severe Diarrhea	Upper Respiratory Tract Infections	Malaria	Acute and Severe Diarrhea	Malaria
Tuberculosis	Hypertension	Acute and Severe Diarrhea	Dengue Hemorrhagic Fever	Acute and Severe Diarrhea
Dengue Hemorrhagic Fever	Acute and Severe Diarrhea	HIV/AIDS and Pneumonia	Tuberculosis	Food Poisoning

Source : Provincial Health Offices, MOPH

The MHP team is in a position to regularly monitor target communities and provide an efficient and effective response including diagnosis and treatment of patients where possible. The integration of MCHWs to District/ Provincial Surveillance and Rapid Response Teams (SRRT) is an example of a good practice of the MHP. Thailand often experiences communicable disease outbreaks such as Cholera and Dengue Hemorrhagic Fever, impacting on thousands of migrants in several provinces. This has resulted in local health authorities engaging MCHWs to assist in outbreak investigation and control. MCHWs supported government SRRT with translation services during the case tracing interviews; investigation measures such as rectal swab samples in suspected Cholera cases; and conducting awareness raising campaigns to migrant communities. Tak and Ranong were the first provinces to introduce this approach. They consider that MCHWs were an essential element to the efforts of the local SRRT. Samutsakorn Provincial Health Office adopted the same approach and declared all credit to MCHWs for the timely halt of the 2007 Cholera outbreak (within one week of the outbreak).

The 2007 event was used as an agency to raise awareness and prevent further transmission. MCHWs intensified health education efforts on Cholera, Diarrhea and sanitizing strategies whereby over 150 lavatories were chlorinated and over 4,000 migrants responded to health education sessions split into three groups according to

language. This incidental reaction strategy resulted in a total response of 7,559 migrants being reached across seven related health topics.

MCHWs and MCHVs play an essential role in communicable disease control and prevention in that they also make the necessary links and referrals to appropriate health facilities or NGOs. This works toward greater collaboration with NGOs and is a further example of good practices developed throughout the MHP. An example of this is evident within MHP teams in Ranong and Samutsakorn Provinces who exclude HIV/AIDS and Tuberculosis from their service coverage but rather refer migrant cases to NGOs working specifically on these issues in the same target communities with support from the Global Fund to Fight AIDS, Tuberculosis and Malaria. In line with the MOPH's policy to identify Tuberculosis cases among migrants in Thailand, in June 2009, the MHP in Samutsakorn Province undertook a campaign to screen for Tuberculosis in 28 factories using a mobile x-ray machine. Of the 4,001 labour migrants who were screened, 52 (0.01%) abnormal chest x-rays were detected and the suspected cases were subsequently referred to nearby public health facilities for further investigation and diagnosis. The confirmed Tuberculosis cases will receive treatment according to national protocols⁹.

Elemental to the success of referral networks is the ongoing role of MCHWs and/or MCHVs who play a key role in following up patients in their communities to ensure treatment adherence as well as controlling the further spread of disease. MCHWs across sites reported an increased response to screening campaigns as identified in the MHP by an external evaluation team.



A mobile malaria clinic



Filariasis screening in migrant community

Key Result 2.5 : Environmental health and community sanitation

The Program piloted solid waste disposal, safe water access, and increasing latrine coverage across sites. Many migrants in pilot areas reported being satisfied with MHP support to communities to jointly install slow-sand water filters, latrines and the distribution of rubbish disposal bins. This support not only assists with improving community hygiene and sanitation, an increased number of latrines near their homes has enabled migrants in some provinces a greater sense of security and safety when using them during the evening and late at night. Migrants also reported an appreciation of MHP support to improve their knowledge about the practical use of such equipment/materials and the links to preventing infectious diseases.

⁹ As of the time of this report finalization, the number of confirmed Tuberculosis cases is not yet available

External evaluation of the Program in Chiang Rai and Tak Provinces identified that all districts had conducted more environmental health related activities than anticipated; numbering four campaigns per district per year. Ranong and Phang Nga Provinces similarly conducted over 150 environmental health campaigns. These campaigns included developing regular practice of appropriate solid waste disposal and strengthening this practice by supplying and distributing over 1,000 garbage bins and installing 12 incinerators in all target provinces. In addition, there were over 1,000 well upkeep and water filter education campaigns implemented to develop sustainable and hygienic water practices.

Tak Province prioritized improving and/or introducing latrine practice. As identified earlier, the MHP in Tak targets migrants and host communities in four very different environmental contexts namely; municipal, industrial, rural and remote environments hosting migrants with different experiences and practices in relation to hygienic waste disposal. Migrants in rural and remote areas of Tak Province were found to be lacking general basic latrine hygiene and the MHP assisted with over 526 toilets being built and much education conducted specifically targeting an increased awareness about hygiene practice. Employers and home owners were initially obstructive/non compliant with building latrines, however, their acceptance levels improved over time once they had processed information and health education about the consequences of not practicing appropriate latrine/toilet hygiene.

The impacts of MCHWs and MCHVs on environmental health and community sanitation are far reaching with longstanding benefits that are not always neatly numerically quantifiable. The ongoing presence of MCHWs and MCHVs works to ensure that environmental health and community sanitation standards are maintained and to monitor that migrants are living or striving to live in environments where they are familiar with the techniques and prevention practices that reduce communicable diseases and improve their overall health and wellbeing.

Foggy spray and ABATE Sand were consistent strategies in Chiang Rai Province, with a total of 94 occasions of foggy spray in 111 communities to control mosquitoes during high Dengue Hemorrhagic Fever and Malaria seasons. ABATE Sand to control mosquito larvae took place in 178 communities in Chiang Rai. Samutsakorn Province prioritized ABATE Sand and mosquito larvae surveys reaching 7,221 migrants' living quarters within the target area. This activity complemented health promotion and education campaigns conducted on vector-borne disease control.



Migrant Community Health Workers conduct vector control activities.



Examples of a slow-sand water filter (left) and a community incinerator (right)

Strategy 3 : Development of sustainable and replicable migrant health program models

It was agreed at the beginning of the MOPH-IOM collaboration that the MHP should document its good practices with an aim to develop sustainable and replicable models for migrant health programming in Thailand. By working towards achieving the Program goal to improve the health condition of migrants and their host communities, the MHP has attempted several approaches to deliver quality and accessible health services to target populations. Several brainstorming workshops, annual program reviews by MHP teams, individual interviews at central and local levels and external evaluation have been conducted to identify good practices and lessons learned from the Program, resulting in this MHP model document. The review and evaluation results identify the following strengths of the MHP which can be considered as key components to be replicated elsewhere.

1. **Program Structure** is appropriate because it is incorporated and well-embedded into the existing Thai public health system. The Program has both provincial and district level support as a key driving force for Program administration. All activities are implemented via government health providers with assistance from trained and qualified MCHWs/MCHVs. Central and local level health authorities have recommended that all organizations working on migrant health in Thailand adopt the MHP structure to their projects. This is primarily because the integration of Program activities into existing government structures encourages a relatively promising level of **sustainability** should donor funding come to an end. It also ensures that health authorities are more aware and informed of migrant health issues, and therefore, engaged to address the issues. After all, the health of all individuals in Thailand, regardless of their citizenship or ethnicity, remains the responsibility of the Thai government.
2. **Human Resources**, especially MCHWs and MCHVs, are key catalysts for improving the reach of the MHP to migrant communities. The mechanism of MCHWs/MCHVs not only helps to improve community participation with Program implementation but also empowers migrants to take charge of improving the health of their own community. MCHWs are able to reach out to migrant communities more efficiently than public health personnel and Thai Village Health Volunteers. Their networks with Thai Village Health Volunteers have been strengthened which allows the community to work in a more holistic approach rather than providing separate services for Thais and migrants living and working in the same community. This approach has also helped reduce conflict between migrants and Thais in host communities.

3. Co-management modality between IOM and the MOPH at central and local levels demonstrates a shared responsibility and accountability of the Program. Local health authorities and providers in all target provinces not only require financial support but more importantly human resources and technical assistance. The co-management of activities and budgets at all levels of IOM and MOPH, including migrant representatives in the form of MCHWs, can maximize **participatory** aspects of the Program and promote mutual understanding of Program objectives and expected results. Furthermore, honest discussions can take place about real needs and gaps and how to best maximize limited financial and human resources. This also helps to promote mutual partnership and ownership of the Program among public health personnel who all aim to sustain services after donor funding has ceased.

4. Program services that are **comprehensive** in terms of approach include both outreach and facility-based services and health service coverage across a whole continuum from disease prevention, health promotion, primary care and treatment and environmental sanitation; as well as the introduction of migrant community health posts and health corners to assist with improved access to public health services. The MOPH and local health authorities and providers have recommended that all organizations working on migrant health issues in Thailand adopt the MHP model for its comprehensive primary health care approach rather than a vertical project with focus on a specific disease. However, this may face challenges with obtaining donor supports due to a focus on selective health issues such as reproductive health, tuberculosis and HIV/AIDS. Delivering an integrated range of priority primary health care services through similar implementation mechanisms is not only for target populations, but also for **cost-effectiveness**. Higher degrees of mutual synergy are achieved when multiple health interventions address a comprehensive range of real needs among migrant communities, rather than implementing vertical interventions alone. The local health authorities and providers have also realized that a strong primary health care system is a good platform for other vertical programs. They tend to report higher success of vertical programs such as HIV/AIDS, tuberculosis and malaria with the existence of a migrant inclusive primary health care system.

5. Appropriate implementation sites were selected based on the size of migrant populations as well as evidence of previous major epidemics, particularly infectious diseases. The Provincial Health Office and public health facilities report that the Program enables them to dramatically reduce local health burdens. They were also able to leverage human and financial resources as well as fill the gaps in responding to migrant health issues.

6. Multi-sectoral collaboration with government and non-government as well as health and non-health organizations (see more details under Strategy 4 results below).

7. High level of participation among various stakeholders helps to improve mutual partnership and mutual ownership of the Program. Representatives from health offices and facilities as well as from target migrant communities in the form of MCHWs participate in the complete management cycle of the Program. They provide background information and input for new project development and planning, directly implement planned activities, and participate in joint review/evaluation of the Program with IOM and MOPH technical staff from Bangkok as well as with external evaluation teams.

Participation of Target Migrants

In Tak Province, the MHP encourages migrant mothers to bring their available ingredients from home to share with their peers and cook and feed their children together. Prior to cooking, mothers are educated about nutrition using the ingredients they bring and additional materials from the MHP, depending on what is lacking nutritionally. This method enables migrant mothers to improve their knowledge on child nutrition while children receive nutrients necessary for their growth.

8. Potential for sustainability is a unique outcome of the Program. To enable sustainability, the Program places a lot of emphasis on human capacity development, particularly on MCHWs, and the gradual transition of Program operations to local health authorities and facilities. Following two years of Program implementation, MCHWs obtain sufficient skills to take care of their communities and also to gain trust from both migrants and Thais in target communities. Many MCHWs express that they are willing to continue in a volunteer capacity to provide health services to their peers once Program funding has ceased.

Sustainability of Migrant Community Health Workers and Volunteers

The value of equipping Migrant Community Health Workers and Volunteers to work with the public health system is well recognized by health authorities and providers. Towards the end of the pilot phase of the MHP (2003-2008), several health authorities and facilities agreed to use their own budgets to maintain these workers and volunteers within the public health system. Through systematic integration, the sustainability of the MHP is further ensured.

During the course of Program implementation, the MHP organized regular coordination and team meetings at the district, provincial and national levels to share experiences and lessons learned with the specific aim to improve and promote systematic Program implementation. In addition, the Program employs Participatory Learning for Health Development and health IEC activities. These methods enhance participation among target migrants and enable change towards more positive health behaviors.

Sustainability of Migrant Community Health Posts

One community health post in Mae Fah Luang District of Chiang Rai Province is administered by a MCHW who is a Thai citizen from the same ethnic group of the target population. Two years after joining the MHP as a Migrant Community Health Worker, she is well recognized among villagers and was elected as a member of the government's Local Administrative Organization. Even though project funding support has ceased from the European Commission, she continues to volunteer to serve her community as a Migrant Community Health Worker.

The fact that the Program structure is embedded in government structures is another thing that ensures sustainability. Although the government cannot allocate a national budget for migrant healthcare, particularly to unregistered migrants, it is clear that local health authorities attempt to leverage limited government financial resources. This would maintain MCHWs as a minimum requirement to sustain the Program should external support cease. In addition, they also maintain selected services, particularly facility-based care since the government has limited budget for outreach activities. Although small in number¹⁰, this can be considered a positive impact of the MHP in terms of sustainability.

¹⁰To date 18 MHP's Migrant Community Health Workers are hired by the local health authorities and facilities of assist them with migrant health service.

9. Cost-effectiveness of the Program can support the Program's sustainability. Although difficult to prove with scientific backup since a cost-effective analysis has not been conducted, several mechanisms and approaches adopted by the MHP demonstrate a meaningful leverage of human and financial resources that can lower Program implementation costs. The mechanisms mostly include: multi-sectoral networks to avoid service duplication, establishing referral networks and conducting joint activities (see details in Strategy 4 results below); an embedded Program structure and implementation by existing public health personnel requiring a

Joint Implementation of Health Services for Thais and Migrants

In several Program sites, MHP teams incorporate MHP activities into activities planned for Thai citizens. Teams usually conduct joint campaigns for health prevention and promotion to both Thais and migrants in the same communities. This was particularly the case with issues affecting the community at large, such as child immunization and mosquito larvae control campaigns and World AIDS Day. During campaigns, public health staff and Thai Village Health Volunteers focus on providing health information and services to Thai citizens while Migrant Community Health Workers and Volunteers do the same to migrants. This helps reduce both human and financial resources as well as maximizing impacts of joint activities since it can ensure there are no geographical gaps. In addition, joint activities assist with promoting a harmonious coexistence of populations from diverse cultures.

much smaller budget than implementing parallel systems, particularly in relation to human resource budgets; joint implementation of MHP activities to include local Thai populations, especially for health prevention and promotion; and increased emphasis on early detection and effective responses to key infectious diseases as described earlier.

Although government budgets for healthcare are allocated based on the head count of registered populations, and are therefore required to be spent accordingly, the government budget for health prevention and promotion can be utilized for the overall health of the public. Therefore, local health authorities and care providers can provide drugs and other medical supplies as an in-kind contribution to the MHP's health prevention and promotion of migrants, while the MHP supports salaries for MCHWs who perform health investigation and follow-up cases for proper treatment at public health facilities. This method is evidence of how the MHP and government budgets were efficiently used to maximize results.

Strategy 4 : Strengthening collaboration among key stakeholders

Multi-sectoral collaboration throughout the Program period has improved the effectiveness of the Program. It is tradition for the MHP to conduct consultative meetings in each province with key stakeholders from all levels of various sectors prior to beginning a project.

Collaboration assists with reducing a duplication of services when there is more than one agency working in a target area, enhancing a coordinated and collective response, and leveraging limited resources as mentioned earlier. For example, MHP teams do not provide certain health services to target communities when issues are already addressed by NGO(s) working in the same areas. On the other hand, where there is a need for the MHP to implement similar health activities to other organizations, different sub-populations are targeted to avoid duplication while attempting to fill the gaps and ensure complementary efforts. However, this approach can only

be applied when the Program implements a comprehensive health service like MHP whereby selected health issues can be prioritized according to the real needs of each setting. Regular partner meetings are also conducted among government and non-government partners to ensure better coordination and leverage of limited resources. When organizing MCHW training workshops, the MHP teams invite NGO staff working in the same target communities to participate in the training. Some IEC materials are also shared among network organizations to maximize resources. Referral mechanisms among government and non-government services are also enhanced through this strategy. Because the majority of migrants are unregistered, health staff try to coordinate with local authorities to concede regulation for patients, particularly during emergency cases. The Program review and evaluation reported that partner and network agencies work very well together through both formal and informal coordination mechanisms.

In addition, the project provides opportunity for cross-fertilization which allows stakeholders from different geographical environments and various sectors at both central and peripheral levels to exchange experiences and lessons learned. This kind of peer-peer discussion and learning can help to strengthen multi-sectoral collaboration and coordination, in addition to sensitizing and improving attitudes toward migrants among government care providers.



Military assists the MHP to provide polio vaccines to migrant children.



Thais and migrants in the target community build toilets with equipment and materials supported by the MHP.

Strategy 5 : Facilitating the development and supporting the implementation of positive migrant health policies

In terms of policy advocacy and implementation, the MHP works on all dimensions: top-down, horizontal and bottom-up. Periodic joint field monitoring visits by technical staff from IOM and the MOPH in Bangkok provide new policies and guidance as well as reiterate and refresh existing policies and guidance to MHP teams at the field level. The MHP teams also attempt to analyze existing policies to see whether government and other budgets can be allocated for migrant health activities as described above. The MHP teams also advocate and provide input on migrant health issues to central level MOPH by addressing service gaps and constraints due to insufficient policies. Various forums are organized and/or co-organized by the MHP such as the annual Joint Technical Team Meeting and the National Migrant Health Conference as part of the advocacy process. In addition, IOM technical staff provide technical input through participation as speakers and/or commentators in several national and international forums related to advocacy around migrant inclusive health policies. The MOPH’s Migrant Health Strategy

mentioned earlier was in fact drafted and based on the considerable experiences and lessons learned from the MHP.

Strategy 6 : Strengthening community preparedness and response to potential disaster and/or disease pandemic

Key Result 6.1 Humanitarian response for Tsunami relief

IOM's established rapport with the MOPH enabled the MPH to be in a good position to immediately respond to Tsunami affected migrant communities in Ranong, Phang Nga and Phuket Provinces. IOM assisted in the response by conducting a rapid assessment of the affected areas of Thailand following the Andaman Sea Tsunami in 2004. Some 7,000 migrants were reported to be affected by the Tsunami. Given that the majority of relief assistance prioritized Thai nationals and foreign tourists, migrants were inevitably excluded and, therefore, highly vulnerable to poor health and well-being. The MHP mobilized resources from donors and IOM to provide humanitarian emergency relief services to affected migrants and Thai host communities. The immediate response of the MHP was to procure and distribute humanitarian relief packages that were donated to the project by the Thai Ministry of Foreign affairs, the Irish Government, the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and WHO. Over 4,000 packs of essential items were distributed to migrants in Ranong, Phang Nga and Phuket Provinces. Each pack contained essential items such as clothing, mosquito nets and sanitary items. Six-hundred (600) charcoal water filters and 1,050 water containers were distributed in Phang Nga and Phuket Provinces.



The MHP distributes basic essential items to Tsunami affected migrants and families.



A migrant girl helps prepare a bag containing basic essential items for distribution to migrants.

Key Result 6.2 Tsunami disaster victim identification

Following the 2004 Tsunami, IOM took steps to collaborate with MOL, MOPH and the Royal Thai Police in mapping lost migrants, collecting identification information and remains including for Deoxyribonucleic Acid (DNA) testing. One-hundred and fifty (150) migrant families were supported by the MHP to process their petition to identify and claim the bodies of relatives under the Thailand Tsunami Victim Identification (TTVI) operation initiated by the Royal Thai Government. This was achieved by assisting the TTVI's Information Management Centre of the Royal Thai Police by facilitating migrant related information. A total of 264 family petitions were processed and assisted to claim and identify victims. One-hundred and fourteen (114) cases were identified through DNA and

other identification information matching by the authorities, and the MHP successfully advocated and facilitated on behalf of families and employers to have their remains released. Assistance was provided to 58 families and employers to enable them to farewell loved ones via cremation ceremonies. Collaboration between IOM and the Thai Action Committee for Democracy in Burma assisted migrants and employers with releasing the remains of an additional 70 cases. These efforts reflect the capacity and rapport of the MHP and, in particular, that of MCHWs who are essential links to extended migrant communities. Without these key community links, it is unlikely that migrant communities would be afforded the same attention during such a disaster due to their almost invisible presence and marginalized positions. In addition, the MHP worked in close collaboration with NGOs to assist 14 migrants to file government compensation claims for registered family members who died during the Tsunami.



The MHP assists the Royal Thai Government to conduct community mapping and collect identification information including DNA samples (top) for Tsunami affected migrants as well as to facilitate information matching and the release of remains to migrant families (bottom).



Key Result 6.3 Disaster and pandemic preparedness

In addition to the Tsunami relief, the MHP conducted follow-up activities for disaster preparedness in the target areas. Two-thousand (2,000) books and 3,000 calendars were developed and disseminated in Thai and Burmese raising awareness on Tsunami warning signs. Over 1,500 self-powered radio sets were distributed to enable communication regarding Tsunami alerts in the region and appropriate training was provided to accompany the supplies. Three-thousand (3,000) disaster wheels were distributed; clearly identifying in a graphical manner the variety of natural disasters that require certain responses. Furthermore, 1,000 migrants in Phang Nga Province took part in early warning disaster evacuation drills delivered by IOM in collaboration with the Thai Department of Disaster Preparedness and Mitigation and the German Technical Cooperation Agency.



A drill exercise for Tsunami disaster preparedness conducted among Thais and migrants

IOM's experience working with undocumented migrants and familiarity with the health related consequences of migration has effectively worked to assist the MHP to advocate for a multi-sectoral pandemic preparedness that specifically identifies and isolates the needs and appropriate strategies of migrants at local and provincial levels. Although an ongoing interactive process, IOM has taken steps to ensure maintenance of essential functions to enable continuity of livelihoods, security, governance and economic systems in the event of a pandemic. To date, key results of disaster and pandemic preparedness can be summarized as follows.

One-thousand, two-hundred and fifty-eight (1,258) migrants were reached via AHI information campaigns in Chiang Rai Province. Up to 5,079 migrants, students and host communities were also reached through AHI prevention and control activities in Tak Province. Three-thousand (3,000) multi-lingual leaflets and posters on AHI prevention were designed by MCHWs and distributed amongst different population groups in target communities. Weekly radio broadcasting was conducted in Chiang Rai Province, addressing a variety of AHI related topics including a quiz with prizes, with an average of 10-20 callers per week. This strategy demonstrated an effective avenue to reach remote areas.

Since 2007, a pandemic contingency plan has been developed by the MHP in Chiang Rai, in collaboration with over 100 representatives across 45 organizations from health and non-health sectors, public and private sectors, as well as community leaders and representatives including Thai Village Health Volunteers and MCHWs. The plan aims to facilitate an efficient, migrant inclusive multi-sectoral response and preparedness in the case of a pandemic. Technical staff from IOM have been providing assistance to the team in facilitating a series of workshops to develop the plan, as well as in facilitating a series of simulation exercises including a full-scale exercise to both test and update the plan. The Pandemic Preparedness activity in Chiang Rai Province was the first of its kind in Thailand, and perhaps across the globe. These activities not only reflect the flexibility of the MHP to address emerging health issues, but also the innovative approach of the MHP and its unique capacity to use good rapport and relationships built with multi-sectoral agencies to the benefit of the community and nation in general.



The MHP in Chiang Rai assists 45 health/non-health and public/private organizations to conduct a simulation exercise for pandemic influenza preparedness (Clockwise from upper left: the war room commands the actions; a military officer restricts border crossing and brings travelers to the health screening unit; health screening at the border health control unit; the surveillance and rapid response team conducts disease outbreak investigation; a livestock officer disinfects the community outbreak).



VI. Challenges and Lessons Learned

As described earlier, the MHP has experienced great results. However, as a very first program of its kind in Thailand, the Program has learnt lessons and experienced challenges that need to be further addressed. The key challenges of the Program were observed at both policy and implementation levels.

Policy and Implementation at the National Level

Despite a necessity to fill labour force gaps, particularly within unskilled labour sectors, Thailand continues to lack a clear, long-term government policy related to the management of labour migrants from neighboring countries and beyond. Several interim cabinet resolutions have been recurrently launched on an impromptu basis, however, this approach has no long-term benefits. The first resolution announced in the mid 1990's permitted labour migrants, already illegally working in Thailand, to register with the government, allowing them to work in specific business sectors for a limited period of time. The subsequent resolutions were launched every one to two years with different variations, mostly in relation to the type of business and the physical location in which migrants were allowed to work. Regardless of several government attempts to improve migrant labour management, the impromptu policy remains unstable. This is reflected in the total number of government registered migrants over several registration rounds which have been insignificant compared to the estimated number of migrants and dependents who actually live and work in Thailand. As of 2008, there were some 500,000 registered labour migrants with official government work permits, however, it is generally accepted that there is somewhere between 2-2.5 million migrants and dependents currently working and living in all 76 provinces of Thailand. [7]

According to migrant registration procedures, migrants first have to register themselves with the Ministry of Interior to obtain a household registration and identification number. Once registered with the Ministry of Interior, they are eligible to apply for a work permit from the Ministry of Labour and Social Welfare. In order to receive a work permit, they must undergo a medical examination and submit a MOPH issued certificate to identify that they are fit to work and have joined the MOPH Compulsory Migrant Health Insurance Scheme. Unregistered migrants and dependents are not eligible to receive public health care according to the National Universal Health Coverage Policy, and theoretically, have to pay out of their pocket for health service fees.

As described above, the migrant health policy is interlinked to an overall migrant labour management policy, and for this reason it has always been difficult for the MOPH to effectively manage migrant health issues. Examples of key restrictions to managing migrant health issues which are directly related to a lack of appropriate policy are listed below.

1) Limited human and financial resources at all levels of the MOPH

As mentioned earlier, there are approximately two million unregistered migrants who in theory are not eligible to receive public health services, and accordingly there is no government budget allocated for these populations. However, considering that health is a basic human right, the MOPH inherently provides health services to unregistered migrants, inevitably resulting in shouldering a large proportion of the healthcare costs incurred¹¹.

¹¹For more information, please refer to IOM/MOPH/WHO joint publication entitled "Financing Healthcare for Migrant : A case study from Thailand" published in 2009.

This is the case for individuals who are ineligible according to policy but who have a right to receive immediate care on a humanitarian basis. Furthermore, given that some diseases, especially infectious diseases, affect the health of a whole society it is clear they need to be addressed regardless of a patient's eligibility. In addition, the MOPH's human resources do not actually meet the additional workload, particularly at the central level and in migrant-populated provinces.

This compels public health authorities and facilities, particularly in migrant-rich communities, to take their own financial and legal risks to provide services to unregistered migrants. Some local health authorities and facilities have tried their best to leverage the limited resources available to provide basic essential health services, especially for health prevention and promotion to both registered and unregistered populations. However, some basic essential health services are costly, including vaccines and contraceptive implantation, and so a compromise is required. Some migrants are eligible to receive high cost basic health services if they live or work in areas where external assistance from IOM and other international and local NGOs are available. Nonetheless, the level of coverage addressed by external assistance is only just slightly reaching the tip of the iceberg. All migrants and public health personnel interviewed during Program reviews and evaluation report being satisfied with the quality of services the MHP provides to migrants but many have provided comments about insufficiency, particularly in relation to human resources and drug and medical supplies.

The primary health care approach employed by the MHP assists with addressing population health needs in a resource-constrained setting. In addition to providing medical treatment, the MHP teams also promote alternative health prevention, promotion and care that does not require a large budget. For example, many migrants have chronic skeletal and muscular problems due to extremely long working hours and inappropriate physical work environments and they subsequently become dependent on pain killers. The teams educate and promote rehabilitative exercises that assist with muscle relaxation in place of providing pain killers due to a lack of budget. The teams also incorporate training about oral rehydration solutions as a measure to treat diarrhea instead of distributing instant solution packs that must be procured from pharmacies. However, coverage of the MHP is only within selected migrant-populated communities in five provinces. Most migrant health services implemented by other agencies focus on specific health issues; particularly HIV/AIDS, Tuberculosis and Malaria; which highlights how it might be difficult to apply a primary health care approach to meet the real needs of migrants in many communities.

The collaboration between the MOPH and IOM has always been a lucrative strategy which is one of the key factors influencing the systematic development of the MHP. However, some limitations toward actual Program implementation have been observed.

As a consequence of decentralization, the key role of the MOPH has been limited to policy strategy development and the provision of technical support to its offices and facilities at peripheral levels. Accordingly, the central budget has decreased with a limited number of staff involved at the ministerial level. The MOPH's support to the field level is limited in general, and even more limited when considering migrant health issues. The frequent turn over or rotation of MOPH staff who leave the Program results in limited institutional memory and subsequently a continually inconsistent approach to developing migrant health policies. This, perhaps, reflects the lack of clear

migrant health policies from the MOPH which in turn makes it difficult to retain direction and plan for migrant health programming at all levels.

2) Lack of systematic development of the migrant health service system

2.1 Lack of performance indicator for migrant health service

A lack of supporting policy results in a fragmented migrant health service that is not yet systematically developed within the MOPH framework. Consequently, migrant health services are generally not considered to be key performance indicators among public health personnel at both central and peripheral levels. This very much discourages the involvement and commitment of public health personnel from addressing migrant health problems. In some cases, providing health services to migrants is considered an additional workload rather than filling a critical gap in health services. The MHP has witnessed this to be a key obstacle influencing the attitude of most public health personnel in Program implementation sites, particularly at the beginning of the Program, ultimately causing a slow response and establishment of the Program.

2.2 Employment of MCHWs

A key issue that was regularly discussed during Program review and evaluation in all MHP implementation sites was how to ensure sustainability of the Program once donor funding has ceased. In all cases, public health partners expressed agreement that the minimum requirement to sustain the Program is to maintain MCHWs within the public health system. However, this recognition is practically constrained due to insufficient migrant and migrant health policies. Firstly, there is no government policy that allows migrants from neighboring countries to work as health workers since they are only permitted to be employed in unskilled or low-skilled work whereas health work is considered skilled work. Secondly, there is currently no official national training curriculum and accreditation from the MOPH for MCHWs, although this is being prioritized for the future. The curriculum developed by the MHP is utilized at implementation sites but has not yet been compiled and standardized at the MOPH level. Finally, there is no government budget allocated, nor a clear guideline on how to mobilize other existing budgets, to hire MCHWs due to a lack of supporting policy frameworks. However, local health authorities and facilities continue to admit the challenges by maintaining as many MCHWs as they can through the leveraging of some existing budget items, external support from IOM and other agencies, and self-generated revenue. MCHWs who have already obtained Thai nationality are prioritized by local health authorities and facilities to avoid misconduct and to support the sustainability of the Program as they can be employed through regular government budgets for certain purposes. However, this kind of MCHW is very limited in number and only exists in a few implementation sites. If MCHWs were able to be employed by local health authorities and/or facilities, the provinces confronting emerging and ongoing migrant health issues would be in a better position to respond more consistently and effectively.

2.3 Migrant health information system

Although Thailand has observed a substantial influx of labour migrants for almost two decades, there is still no standardized migrant health information system available, despite a number of attempts made by several MOPH

departments¹². The lack of a firm migrant management policy makes it difficult to distinguish the extent and scope of migrant demographics in addition to the health information that should be collected. The main tool for regular reporting among migrant cases is the Bureau of Epidemiology's routine passive surveillance report. However, the report is limited to the key infectious disease services provided to migrants at public health facilities. Furthermore, the tool is designed for Thai populations, and therefore, lacks the necessary detail to enable analysis of migrant health circumstances. Several tools have been created and applied to vertical programs in relation to specific diseases such as Tuberculosis, HIV/AIDS, and Malaria. However, since most, if not all, of the vertical programs are funded by external donors with specific requirements, the program reports tend to serve donor reporting systems rather than being relevant to the MOPH's health information system for longer term policy and program planning. In many cases, analytical feedback about collected information from the relevant offices is not available, resulting in irrelevant data for program planning.

[2.4 Inter-departmental coordination within the MOPH](#)

The large number of migrants and their dependents reflect a diversity of demographics that range from zero to over 60 years of age, with almost equal distribution of male and female populations, in varying occupations. Considering this fact, health services required by these populations varies widely, and therefore, it is technically sound for the MOPH to emphasize the development of a whole migrant health system. Since the Department of Health Service Support has a mandate for developing the health service system for general populations in Thailand, it is also technically sound for this department to function as a focal point for the development of the migrant health system. Nonetheless, it is important for the Program to diversify partners from a range of offices within the MOPH in line with their relevant mandates. For example, ensuring safe maternal and child health is the mandate of the Department of Health; immunization of preventable diseases and all infectious diseases control and prevention is the mandate of the Department of Disease Control; the overall migrant health policy development is the mandate of the Bureau of Policy and Strategy under the Permanent Secretary Office. These three key authorities have to be proactively and systematically involved in migrant health systems and policy development to ensure a collective response.

[2.5 Monitoring Program development](#)

Joint monitoring visits by IOM and MOPH technical staff are regularly conducted. The visits were more frequent in the early stages of the Program in order to fine tune understanding of the concept, strategies and expected results. Follow-up visits were made on a quarterly basis to different implementation sites. A technical officer of the Department of Health Service Support who also serves as the secretary of the CCHM has been involved in the MHP since the beginning and usually participates in joint monitoring visits. When opportunity allows, senior staff of the Permanent Secretary Office, Department of Health Service Support, and Inspector General Office also participate in field monitoring visits. Site visits by senior MOPH staff encourage and reinforce local health officers and care providers to maintain active involvement and commitment to the MHP. However, the Program still needs to develop a clear systematic monitoring and evaluation mechanism at all levels of the MOPH, in conjunction with a clear migrant health policy.

¹²For more information, please refer to WHO-MOPH's Migrant Health Information System.

2.6 Inter-ministerial coordination

As international migration issues are related to a number of ministries and authorities, it is important to develop effective coordination mechanisms to ensure a collective response to managing international migration. Although the National Committee for the Management of Foreign Labour Migrants was established with participation from all relevant ministries and authorities, the direction and recommendations of this committee have always been based on concerns of national security. Recommendations from this Committee to the Cabinet are usually made on an impromptu, mostly annual basis rather than with a long-term direction for labour migrant management. Despite the presence and participation of the MOPH, health security has not been given a priority by the Committee. Providing health services to illegal migrants is not prohibited but rather supported by the Constitution and other related laws as a component of basic human rights. However, a lack of policy support from relevant ministries, especially the national security authorities and bodies, can also affect the willingness and efforts of public health personnel to actually address the health issues of their communities.

3) Contradictory health and national security concerns

Since many migrants are not registered, making it difficult to trace their whereabouts, and given that many have migrated from countries with ongoing internal conflict, their presence in Thailand is a serious national security concern for the Thai government. The several migrant registration resolutions mentioned above were created with deep consideration of protecting national security. Although health security can be considered an element of national security, it is difficult to mobilize this idea among many national and local administrative and security authorities. As a result, Thailand still lacks a firm policy on labour migrant management at the national level consequently jeopardizing filed requests due to concerns of national security.

For example, community radio broadcasts are considered to be one effective means to reach migrants, especially those who work in isolated and remote geographical areas such as agricultural farms and plantations. The MHP applies this methodology to disseminate health information, particularly when community radio is popular among target migrants. A number of MCHWs with advanced communication skills were selected and trained to deliver public announcements in migrant languages, in consultation with the local health office. However, due to security concerns, broadcasting in migrant languages was banned in some areas and the Program had to make the same announcement in Thai which of course meant less chance of reaching a large number of migrants.

Implementation at the Field Level

In addition to the limited human and financial resources and the contradictory concerns of health and national security described above, some other key challenges have been observed during Program implementation at the field level.

1) Migrant Characteristics

1.1 Low level health knowledge and concern among migrants

Limited experience and exposure to health information and health related services in the past significantly obstructs migrants from recognizing the importance of raising their health awareness. To ensure effective services,

the MHP has attempted several ways to improve health awareness. These mostly include, but are not limited to, community outreach awareness raising campaigns and improved access to migrant-friendly health services. Across all implementation sites, bilingual maternal and child health handbooks are provided to parents so that they can adequately follow their child's vaccination schedule and other follow-up services. However, it has been observed that many parents, especially those who are highly mobile, often lose their handbooks and do not remember the vaccination history of their children. The MHP teams must spend significant time asking parents to recall their child's age, their vaccination history and then make an attempt to guess the kind of vaccinations the children may have already received. However, many migrant parents are unable to remember, and the MHP teams often have to assume the children have not received any vaccines and therefore proceed to provide all basic essential vaccines according to age. This does not only result in an increased team workload but also increases costs when it could be that migrant children have a tendency to receive multiple doses of the same vaccines, as well as resulting in potentially missing the opportunity to receive other vaccines.

1.2 Difficulty in personal identification among some migrant groups

Most migrants do not hold any official or authorized documents issued in their country of origin such as a birth certificate or a passport. Many have similar names commonly used in their cultures while some keep changing names when they migrate to different cities in Thailand to avoid being notified or traced by Thai authorities. The MHP teams have brainstormed several ways to trace migrant patients including the use of technology such as finger print scans. However, some concerns were raised and discussed, especially about the cost to install and maintain data and most importantly that it may be considered a violation of basic human rights if any information leaks from the system. Teams in some provinces finally decided to take photographs of migrant patients to assist with patient record keeping at health facilities. This helps solve problems among migrant adults but remains a challenge for migrant children as their appearances changes over time.

1.3 High mobility among some migrant groups

Although many migrants fall within the category of mobile populations, not all migrants are highly mobile. Uprooted persons residing along the border, particularly the highlanders, tend to be less mobile since many of them are not economic migrants but rather have migrated for security reasons. Some indigenous persons, including those who have not obtained Thai citizenship, also tend to be less mobile since many were born in Thailand and have been settled for some time. The MHP tends to experience a higher level of success, both in terms of program coverage and adherence to treatment of infectious diseases, when working with migrants who are settled, less mobile, or well integrated into the Thai community.

A significant Program challenge remains in relation to highly mobile migrants. For instance, despite the willingness of public health personnel to provide basic essential vaccinations to all children in their catchment areas, including unregistered migrant children, it is very difficult for them to map and locate all target populations. Accordingly, in most Program sites, the team can only record the number and type of vaccinations provided or the coverage of vaccinations based on surveyed migrants but not the coverage of total migrant children populations in these areas. However, the biggest concern among the teams is migrant adherence to treatment of infectious diseases, particularly diseases that require long or relatively long-term treatment such as Tuberculosis and HIV/AIDS, since non-adherence to these treatments can lead to issues of drug resistance.

2) Physical environments

Migrants reside in diverse communities with different physical environments that require a range of innovative approaches.

2.1 Urban setting

Migrants in urban settings such as those in Samutsakon Province do not have much difficulty accessing safe water supplies and latrines. Most live in modern housing equipped with tap water and toilets with a built-in flush. Most migrants in urban areas use bottled water for drinking and cooking. However, since the cost of living in urban areas is very high compared to the very low migrant income, many share rental rooms in often overcrowded and poorly ventilated houses. Many migrants share rooms with peers who work on alternate day/night shifts making it possible for a tiny room to be shared with as many people as possible to minimize rental costs. As the rooms are used at all times, there is little or no chance of them remaining clean.



Migrants in urban area often live in overcrowded rental rooms.

2.2 Rural setting

On the other hand, migrants in rural areas are also at risk of poor health due to a lack of basic requirements such as safe water supply and appropriate latrines. Since treated tap water is not available in remote rural areas, all populations groups living in these areas must rely on natural water sources. In many communities, clear well water is used for both drinking/cooking and washing/cleaning, but there is no guarantee that clear-looking water is free of dangerous pathogens. In many communities, mountain and river water is used, however it often contains suspended solids that are muddy and contaminated with pathogens during summer when water levels decrease. In general, migrants do not have a traditional practice of boiling water for drinking, except some indigenous highland persons who have a tradition of drinking hot tea instead of natural water. Insufficient and inappropriate use of latrines are additional issues of concern, particularly in rural areas.

The MHP has made some effort to enhance local capacity and participation to install slow-sand water filters and latrines in some communities, as well as training on appropriate use and maintenance of installed equipment as mentioned earlier. However, efforts were only prioritized in some areas. The cost of materials as well as the characteristics of some communities in agricultural settings where populations live in single houses or in very small clusters of houses scattered all over an area makes addressing these issues a big challenge.



Migrant houses in rural areas

[2.3 Shared concerns in both urban and rural settings](#)

Waste management and vector control tend to be issues of concern in all migrant communities, both in urban and rural areas. Many migrants in all settings are unfamiliar with disposing their garbage in a separate trash bin but instead throw rubbish or waste into the river or the empty space surrounding their house. Some migrants do not cooperate with the MHP teams for vector control since they are afraid that chemicals used, such as foggy spray and ABATE sand for mosquito larvae control, can have negative effects on their health. This is the case despite health education campaigns conducted by the MHP teams.

3) Cooperation from some key stakeholders

[3.1 Cooperation from business and housing owners](#)

Collaboration and active engagement of the private sectors that have significant power is of paramount importance to the success of the Program. The good practice of health corners, mobile clinic services, outreach health education activities and campaigns in the workplace and community could not be achieved without support and cooperation from business owners who employ migrants and the land lords/ladies of accommodation where migrants reside. While cooperation from the private sector is positive and contributes greatly to Program success in some areas, obtaining such cooperation remains a big challenge in some areas. There are still many workplaces and rental houses/ rooms, especially those involving undocumented migrants that the MHP teams cannot access, and therefore, cannot provide health information and other services. In some locations, although the MHP has tried to support the materials to build latrines, the construction could not be realized due to business or housing owners not allowing the team to undertake construction on their property or land. Despite the fact that the latrine will benefit their employees or tenants, they either do not want to formally admit that they hire or host illegal migrants or prefer to use the land for other income generating purposes.

[3.2 Cooperation from relevant agencies](#)

While public health and other authorities cooperate well with the MHP, further cooperation is required from certain agencies/ authorities to increase Program achievements as well as sustainability of the Program. In particular, the Local Administration Organizations in all migrant-populated areas should be involved and contribute to the development of a migrant health system. One result from the national administration reform which focuses on decentralization is an establishment of the Local Administration Organizations at the provincial and sub-district level

in all provinces. The organization is managed by a team of local politicians directly elected by local Thai citizens. The organization is responsible for the planning, budgeting, and implementing and/or managing of all activities and services related to local infrastructure and social issues including public health in their responsible geographic areas. In fact, the control of environmental health and sanitation such as waste management and vector control is a mandate of the Local Administration Organizations rather than the Public Health Offices. However, the Local Administration Organizations do not necessarily have staff that are keen on addressing public and environmental health issues, in fact, very few of them have in-house public health expertise. Several UN agencies and international organizations including IOM, and NGOs have been placing a huge effort to enhance the capacity and awareness of members of the Local Administration Organizations on key social issues such as education, child protection and public health. However, it will take time to ensure that public health issues are integrated into organizational work and budget plans.

4) Local health authorities and care providers

As mentioned earlier, public health authorities and care providers are key drivers for migrant health system development and service. Whether or not and at what level the Program will be successful, is dependent on those in the driver seat.

4.1 Preparedness of relevant implementing partners

Since migrant health systems did not exist prior to the launch of the MHP, the Program faced a big challenge when it began due to an insufficient commitment from implementing partners in some sites. Although a strong commitment was in place, the challenge remained due to a lack of know how and preparedness among local health authorities and facilities to deal with migrant health issues. In addition, the unique approach of the MHP - to embed a migrant-centered focus into government health systems in place of efforts implemented by non-government and international organizations outside the government system⁷⁸ was a cause for some confusion and difficulty with establishing appropriate mechanisms to manage the Program, particularly in the beginning. It took some time for government partners to learn how to manage donor funding and to work in close collaboration with an external body (IOM) as well as for IOM staff to familiarize themselves with the culture of government organizations. Nonetheless, the MHP approach is now considered a good practice and the preferred option by all government implementing partners who recommend other organizations apply the same approach.

4.2 Time constraint and competing priorities

Government health resources are already stretched in the provision of services to the Thai population, and given the fact that the Program is dealing with overall issues related to migrant health rather than vertical programs addressing specific health issues, public health personnel constantly face competing priorities in their work. In addition to daily functions and health services for the general Thai population, public health services must prepare and be ready for emergency responses to outbreaks of disease; unplanned activities requiring attention as assigned by central, regional and provincial levels of the MOPH; and to provide health services to non-Thai populations. As migrant health services are not considered key performance indicators of public health personnel, migrant health has always had less priority in the face of multiple simultaneous demands. An exception was observed when infectious disease outbreaks took place among migrants.

4.3 Management capacity including monitoring and evaluation

With heavy workloads and competing priorities, local health authorities and facilities have insufficient time to plan, manage and monitor activities delivered to both Thai and migrant populations. In addition, whilst regular management training is usually available for senior level government staff, front-line implementers have limited knowledge and skills to manage activities, budgets and human resources, as well as to monitor and evaluate their activities and report writing. Although the Program achieves its objectives and targets, it is mainly due to the fact that MCHWs receive daily mentoring and supervision from healthcare providers which helps improve their service provision skills. However greater achievements could be expected if all levels of government implementing partners have a chance to master their management skills and more time to utilize these skills.

4.4 Migrant health information system

Public health personnel across Thailand find the lack of a standardized migrant health information system a significant obstacle to appropriately managing migrant health issues. Several tools have been created and used for vertical programs addressing tuberculosis, HIV/AIDS, and malaria. This results in the same demographic information being repeatedly recorded and thus an increased workload. Nonetheless, most data collected at the provincial and national levels is insufficient to enable a through analysis that will inform appropriate migrant health program planning. This is also the case in the provinces where the MHP operates. Some have no record of services provided to migrants, mainly because they believed it was not necessary since the exempt costs incurred could not be reimbursed by the government. Some have collected migrant health data in a database that cannot be disaggregated between Thai and migrant clients. Some have created data tools to record migrant health data and services according to their specific needs. Even when the MHP supports, reviews and updates the development of migrant health data systems, it remains a big challenge to integrate systems and reporting lines.

VII. Recommendations for Future Migrant Health Programming

This section describes the rationale and recommendations for future migrant health policy and programming in Thailand which could be applied by government and non-government agencies in Thailand and beyond.

Development of a Long-term Policy and Mechanism for the Management of International Labour Migrants

In order for a country to appropriately manage cross-border labour migrants, including their health, an orderly migration management system needs to be developed. In the past few years, the Thai government has experienced big achievements in progressing the official exchange of labour migrants from Lao PDR and Cambodia via the mechanism of bilateral MOUs. However, it is costly and time consuming for migrants from Lao PDR and Cambodia to obtain a passport from their government, apply for a Thai visa and a work permit, sign a contract with a recruiting agency and/or employer, and travel to Thailand to work. As of May 2009, only 6,932 migrants from these two countries work through this formal mechanism in Thailand. Although a similar bilateral agreement between Thailand and Myanmar has been initiated, it will take some time to translate such an agreement into practice. As a result, there is no evidence to demonstrate a decrease in the number of irregular migrants in Thailand, even with the materialization of official MOUs between Lao PDR and Cambodia.

It is important for all relevant authorities and agencies to accept the fact that migrants make significant contributions to the Thai economy. This contribution is not only limited to their productivity but also their consumption while in Thailand. Some business owners in migrant-dense communities admit that if all migrants were to be deported, the local economy would probably collapse. [8] Thai society will continue to require migrant labour forces to replace Thai laborers who migrate to work in countries with greater economic development and those who refuse to undertake any 3D employment; that is, dirty, dangerous, and difficult jobs. On the other hand, it is unlikely that political and economic circumstances will stabilize in neighboring countries in the near future. The push and pull factors will continue to mobilize new generations of migrants into Thailand, and thus, long-term migrant management and migrant health policies are required.

As mentioned earlier, a long-term migrant management policy must take into consideration an appropriate balance of national, economic and health security for migrants and the public in general. Labour laws should be strengthened and their enforcement be respected. Agreements about migrant labour import-export between the Thai State government and neighboring countries are possible and in process however it will take time. Although a long-term policy is being developed, a sound interim mechanism is required to minimize the impacts of migration on Thai society. All labour migrants and dependents should be allowed and encouraged to register with the government. When unregistered migrants and dependents are arrested and deported, employers or house owners who lease accommodation to unregistered migrants should also be filed for criminal charges. Although, it is important to recognize that no matter what kind of mechanisms are in place to control cross-border migrants, it is near possible to attempt to totally mitigate the problems that come with illegal migration. The most efficient option is to have as many migrants as possible who have legally migrated for the benefits of individuals and their native communities as well as for the society in which they move to. Once the majority of migrants are registered, it will be much easier to manage and support these populations. In addition, it will be easier for the government

to generate more revenue from the migrant registration process which in turn could be utilized to provide migrants with basic essential health and social services.

Development of Official Migrant Health Policy, Migrant Health Service, and Migrant Health Information Systems

To date, migrant health policies have mainly developed according to the national policy on cross-border labour migrant management, with a primary focus on national security as mentioned above. In order to effectively respond to the health needs of the MOPH and both unregistered and registered migrants, the MOPH may need to create a policy that is more independent of policies developed by the National Committee for the Management of Foreign Labour Migrants. For instance, the MOPH could develop a clear migrant health framework and make it an official policy or strategy. Since the national health budget is mainly managed by the National Health Security Office, a public organization independent of the MOPH line of command, it is difficult for the MOPH to tap into the specifics of the national health budget allocated to this office. In order to subsidize healthcare costs for unregistered migrants, an evidence-based negotiation has to take place between the MOPH and the central government. As long as the government cannot officially import labour migrants and there is ongoing need for the MOPH to provide health services to unregistered migrants, the central government has no choice but to subsidize the costs. The budget could either be allocated directly from the national budget according to evidence of burden, or by regulating cost-sharing among those who benefit from migrants, such as employers. At all times, it would be beneficial to program objectives if collaborating partners continue their current degree of sensitivity about separating issues related to legal status/ registration from the health service system. Perhaps this could occur in a similar fashion to the approach of the Ministry of Education who has been providing primary education to all children in Thailand regardless of their nationalities. The latter approach could best achieve intended positive impacts if it maintains a non-threatening, pragmatically-oriented and flexible service which can accommodate any shift in political atmosphere.

Simultaneously, the MOPH could develop a systematic migrant health service system based on the experiences and lessons learned from the MHP as well as the MOPH's collaboration with other international organizations and NGOs on other migrant health issues in other settings. Ideally, migrant health services should be integrated into the normal system and structure of all MOPH departments at the central and peripheral level. Adequate human resources should be allocated for this purpose at all levels, and migrant health services should be a part of key performance indicators of relevant personnel at all levels. The development of a systematic and official migrant health service will not only help support front line public health personnel to effectively solve the problem, it will also help promote long-term systemic self-reliance. The function of the CCMH should be strengthened and its role expanded to coordinate the involvement of technical management relating to the health of migrants across all departments within the MOPH. To strengthen the MHP and to ensure the smooth integration of migrant health services into the normal public health system, public health inspectors should be proactive in providing technical support and policy guidance to local public health personnel.

Alternatively, the official establishment of a Migrant Health Unit within the MOPH at central level will ensure more effective coordination within and outside the MOPH. This would require a clear migrant health policy, framework

and Terms of Reference of the Unit and its staff. An official migrant health system would also help improve the migrant health information system. As an official system, a standardized information system based on a thorough analysis of needs and application will be automatically required. If the alternative recommendation to establish a Migrant Health Unit within the MOPH were selected, this Unit may also serve as a Migrant Health Information Center. It is estimated that the establishment of a Migrant Health Unit will not require much extra budget. Since many departments have already been working with external donors to develop Migrant Health Information Systems separately, according to their mandates, and that some NGOs have the funding and are trying to advocate for the development of a systematic Migrant Health Information System, leveraging of these human and financial resources should be sufficient to set up the essential infrastructure to run the Unit. However, maintenance and running costs, which require only a small amount for the long term, would most likely need to be shouldered by the MOPH.

The Migrant Health Unit or the Migrant Health Information Center would also be in a good position to coordinate between government, international, and non-government organizations. The Unit or the Center would maintain and update information on health issues among various sub-population groups of migrants, as well as the health services provided to them by both government and non-government agencies across the country. A gap analysis could be performed by the Unit or the Center for future program development as well as for justifying additional supports to address the issues. A Unit or Center could also be established at the provincial level for a similar purpose, especially in migrant-populated provinces. The information could be shared among stakeholders on a regular basis to avoid duplication as well as to promote a leverage of human and financial resources. Whether the Unit or Center is to be established at the central or peripheral level, it is important to conduct a thorough analysis of necessary information to enable improved understanding of migrant health conditions and the development of programmatic strategies and responses, including a typology of migrants and their mobility patterns particularly since a constant updating of tools and information systems can be cumbersome.

MCHWs should be officially incorporated within the MOPH's human resource structure. Local public health personnel have consistently reported and advocated that MCHWs should be a minimum requirement to ensure efficient support of migrant health services. In doing so, the MOPH has to break through several logistical hurdles. Firstly, to develop and endorse a standardized curriculum for MCHWs capacity building; a standardized mechanism to measure required knowledge and skills; as well as a system to provide accreditation/ certification of qualified MCHWs. Secondly, the position of MCHW has to be created and recognized within the MOPH's migrant health service framework. This will require consultation and a thorough analysis with the Ministry of Labour and Social Welfare about demand and related national and international labour laws in addition to other regulations to determine the most suitable mechanism to hire migrants within such a position in the MOPH system. This is because labor migrants are currently only permitted to work in unskilled and low-skilled sectors, while health related work is considered to be skilled work. If required, an exception or waiver to current laws may have to be pursued for this specific purpose. And finally, a consultation and agreement between the MOPH, Ministry of Labour and Social Welfare and the Ministry of Finance should take place to secure the availability of sufficient government mechanisms and budgets in order to hire MCHWs.

Demonstration of the Transparency of the Program at all Levels

Since cross-border labour migration is still considered a threat to national security, enormous efforts are made to advocate the positive contributions of labour migrants to Thai society as well as to sensitive communities and society to provide non-judgmental, non-discriminate health services. The provision of health services to irregular migrants tends to be seen as a pull factor for more migrants to migrate to Thailand. However, there is no clear evidence to support this suspicion but rather the opposite as mentioned at the beginning of this document.

One good way to advocate and sensitize the need to provide health services to migrants, according to the MHP experience, is to demonstrate the transparency of the Program to relevant stakeholders at all levels. This not only includes the public health sector but also, or even more importantly, sectors that involve national security such as the National Security Council at the central level and the Governor, Local Administration Organization, Military and Police Divisions at the local levels. These authorities should have a good understanding about Program objectives, strategies, activities and even materials used. It would be a good idea for all Program materials to be in Thai language alongside migrant languages. This not only assists with demonstrating Program transparency, but also benefits Thai populations in host communities so that they receive the same health information and it would ultimately reduce their suspicion towards Program activities.

Scaling-up Migrant Health Services by Promoting Good Practices and Effective Strategies

Several strategies and practices have been documented throughout the IOM-MOPH Migrant Health Program implementation over the past half decade. Some aspects of MHP strategies and practices have also been implemented by other agencies, particularly the introduction of MCHWs and MCHVs to migrant health services, demonstrating a broad acceptance of this approach. However, further piloting of the migrant health service model may not produce much benefit in terms of innovation and level of service coverage. In order to maximize impacts on migrant health development, boutique pilot projects that explore good practices and models should not be an emphasis of future migrant health programs in Thailand. Instead, an expansion of the scope and scale of migrant health services will ensure increased access to essential health services among vulnerable populations including irregular migrants which in turn will improve the health condition and health security of society as a whole. Strategies and practices, especially those agreed by various stakeholders as good practices, should be applied and/or modified to scale up migrant health services across the country. Listed below are recommended strategies and approaches that should be taken into consideration by all future migrant health programs. It is important to note that only key recommendations presented below are considered applicable for all settings. Additional strategies and approaches to suit different settings should be considered and applied to maximize program outcomes and impacts.

1) Capacity building and meaningful involvement of stakeholders including the target beneficiaries

1.1 Public health personnel

Public health is not solely concerned with health issues but in fact is closely linked to other social determinants within society. Public health issues, therefore, cannot be solved by focusing on medical and public health methods alone. Migrant health is a particularly complex issue that involves a consideration of several social and legal

aspects when designing a beneficial and friendly service system. In addition to understanding public health theory and practice, service providers and policy makers must have good insight into the social determinants that influence migrant health, awareness and behavior. This should range from an understanding of the influence of globalization on international migration; typology and mobility patterns of migrants; their health conditions, health knowledge and practices; the barriers of the existing legal framework in place to deal with migrants, particularly for undocumented migrants; and how to effectively provide a service through an interpreter or migrant assistants, just to name a few.

1.2 Target beneficiaries

The meaningful involvement of migrants and Thais is essential to ensure the success of the program. MCHWs and MCHVs are considered by all stakeholders as a minimum requirement in the appropriate provision of health services to migrants, particularly since they understand the language, culture and other social determinants that influence the health of migrants. Thailand has extensive experience through its globally recognized primary health care system which targets populations in individual and community care via Village Health Volunteers. This concept can be applied for migrants as demonstrated by the MHP and other migrant health services implemented by other organizations. [9] A systematic training with standardized training outcome measurements is required to ensure their capacity to work with communities. The migrant health service workplan should also include a workplan for MCHWs and MCHVs and be communicated periodically with good time management. In particular, MCHVs need to be aware of activity timelines ahead of time so that they are able to efficiently manage their schedules to participate in project activities. Official recognition and certification of MCHWs and MCHVs should be developed. Accreditation would not only empower them to take care of their communities but also increase confidence among migrant beneficiaries and host communities. MCHWs and MCHVs must be systematically recruited, trained and retrained to ensure their capacity and a continuity of service. An integration of MCHWs and MCHVs to the existing Thai Village Health Volunteers network to develop and strategies, joint workplans and service delivery would be an ideal system since a collective response to community health issues will ensure a greater impact.

2) Prioritization and effective planning of migrant health services

As mentioned earlier, the health needs of migrants and their dependents vary widely, however it is difficult to mobilize sufficient human and financial resources to respond to all needs. It is important for the program planner to prioritize evidence-based health services for migrants. Certainly, all basic essential health services such as primary care; reproductive health including family planning and maternal and child health; and prevention and control of key infectious diseases must be considered. However, these three key health service areas cover a wide range of health issues and services that must be prioritized based on the magnitude of the problem as well as on the available human and financial capacities of each locale. Effective strategic planning is essential to minimizing health burdens, for example, a prevention campaign should be planned and conducted prior to the outbreak of endemic seasonal diseases. Strategic planning can only be effective if reliable migrant demography and migrant health information is in place, critically analyzed and utilized.

3) Innovative solutions

3.1 Adjustment of health service protocols

It is important that health service protocols take into consideration that many migrants are highly mobile, and therefore, services should be adjusted to fit the related circumstances of each population group. For example, the MHP experienced a large number of migrant children aged over five years old who had not completed basic essential vaccination schedules. To address this issue the teams expanded the age threshold to all migrant children aged between 0-15 years to ensure that as many migrant children were vaccinated. Also due to mobility patterns, many migrant patients do not adhere to treatment plans, especially for diseases that require longer term treatment or multiple follow-up visits to health facilities. It is recommended that directly-observed therapy be applied to all migrant patients under such treatment, especially for infectious diseases. Although this approach will be resource intensive, the well developed networks of MCHWs and MCHVs should be able to fulfill this function if they are appropriately trained and incorporated into the health workforce. Unless adherence can be guaranteed, long-term treatment of infectious diseases should not be provided to highly mobile migrants or cross-border patients. This will obviously confront a potential violation of migrant rights to healthcare and ignore the overall benefits to society in mitigating drug resistant diseases. Such a difficult decision must be made in consultation between health and migration experts and the patients themselves.

3.2 Promoting strategic communications for behavior change

Although migrants' awareness about available health care services has improved, it is more important for one's livelihood and well-being to prevent diseases rather than to receive treatment after developing illness. Living and working conditions as well as additional external factors cause many health concerns among migrants. However, many health concerns among migrants are behavior-driven. While environmental factors need to be considered and often require significant long-term investment to improve infrastructure, it is just as important to educate and empower migrants to take charge of their self and community health through positive behavior change to address unhealthy behaviors.

Strategies, approaches and key messages for target BCC have to be developed for specific migrant sub-populations based on the nature of their work and daily living as well as the environmental setting. BCC strategies, approaches and key messages are not only important for effective health prevention and promotion, but also to educate about appropriate health care and treatment. To ensure treatment adherence, treatment literacy should be developed based on BCC concepts. However, changing behavior is not easy and is often time consuming. In addition to one's self awareness and perception, supporting enabling environments is also essential to catalyze expected actions. Therefore, BCC for health prevention, promotion, care and treatment must be repeatedly emphasized, not only among target migrants or patients but also toward their support networks including family, friends, and employers.

3.3 Expansion of program to hard to reach populations

The MHP enables many migrant women and children to access basic health services. Population-based approaches are technically sound since women and children are often placed in vulnerable and marginalized

circumstances causing greater risk for illness due to their lower levels of knowledge and access to health services. However, migrant health programs should not exclude specific approaches that target male migrants who tend to be more mobile. Several creative and innovative means should be developed in order to reach these population groups. For instance, it might be more effective in terms of reaching migrant seafarers during full moon days since these are days that fishing activity is usually put on hold because there is minimal fish product available in the ocean and the seafarers often return to their communities during this time. In some circumstances, secondary peer educators such as employers and house owners should be recruited, trained and empowered to assist migrants on health issues. The annual compulsory medical checkup to meet the requirements of the annual migrant labor registration process is a further opportunity to reach highly mobile migrants, including male seafarers. Should health personnel use this opportunity to provide health IEC to migrants undertaking registration, it is important to emphasize that any information received should also be shared with peers and/or dependents who may not have the opportunity to register themselves and consequently may be unreachable through traditional project outreach activities.

[3.4 Financing healthcare for migrants](#)

Once a policy is developed and the boundaries and content of a migrant health framework are defined, the next immediate challenge is identifying costs, revenue sources, financing mechanisms and cost recovery. Ideally, a compulsory migrant health insurance scheme is preferred. However, in order to achieve compulsory health insurance, all migrants must be registered to join the insurance scheme, which is unlikely to happen in the foreseeable future.

Alternatively, a local mutual fund or trust fund may be employed. Securing private sector resources is not an impossible task if they were to realize the value of MCHWs and MCHVs in preventing and promoting the health of their employees, ultimately improving their productivity. Throughout Program reviews, many migrants expressed a willingness to join a health insurance scheme, however the majority are not eligible to join the scheme due to their undocumented status. A combined contribution from local tripartite; local health offices and facilities, employers of migrants, and the migrants themselves should be sufficient to support selected high cost care, either partially or in full, as well as self-reliance low or no-cost health services (see more details below). A committee with representatives from the tripartite should be established so that the funds can be managed with transparency and that further promotion and external resource mobilization for funds, such as donations from donors or public, are achieved.

Although potentially difficult to manage and requiring a thorough formative analysis, an additional alternative is to allow provincial health offices to provide health insurance at full cost to irregular migrants. This would include: waiving registration requirements with the Ministry of Labour and Social Welfare; encouraging employers to buy cards on behalf of their workforce if migrants cannot afford to pay a lump sum payment; allowing NGOs and relevant community-based organizations to purchase cards and distribute to target migrants; and allowing NGO clinics to make up part of the pool of service providers under this scheme. To ensure the effectiveness of this alternative, a compulsory scheme would be ideal however a voluntary scheme could also be negotiated if migrants' awareness about the importance of health insurance coverage is raised and a sufficient number of scheme members can be recruited. This would avoid a negative cost recovery balance and self-selection bias. If a sufficient

number of migrants join the scheme and funds from the collected revenue are properly managed, it is anticipated that local health offices may gain some profit from the scheme, according to evidence from a private hospital in Samutsakorn Province.

Nonetheless, local health offices/ facilities would still be required to continue some level of financial commitment to health expenditure. This is particularly useful and politically more justifiable among services of public utility whose benefits impact directly on the Thai population and subsequently does not require a large budget. Such services can include free diagnosis and treatment of highly infectious diseases, child immunization, and temporary contraception methods. On the other hand, providing free services to all migrants is not an appropriate way to resolve the problem. Care providers should not assume that all migrants cannot afford to pay for their health. Undocumented migrants without health insurance should contribute to health care costs, either in part or full according to their ability to pay, not according to services utilized. This will not only help subsidize uncollected health care expenditure but will also encourage migrants to take responsibility of their own health.

[3.5 Promoting low or no-cost health prevention and health promotion](#)

In general, basic health prevention and promotion activities do not require a large budget. There are a number of activities that disseminate health IEC which do not require extra budgets. For example, the cost of mobile clinics can be cut, particularly in urban settings where public transportation is available, and this would therefore promote the utilization of health services at the local public primary care unit near their workplace or residential area. The community health post can be established and maintained at minimal to no cost. Safety education and appropriate exercise should be promoted to avoid injuries and to reduce the use and dependence on pain killers among migrants who have chronic muscle pain. Safe water supply can be improved with basic or zero technology, such as promotion of household or community slow-sand water filters made from natural and low-cost materials including rock, stone, sand, charcoal and chlorine. Local community waste management funds could also be established. In the previous half decade, the MHP has invested much time, effort and budget into the public health workforce which is essential to sustaining the Program. The bottom line for health authorities and facilities is to ensure that a skillful health workforce, especially MCHWs and MCHVs, is maintained within the system and that referral networks are upheld at all times.

[3.6 Promoting community participation and responsibility in self and community care](#)

Community participation plays a key role in the success of several recommendations described above. In addition to participation in local health funds, health communication sessions and campaigns, and the contribution of health expenditure, migrants should also be encouraged and empowered to take charge of their self and community health care and well-being. Besides health awareness raising, a sense of belonging and being part of the community should be promoted to raise ownership of community health and well-being. While raising awareness about migrant rights to health, promoting the concept of a good citizen who is aware of his/her responsibility to maintain the health security of the host community should also be considered. Migrants should be encouraged as much as possible to join volunteer networks, particularly community members who are more senior and less mobile to dedicate some of their time to helping their community. A health card or handbook similar to the maternal and child health handbook could be developed and distributed to migrants to emphasize their responsi-

bility to keep medical records. Both migrants and Thais should be educated and encouraged to monitor the mobility of humans and animals in their community and to report changes to relevant authorities or MCHWs/MCHVs. This would enable initial basic health screening and information on available health services to be delivered to the new comers rather than waiting for problems to occur. Thai citizens, particularly community leaders and Local Administration Organizations, should also be engaged in solving migrant health problems. This will not only help improve their understanding about challenges faced by migrants and in turn create a supportive attitude towards migrants, it will also help promote a harmonious community and collective response to local concerns.

[3.7 The domino effect of other migration and human security issues](#)

Despite the challenges to developing and implementing a migrant health service system, addressing migrant health issues is potentially less complicated than other issues related to migration. This is perhaps due to the fact that health issues are considered humanitarian issues. Once migrant community health networks are established, they can be equipped with appropriate knowledge and skills to address other social issues that impact on health. For example, MCHWs and MCHVs can also raise awareness about human trafficking and appropriate prevention measures for trafficking to migrant communities. However, this has to be done in close consultation with health authorities and/or facilities based on the line of command and supervision of MCHWs and MCHVs.

Strengthening Cross-border Collaboration

Initiatives to strengthen cross-border collaboration are important and need to be encouraged. It is noted that actual implementation is often challenging and that cross-border collaboration is not the only action that can be taken for a meaningful longer-term impact on health care access among migrants. While the Joint Action Plan for cross-border collaboration between Thailand and Lao PDR and Thailand and Cambodia is beginning to demonstrate some achievements, a similar collaboration between Thailand and Myanmar is an ongoing challenge. The essence of the Joint Action Plan was initiated and agreed upon in July 2000 by the Ministers of Health of Thailand and Myanmar. The aim was to collaborate on health solutions; however there is a definite need for the plan to be revitalized. In whatever capacity or extent possible, this could potentially include joint problem-solving, troubleshooting and sharing of epidemiological data and tools (e.g. immunization cards, primary data collection forms, health cards, treatment follow-up registration forms, etc.) as well as health education materials. It would be optimal if all such contacts are coordinated closely between the MOPH in both countries. WHO has a strong presence in both countries and a mandate to push forward the World Health Resolution on the Health of Migrants endorsed at the World Health Assembly in 2008, and perhaps could play a key role in facilitating this collaboration with support from relevant partner agencies.

Cross-border collaboration does not interfere with sharing information or patient referrals. The major source communities of labour migrants in neighboring countries are quite well known. It is not difficult to identify potential migrants and families of migrants who remain at source communities. Local authorities and community organizations in source communities should place more effort on providing pre-departure activities to educate migrants about safe mobility, migration and related health risks. On the other hand, families who remain at source communities should also be educated about safe mobility and migration health issues. Since many migrants

regularly return home to visit their families and/or contact their families, family members can take these communication opportunities to serve as secondary peer educators. Alternatively, if there are too many source communities and it is too difficult to target activities on safe mobility and migration health education to specific locations and population groups, a campaign at national level for general populations should be considered since many of them will sooner or later become migrants, internally or internationally.

Large numbers of people from neighboring countries cross the border into Thailand every day seeking health care. Many cannot afford their healthcare costs and consequently either Thai public health facilities or NGOs working in border areas are left to absorb the cost. This group of cross-border populations travels into Thailand with a specific purpose and as they do not intend to stay in Thailand to seek jobs, they usually return home to their country once they have received health care in Thailand. The key reason for this phenomenon is that health infrastructure and services are insufficient in surrounding countries. Improving health infrastructure and health service systems in these countries may improve the situation. It is important for Thai governments and neighboring countries to work hand in hand to bridge service gaps on both sides of the border to improve the situation. Several donors could be approached for funding support to strengthen infrastructure and systems in neighboring countries while Thailand can provide technical support to the health workforce of its neighbor, especially through a series of training and field exchange visits.

VIII. Conclusion

IOM's unique ability to work collaboratively with the Royal Thai government identifies them as the first agency to work on migrant health issues from a ministerial to community level. The IOM-MOPH MHP structure is the backbone foundation that enabled the Program to become well-embedded within existing national and peripheral levels of public health administration. The Program model employs a **comprehensive** community health approach to field activities by integrating health services that have traditionally been planned or implemented separately for migrants or Thais in host communities, in addition to providing a comprehensive health service. The Program, therefore, contributes to minimizing gaps in health knowledge and access among different sub-population groups living in the same communities.

Due to the unique structure of the Program, all project activities are able to be implemented in a highly **participatory** manner through public health personnel at government health authorities and/or facilities, with essential assistance from trained and qualified MCHWs and MCHVs, throughout the cycles of program planning, implementation and monitoring and evaluation. In particular, the establishment of the Provincial Migrant Health Committee serves as an important function to bring together various stakeholders to cooperate and collaborate towards improving the health of society. Through these elements, the Program was able to integrate activities into the local public health offices' annual workplan; enhance networks of local government and non-government agencies, public and private sectors, as well as representatives from both migrant and Thai communities; strengthen the linkage between MCHWs and the Thai Village Health Volunteers; and develop project approaches for different settings.

The idea of working in close collaboration with the MOPH and deeply embedding the Program into the MOPH structure strengthens capacity for long-term sustainability of the Program since it demonstrates a relatively promising continuation of the Program once donor funding has ceased. However, **sustainability** does not only refer to program implementation and financial support. Enhanced capacity of government and non-government counterparts will also be sustained, particularly the knowledge and skills that MCHWs, MCHVs and migrant beneficiaries have gained from the Program. The knowledge and skills will remain at the community level and will accompany them should they move to other parts of Thailand or return home to their countries of origin. As the Program ensures a certain level of sustainability, and a central focus has been health prevention and promotion to prevent illnesses that may require costly advanced medical treatment, it is strongly believed that the Program has accomplished **cost-benefits**.

Thai society will continue to require migrant labour forces to replace Thais who migrate to work in more economically developed countries and those who refuse 3D employment positions - namely the dirty, dangerous, and difficult jobs. On the other hand, it is highly unlikely that political and economic circumstances in neighboring countries will stabilize in the near future. These push and pull factors will continue to mobilize returned and new generations of migrants into Thailand. Therefore, there is a clear need for an appropriate migrant health service system to be further developed, strengthened, and expanded beyond this pilot Program. The MHP and some NGOs have demonstrated good practices in improving health knowledge and access among migrants in diverse settings. The appropriate next step is to scale up the model to replicate and/or modify good practices on a national

level. As migrants no longer limit themselves to live and work in border provinces but rather move around according to labour demand in all 76 provinces of Thailand, the migrant health service system should be considered and implemented by all public health authorities and facilities in all provinces. However, it is acknowledged that each locale will require a different level of effort according to the magnitude of the problem.

It is important to note that good practices drawn from a half decade of MHP implementation have had different levels of achievement in different settings based on a variety of factors, and certainly one size does not fit all. The MHP's experience has identified that a good understanding and analysis of local contexts is required to effectively replicate, apply or modify the model and employ good practices. Since the nature of migrant health services involves a provision of service to illegal migrants, public health personnel are discouraged from participating in such a program. The following key factors for success are essential regardless of replicated approaches applied in any setting.

A Clear Vision on Solutions to Migrant Health Issues and Leadership of Relevant Health Offices

Managers and coordinators should have a thorough understanding of the situation and a clear vision on solutions to migrant health issues in their responsible sites. This will help to shape program design, planning, implementation and evaluation. A transparent vision and direction should also be clearly communicated to all migrant health team members for effective contribution and implementation within the team.

Commitment from all levels of Relevant Government Agencies

The endorsed MOU between MOPH and IOM as well as the great contribution of MOPH staff at all levels of the MHP to date is demonstrative of the government's commitment to the development of the Program. Commitment at the central level motivates public health personnel at the provincial and field levels to feel more secure and protected to implement activities for irregular migrants. However, public health offices at provincial and district levels should have some level of autonomy to make the final decision about whether or not they are ready to take on the responsibility and to ensure local commitment to the program.

Effective Mechanisms for Program Management and Coordination

To ensure appropriate strategies and approaches are effectively implemented and that positive program outcomes can be expected, effective mechanisms for the program management and coordination are essential. As part of the management and coordination mechanism, periodic and systematic monitoring and technical support by relevant authorities is crucial to the improvement and success of the program.

Meaningful Involvement of Migrants

As a hidden population, irregular migrants are difficult to reach. Even if some sub-populations can be identified and physically reached, their diverse cultural backgrounds and languages do not allow for benefit from the physical reach of public health personnel. Meaningful involvement of migrants, particularly through MCHWs and MCHVs, is crucial. MCHWs should be formally recognized within the public health system to raise their self-esteem,

awareness and responsibility in helping peers and communities as well as to gain trust from target migrants. An improved awareness and responsibility of self and community care among migrants in general is also required to ensure positive changes in health and health seeking behaviors among this population.

Understanding and Cooperation from Thais in Host Communities

Porous borders between Thailand and neighboring countries and a disparity of social and economic stability, make it difficult to control cross-border migration. However, migrants could not live and work in Thailand if Thais in the local host communities do not allow them to do so. Accordingly, it is clear that there is a need to hire labour migrants, and that there are a large number of Thai populations who benefit from having migrants in their communities. Since these particular Thai populations are informed about where irregular migrants are and what kind of activities they engage in, a proactive involvement of the Thai populations who utilize labour migrants as well as those in host communities is critical. They need to understand the circumstances of migration, the benefits of orderly and appropriately managed migration, as well as the consequences of having a large number of undocumented migrants in their communities, not only in terms of the legal context but also in terms of health and social aspects. If an understanding and cooperation from local host communities is obtained, access to hard-to-reach irregular migrants could be realized.

It is vital to note that the Program also has great benefits to Thai host communities and government authorities. In addition to benefiting public health personnel, the MHP also benefits government officers in other sectors. For example, the Program provides training to Immigration Police Officers from key Immigration Detention Centers on general health prevention as well as those related to closed settings such as maternal and child health, stress management and the prevention of Tuberculosis and other respiratory and skin diseases.

Although the MHP was launched long before the development and endorsement of three National strategies; namely the Border Health Development Master Plan, the Migrant Health Strategy and the HIV/AIDS Master Plan, the Program design could contribute to and complement all three strategies. There is no doubt that Thailand will continue to attract migrants from neighboring countries, it is therefore important for government and/or non-government agencies to replicate the Program model and expand services to as many documented and undocumented migrants in Thailand. Adopting the Program model will contribute to the success of the Royal Thai Government's commitment to achieving "Healthy Thailand" agenda.

Reference:

1. United Nations Economic and Social Commission for Asia and the Pacific (UNESCAP). “*Statistical Yearbook for Asia and the Pacific 2007*.” Bangkok, Thailand. 2007.
2. Brian D. Gushulak and Douglas W. MacPherson. “*Health Issues Associated with Smuggling and Trafficking of Migrants*.” *Journal of Immigrant Health*, Vol. 2, No. 2, 2000.
3. International Organization for Migration (IOM). “*Migration Health - Challenges for the Future*.” Paper presented at the International Symposium on Migration. Bangkok, Thailand. April 1999.
4. Akram A. Eltom. “*Joint Assessment of Burmese Migrants’ Health in Thailand*.” International Organization for Migration (IOM). Geneva, Switzerland. December 2000.
5. Belton S. and Maung C. “*Working Our Way Back to Home*.” Melbourne University and OSI. 2005.
6. Penparktr Uthis, et al. “*Evaluation Report of IOM-MOPH Migrant Health Program in Tak and Chiang Rai*.” International Organization for Migration. Bangkok, Thailand. 2008 (unpublished).
7. Rosalia Sciortino and Sureeporn Punpuing. “*International Migration in Thailand 2009*.” International Organization for Migration. Bangkok, Thailand. 2009.
8. Srithamrongsawat, S. et al. “*Financing Healthcare for Migrant: A case study from Thailand*.” International Organization for Migration and World Health Organization. Bangkok, Thailand. 2009.
9. Bram Press. “*Migrants’ Health and Vulnerability to HIV/AIDS in Thailand*.” Prevention of HIV/AIDS Among Migrant Workers in Thailand (PHAMIT). http://www.phamit.org/download/migrant_health_hiv_vuln_phamit.pdf. Retrieved on 17 July 2009.
10. Penparktr Uthis, et al. “*Evaluation Report of IOM-MOPH Migrant Health Program in Samutsakorn, Ranong and Pang Nga*.” International Organization for Migration. Bangkok, Thailand. 2009 (unpublished).

Annex 1. Border Health Development Master Plan, 2007-2011

Introduction

Thailand shares long border with Myanmar, Laos, Cambodia and Malaysia by both land and sea. As technology and communication have been steadily improved, the world as well as disease epidemic becomes one without frontier.

The Ministry of Public Health developed the border health master plan to address its concern on the health situation of the border population. The plan is in line with the national security policy with in the aspect of human security. Efforts in improving the border health situation from the past until present have involved various partners and required tremendous work on collaboration and coordination. Therefore this initiative - border health master plan development is aimed to strengthen collaboration and coordination among relevant stakeholders from all sectors with the intention for the plan to be used as a partnership framework development all concerned. In addition, the plan should be viewed as a tool to guide all concerned agencies for their program development and fund raising that the common goal in “improving the quality of life of the border population” can be achieved.

This master plan is focusing at the border area in the Thai territory. However given the complexity and differences in politic, administration and policy in each country, the coordination and collaboration framework at the national level is viewed as a crucial component to promote the smooth collaboration between Thai and its neighboring countries, therefore inter - country collaboration is also pointed out in this plan.

Background and Rationale

1. Geographical Condition

The long border stretches over 5,820 KM. of Thailand, of which 3,205 KM is by land and 2,165 KM is by sea connected with its four (4) neighboring countries, including Myanmar, Laos, Cambodia and Malaysia. Totaling 30 border provinces; 10 provinces are adjacent to Myanmar, 11 provinces are located at the Laos border, 7 provinces are at the border to Cambodia and 4 provinces are bordering to Malaysia.

Some border provinces are located in the highland and difficult to access by road. In term of national security point of view, these provinces are posed as a vulnerable area for the country security's treat.

2. Thailand and its relationship with the neighboring countries

Situation in one country will always affect another; especially with countries shares their border. Differences in political, economic and social status have created disparity between Thailand and neighbors which leads to massive population movement from neighbors to Thailand. The massive migration of population from Myanmar, Laos and Cambodia to Thailand has created a negative impact on the Thai public health in particular at along the borders.

3. Border Context

There are populations with various ethnicities living along the Thai border. Many of them are stateless-hill tribe, legal and illegal migrant workers and their families. The context of each border area is difference by various aspects. All attributes, such as social, culture & custom and language used will have to factor in when working with these border communities.

4. Public Health Problems

Public health problems vary from border to border; however main health problems for all borders can be summarized below:

4.1 Communicable diseases, emerging and re-emerging diseases

Malaria, TB, STIs, HIV/AIDS, Diarrhea, SARS and Avian Flu are posed as main public health burden along the borders.

4.2 Mother and Child health and family planning

Reported maternal and infant mortality rates in the borders are still higher than the national target rates. Social value and inaccessible to health services, especially for family planning could be a factor that contributing to the unmet country target rates.

4.3 Access to health services

At present, RTG - MOPH universal health coverage applies only for Thai nationality. Ethnic minorities holding non Thai nationalities as well as illegal migrants are currently not included in the national universal health care scheme. This condition is limiting their accessibility to public health services.

4.4 Burden on health care expenditure

Thailand health service system is considered as more advance when compared to the 3 neighbors, except Malaysia. This better condition has attracted border population from the 3 neighboring countries to seek health care in Thailand, causing burden to the Thai public health along the borders.

4.5 Influx of migrant workers

Often a case that migrant workers move in and out across the border, however this mobility is not limited only at the border areas since the demand of cheap labor is noted through out the country, in particular in larger provinces.

4.6 Smuggling of illegal and unsafe consumable and non consumable products: food and drugs

4.7 Health Information Management

Current health Information of the border populations is scarce and still kept fragmentally in various offices/ organizations.

4.8 Increasing number of displaced persons in temporary shelters (camps)

Increasing in number of displaced persons residing in camps as well as migrants moving in and out camps is contributing to diseases outbreaks in camps.

4.9 Increased number of Thai population crossing border

Existing of casinos located at the other side of border attracts large number of Thai people and increased cross border activities. This could allow one to contracting out disease from as well as spreading out to others.

4.10 Other problems

Other major problems that Thailand is currently facing include unrest situation in the 3 southern provinces, criminal, illegal crossing border and human trafficking. These all factors will have a negative consequence on the Thai public health.

4.11 Loss follow up for medical treatment

Diseases such as Malaria and Tuberculosis require continuous treatment for a certain period of time. Drop out of treatment will result in poor health outcome and create resistance to microorganism strains.

4.12 Budget constraint

Facing scarce resource is another challenge for Thai public health authorities at the borders. At present additional population e.g. undocumented migrants and ethnic minority - hold non Thai ID card are not accounted for budget allocation from central MOPH.

5. Poor health condition affects country's economy and national security

Poor health condition will reduce one's capacity, especially with chronic diseases. This will lead to decreasing individual and family income which in the end will have a negative impact on economy in all level of society that finally would affect country security.

6. Central public health policy is not addressing the local needs

At present, local public health program planning is based on central policy, often a case that local needs are not properly addressed. Additionally lacking of supporting policy and budget support from central level has contributed to the additional challenges for local level to address the border health concerns.

7. Impact of Globalization on Epidemic occurrence

Globalization and country's infrastructure development are promoting migration and movement. This will contribute to increase the risk of disease epidemic/pandemic occurrence - for instance HIV/AIDS, SARS and Avian Flu.

8. Complexity of borders and border health

The context of each border is very complex; it involved various partners from various agencies and ministries. Since borders has various issues of concern, so border health is viewed as a complicated and sensitive issue. It can not be talking with one dimension approach. Additional challenges include diversity of ethnicity, culture, custom, belief and language used.

9. Cooperation with neighboring countries

Addressing public health concerns along the borders will not be success without strong cooperation from neighbors. Given the differences in socio political and economic among the 4 countries, it is crucial to have inter-country collaboration framework to foster the mutual collaboration.

Vision

Basic health service system is put in place in the border communities with universal access for all, in accompany with the effective diseases surveillance system by the year 2011.

Mission

1. Strengthen collaboration among stakeholders and develop quality health service system.
2. Promote access to primary health services with the participation from all stakeholders.
3. Act as a framework for all relevant agencies including government and non governmental organization in promoting healthy border populations, with regardless of nationality and religion.

Target Area

Total 30 border provinces are included in the target area. They are:

1. Thai - Myanmar Border: Chiang Rai, Chiang Mai, Mae Hong Sorn, Tak, Kanchanaburi, Ratchaburi, Pectchaburi, Prachaubkirikhan, Chumporn and Ranong
2. Thai - Laos border: Chiang Rai, Payao, Nan, Utaradit, Pitsanulok, Nhonkai, Loei, Nakornpanom, Mukdaharn, Amnajcharoen and Ubolratchathani
3. Thai - Cambodian border: Srisaket, Ubolratchathani, Surin, Buriram, Srakaew, Chantaburi and Trad
4. Thai - Malaysian: Songkhla, Narathiwat, Yala and Satun

Border Health Strategy

Six (6) strategies are developed to address the public health concern along the borders. They are including:

1. Promote access to health services and improvement of health facilities.
2. Promote healthy community through local community participation.
3. Improve migrant's health through improving access to health service.
4. Promote and support the community participation to establish the primary health care system at the border communities.
5. Integrate the work- plan and develop appropriate mechanism to promote coordination and collaboration among key stakeholders.
6. Promote inter- country cooperation with the neighboring countries.

They are elaborated in the strategy map (Please see annex1)

Strategy 1 : Promote access to health services and improvement of health facilities

Methods

- 1.1 Improve access to primary health services for the border population.
- 1.2 Up hold the standard for health centers at the borders on health promotion, curative care as well as assuring the effectiveness of the major communicable disease surveillance system that put in place.
- 1.3 Establish the surveillance system for crossed border products.
- 1.4 Provide support on medicine and medical supplies to border public health facilities.
- 1.5 Develop cross-border referral system.
- 1.6 Strengthen capacity of public health personal.

Strategy 2 : Promote healthy community through local community participation

Methods

- 2.1 In accordance with local context, promote participation of individual, community, Tambol administrative office (TAO), local administrative authorities, and civil society on public health program development.
- 2.2 Enhance collaboration and networking among public sectors, civil society and local community.
- 2.3 Provide health messages to target community via community radio in order to promote access to health education.
- 2.4 Establish public health volunteer network to promote individual and community health including performing health products surveillance.

Strategy 3 : Improve migrants' health through improving access to health services

Methods

- 3.1 Establish the public health service system for migrants.
- 3.2 Promote the universal health coverage.
- 3.3 Promote migrants and their community participation to look after individuals and their family health.
- 3.4 Develop migrant information management system.
- 3.5 Establish administrative system to manage migrant health service system.

Remarks : In details please refer to Migrant Health Master Plan, developed by Department of Health Service Support, Ministry of Public Health

Strategy 4 : Promote the community participation to establish the primary care system at the border communities

Methods

- 4.1 Strengthen networking among public and private sectors that compliments to the primary health care system development targeting ethnic minority, migrants and refugee community.
- 4.2 Establish migrant community health volunteer and core leaders in migrant and ethnic communities to promote individual and community health.
- 4.3 Develop IEC materials in local languages so that ethnic minorities and migrants can access to health information.
- 4.4 Develop transferal and referral systems.

Strategy 5 : Integrate the work-plan and develop appropriate mechanism for coordination and collaboration among key stakeholders

Methods

- 5.1 Formulate policy and policy recommendation based on the context and health problem of the borders.
- 5.2 Advocate for border health issue to be incorporated into the integrated provincial management strategies under the governor CEO.
- 5.3 Develop the integrated work-plan for border health program with relevant stakeholders including government agencies, local administrative organizations, private agencies and other relevant organizations.
- 5.4 Establish mechanism for fund raising and allocation of funds to support the implementation of the border health program.
- 5.5 Develop health information system that can be accessed and utilized by relevant offices as well as develop database on disqualified imported products that can be harmful to consumers.
- 5.6 Develop monitoring and evaluation system that is integrated into the existing system.
- 5.7 Establish public health networking among government agencies, private agencies, civil society and other organizations in the border area.
- 5.8 Strengthen cross border cooperation on public health issues with the neighboring countries.
- 5.9 Develop public health network in border area through appointing key responsible persons and focal persons in both national and provincial level.

Strategy 6 : Promote the cooperation with the neighboring countries

Methods

1. Corporate with neighboring countries to address the border health concerns with the common goal on the long term.
2. Coordinate with the Ministry of Foreign Affairs to ensure the border health plan is implementing in accordance with the government policy as well as using ASEAN, ACMECS and GMS agreement frameworks as a platform to formulate the international cooperation strategy.
3. Coordinate with relevant authorities dealing with neighboring countries to seek their support in addressing the border health concerns.
4. Coordinate with international organizations to strengthening all parties' efforts.

To effectively address the concerns on border health, all six (6) strategies must be incorporated with the well balance as they all are associated. Concentrating in one strategy is discouraging.

Factors contributing to success in addressing border health problems and development of the border health program

1. Apply new paradigm in dealing with challenges along the borders. These require common vision among person/ office concerned as well as strong intention and support from all managerial level.
2. Develop integrated public health planning with sufficient resources including budget.
3. Develop provincial public health network including migrant health volunteers.
4. Develop border health information system.
5. Establish effective collaboration and coordination among relevant stakeholders including neighboring countries.

Strategic Goals

1. All public health facilities up hold standard in providing health services to all. Basic health services can be access by all.
2. 30-50% decreased on public health problems/threats in the border areas (to be defined according to local context and national policy)
3. Effective Health Information System, Disease and other health threat Surveillance Systems developed.
4. Primary Health Care System in all border communities established at the end of 10th National Health Development Plan.
5. Public health network within country and inter country cooperation established.
6. Sufficient resources with good management in place to support working at local level.

Indicators

1. Existing of communicable, emerging and re-emerging diseases surveillance systems in border areas.
2. Effective disease control measures in place when diseases outbreak declared.
3. Percentage of migrant population accessible to public health services.
4. Implementation of border health activity against the integrated plan.
5. Level of community participation in implementing the border health activity.
6. Quality of imported consumable and non consumable goods.

Roles and duties of relevant government agencies to support the Border Health Master Plan implementation

Ministry of Public Health

1. Perform disease surveillance and control of main communicable, emerging and re-emerging diseases.
2. Strengthen capacity of health care facilities under MOPH structure.
3. Conduct surveillance on quality of health products to ensure consumer's safety.
4. Provide health information on endemic communicable and re-emerging diseases to the public.
5. Provide health check, treatment, health prevention and promotion to registered migrants.
6. Expand health service coverage to ethnic minorities and non registered migrants.
7. Perform health products surveillance along the borders.

Ministry of Labor

1. Legitimately improve migrant employing system, in accordance with cabinet's decision to regularize migrants as well as to fasten the process to import migrants, following the MOU signed with the 3 countries (Myanmar, Laos and Cambodia).
2. Promote understanding among migrant workers and employers on the migrant's benefit on the health service package.

Ministry of Interior

1. Provide security and protection to displaced persons living in camps.
2. Facilitate and cooperate with all agencies providing humanitarian services to displaced persons living in camps e.g. AMI, ARC, IRC and MI.
3. Assist in disseminating of health information including disease outbreaks to local Thai population, village health volunteer, village headman and district officials for their proper cooperation and action.
4. Strengthen capacity of local community and local administrative offices in promoting community health and controlling of communicable and re-merging diseases.
5. Provide financial support to implement border health activities in integrated manner with other offices.

Ministry of Defense

1. During crisis, provide support on disease surveillance and control in accordance with ministry's capacity.
2. Provide relevant health information to military troops who station at the border areas.
3. Provide support for public health personnel and international organization staff to coordinate with neighboring countries on border health problems.

Ministry of Foreign Affairs

1. Responsible for inter- country collaboration to promote smooth implementation of border health activities together with neighboring countries.
2. Provide support to neighboring countries in improving their border health service system.

Immigration Office (IO)

1. Exchange relevant information with MOPH through
 - a. Develop effective information management system.
 - b. Define effective control measures to deal with illegal crossing border.
 - c. Implement effective control measures to cease illegal crossing border.
 - d. Improve its capacity on repatriation and deportation.
2. Collaborate with MOPH in managing migrant who has not received health check clearance.
3. In case of sick migrant found overstay, IO will collaborate with MOPH to ensure that migrant will receive basic/ complete treatment before they are charged according the immigration act.

Royal Thai Police

Cooperate with relevant agencies in preventing and dealing with illegal migration systematically.

National Security Council

Collaborate and coordinate with relevant agencies to maintain country security as well as to ensure the border health activities reaching out to target population.

Roles and duties of relevant international organizations and non governmental organization to support the Border Health Master Plan implementation

World Health Organization (WHO)

1. Provide financial support to implement border health activities including building capacity of health officials.
2. Conduct/facilitate meeting for health information exchange among organizations concerned.
3. Develop Health Information System for Thai - Myanmar border.
4. Provide financial support or relevant study or action research.

International Organization for Migration (IOM)

Support Ministry of Public Health to address the health situation of migrant populations, by working with various offices/bureaus such as Department of Diseases Control, Department of Health Service Support, Department of Health and Provincial Health Offices. These include:

1. Establish health service system for migrants
2. Establish primary health care system which should be included:
 - i) diseases prevention and control,
 - ii) reproductive health, and
 - iii) environmental health component
3. Strengthen capacity and skill of health officials, community health worker and community health volunteer in dealing with migrants' health
4. Provide friendly health services to migrants
5. Extend cooperation with other relevant agencies

United Nation High Commissioner for refugees (UNHCR)

1. Provide financial support to operate humanitarian assistance to displaced persons and Thai host communities.
2. Provide humanitarian assistance and protection to displaced persons living in camps.
3. Provide support to promote educational system in displaced persons camps.

Kenan Institute Asia

1. Follow and document malaria drugs resistance along the borders
2. Provide technical and financial support to establish effective mechanisms for disease surveillance and control along the borders.
3. Promote healthy behaviors among target populations.
4. Provide financial support for technical meeting and training.

World Vision

1. Address the issue on HIV/AIDS in migrant populations along the borders.
2. Provide basic health services to migrants.
3. Strengthen migrant health volunteer's networking.
4. Collaborate with World Vision- Myanmar for patient referral system.

IRC

1. Provide health services to displaced persons living in camps in Mae Hong Son and Rachaburi.
2. In collaboration with PHO Tak, Pob Pra district health office and IOM in providing health services to migrants in Tak province.

SAMEO TROPMED Network

1. Strengthen capacity of health officials on
 - a. Malaria and HIV surveillance
 - b. Uncomplicated malaria treatment
 - c. Using GIS for data management
2. Perform inter county collaboration on tropical disease prevention and control
3. Conduct research on malaria treatments
4. Support the inter-country collaboration meeting on HIV/AIDS

Raks Thai Foundation

1. Expand HIV/AIDS prevention and control program to cover migrant populations in 22 provinces
2. Develop health service system for migrants in partnership with MOPH,
3. Strengthen community development to promote community of life and harmonizing migrants and Thai's host community.
4. Advocate having favorable policy for migrants to access to health services

Thailand-U.S.CDC Collaboration (TUC)

Support HIV/AIDS, TB, STIs prevention and control along the borders

Global Fund

Provide funding to support diseases prevention and control on HIV/AIDS, TB, and Malaria

Annex 2. National Master Plan for HIV/AIDS Prevention, Care and Support for Migrants and Mobile Population (MMP), 2007-2011

Drafted in October 2006 from the results of the meetings of CTWG, PSC, planning workshops. Revised from meeting results of Country Technical Working Group on 10 January 2007, 16 March 2007 and 20 September 2007, as well as from the meeting recommendations of Ethnic Minorities on 13 March 2007.

Target population:

- 1) External migrants: migrants from Myanmar, Lao PDR and Cambodia who cross international borders and live in Thailand either in cross border or inner provinces, including both documented and undocumented to be allowed to stay in Thailand.
- 2) Displaced people residing in camps in Thailand.
- 3) Thai migrant workers: Thai people who cross international borders to work in foreign countries.
- 4) Ethnic minorities

Concept for interventions:

- a) Vulnerability and risk
- b) Safe mobility approach through understanding the mobility process, which lead to contiguous programming at source, transit and destination.
- c) HIV/AIDS and Development: Early Warning and Rapid Response System: EWRRS.
- d) Gender mainstreaming, language and cultural diversity as key consideration to enhance the access to services and effective interventions.
- e) Support the meaningful involvement of migrants and mobile populations.
- f) Integrated sexual health into HIV/AIDS prevention, care and support intervention.

<i>Narrative Summary Indicators</i>	<i>Objectively Verifiable to be defined by</i>	<i>Means of Verification Assumptions</i>	<i>Important</i>
<p>Goal:</p> <p>1) Reduced new HIV infected people among MMP</p> <p>2) Increased quality of life of HIV-infected MMP</p>	<p>1.1 Prevalence of HIV infection among MMP classified by gender and age (<25, 25+) reduced from 2007 by 1/3 in 2011</p> <p>2.1 Percentage of HIV-infected MMP classified by gender and age (<25, 25+) having accepted better quality of life</p>	<p>Country Technical Working Group on Information System Development</p> <p>Country Mobility Technical Working Group on HIV/AIDS prevention, care and support for Migrants and Mobile Populations</p>	<p>A positive and supportive political environment exists for national interventions and regional cooperation on issues of HIV/AIDS and mobility</p>

<i>Narrative Summary Indicators</i>	<i>Objectively Verifiable to be defined by</i>	<i>Means of Verification Assumptions</i>	<i>Important</i>
<p>Purposes:</p> <p>1. Increased access to effective HIV/AIDS prevention, care and support for MMP</p> <p>2. Reduced HIV vulnerability and risk for MMP</p>	<p>1.1 Number and percentage of MMP classified by gender and age (<25, 25+) reached by HIV prevention program annually</p> <p>1.2 Number and percentage of HIV-infected MMP classified by gender and age (<25, 25+) who are on care registration annually</p> <p>1.3 Number and percentage of HIV-infected MMP classified by gender and age (<25, 25+) who are eligible to ART have started ART annually</p> <p>2.1 Evidence of HIV vulnerability and risk identified and reduced for each target population</p>	<p>Country Mobility Technical Working Group on HIV/AIDS prevention, care and support for Migrants and Mobile Populations</p> <p>Country Mobility Technical Working Group on HIV/AIDS prevention, care and support for Migrants and Mobile Populations</p> <p>Country Mobility Technical Working Group on HIV/AIDS prevention, care and support for Migrants and Mobile Populations</p> <p>Country Mobility Technical Working Group on HIV/AIDS prevention, care and support for Migrants and Mobile Populations</p>	
<p>Outputs</p> <p>1) Enabling and feasible policy/ law / regulation for HIV/AIDS prevention and care among MMP</p> <p>a. External migrants</p> <p>b. Displaced people residing in camps</p> <p>c. Thai migrant workers</p> <p>d. Ethnic minorities</p>	<p>a.1 Migrant health workers issue is legally accepted by the year</p> <p>a.2 HIV/AIDS prevention, care and support issues in Thai migrant workers protection plan by the year</p> <p>c. Pre-departure, during working aboard and post-returnee HIV/AIDS program for Thai migrant workers stated in the regulation by the year</p>	<p>Country Technical Working Group on Advocacy</p>	<p>Increased coverage of health insurance for both documented and undocumented migrants (According to Migrants Health Strategies - co-ordinated by Department of Health Service Support, Ministry of Public Health)</p>

<i>Narrative Summary Indicators</i>	<i>Objectively Verifiable to be defined by</i>	<i>Means of Verification Assumptions</i>	<i>Important</i>
<p>d. Health Security Plan for ethnic minorities by year</p> <p>2) Improved capacity of individuals and institutions working on HIV/AIDS among MMP</p> <p>a. External migrants</p> <p>b. Displaced people residing in camps</p> <p>c. Thai migrant workers</p> <p>d. Ethnic minorities</p>	<p>a.1 National network on capacity development for working with HIV/AIDS among MMPs established and functioned by the year</p> <p>a.2 Number of target provinces with HIV/AIDS working network by the year.....</p> <p>c. Pre-departure HIV/AIDS training program for Thai migrant workers customized designed for individual destination country stated in the regulation by the year</p> <p>d. Health network of ethnic minorities linked with other networks by the year</p>	<p>Country Technical Working Group on Capacity Building</p>	
<p>3) Developed database system to provide information for planning, monitoring and evaluation</p> <p>a) External migrants</p> <p>b) Displaced people residing in camps</p> <p>c) Thai migrant workers</p> <p>d) Ethnic minorities</p>	<p>a.1 Annually reports on the situation and response to HIV/AIDS among MMPs at national and provincial levels by the year.....</p> <p>a.2 Annually reports of target provinces on the situation and response to HIV/AIDS among MMPs by the year</p>	<p>Country Technical Working Group on Information System Development</p>	

<i>Narrative Summary Indicators</i>	<i>Objectively Verifiable to be defined by</i>	<i>Means of Verification Assumptions</i>	<i>Important</i>
4) HIV prevention and infrastructure development	4.1 HIV/AIDS impact assessment of infrastructure development project and the HIV prevention project becomes one of the key impact assessments to be done prior to the infrastructure construction begins.	Country Technical Working Group on HIV and Infrastructure Development	
5) Functional collaboration at local cross-border, bilateral and regional level	5.1 Numbers of MOU on continuous operational joint action program for HIV/AIDS prevention and care among MMP 5.2 Numbers of provinces bordering neighboring countries which operate HIV/AIDS prevention projects.	Country Mobility Technical Working Group on HIV/AIDS prevention, care and support for Migrants and Mobile Populations	
Main Activities: 1.1 To revise national laws, decrees and sub-decrees as well as national security which obstructs the implementation of HIV prevention, care and support for migrants and mobile populations. 1.2 To build positive attitude of societies toward migrants and mobile populations thoroughly and continuity e.g. to build up better understanding of MMPs as MMPs are vital workforce of economic growth and to recognize the religious, cultures, community development of MMPs in order to create constructive environment in the community. 1.3 To build capacity of MMPs through migrant rights based approach and to develop mechanism to access information from MMPs and network among governmental organizations, employers and migrant associations.		Focal points (GO/ NGO / INGO):	Collaborating institutions:

<p>2.1 To develop national network of capacity building of institutions working on HIV/AIDS in MMPs</p> <p>2.2 To conduct training need assessment, develop curriculum, training for trainers and develop capacity building plan on HIV/AIDS and MMPs</p> <p>2.3 To deliver training programme to implementation staffs.</p> <p>2.4 To set up and develop center for medias in different languages at national and target provincial levels</p> <p>2.5 To develop more channels to access services, i.e. drug stores, private clinics, private hospitals as well as to provide outreach services, e.g. peer-to-peer education, mobile VCT. To MMPs</p> <p>3.1 To review existing database system and add variables useful for HIV/AIDS prevention and care among MMPs</p> <p>3.2 To empower the staffs working on MMP data and information at national and target provincial levels to develop their database system</p> <p>3.3 To develop information system to the implementation plan at sub-district, district and provincial levels.</p> <p>3.4 To develop monitoring and evaluation system that can be linked at national, specific provincial level and be able to be used for the implementation plan, advocacy and networking among stakeholders.</p> <p>3.5 To develop the exchanging and referring data and information between organizations in the country as well as with source countries for migrants and transit and destination countries for Thai migrant workers</p> <p>3.6 To develop information system management to the evaluation</p> <p>4.1 To set up the Early Warning Rapid Response System in order to potential scenarios of what will happen to HIV vulnerability under conditions of development, to which responses should be built to prevent HIV transmission before hand.</p>		
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<p>4.2 To create collaboration from private sectors for HIV prevention among MMP in infrastructure development projects.</p> <p>5.1 To identify and develop technical methodology needed for the operationalization of the signed MOUs</p> <p>5.2 To set up technical assistance mechanism to operationalize the MOUs</p> <p>5.3 To support the collaborative mechanism between countries at regional, national and cross-border levels</p>		
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Annex 3. Migrant Health Strategy¹³ (draft)

Target group

Migrant populations

Definition

Migrant population refers to labor migrants, their families and dependents, who are of Myanmar, Laotian, Cambodian and other nationalities. The term includes those who have been registered with the Ministry of Interior (with a 13-digit identification number) and those who have not been registered (no 13-digit identification number), as well as ethnic minorities living in Thailand. However, this term does not include any persons displaced from civil conflict who are residing in the temporary shelters.

Vision

Migrants are healthy and have access to quality, comprehensive health services as a result of integrated cooperation and participation from government, local administrative organization, private sector, non-governmental organizations (NGOs), and local communities.

Responsibilities

1. Ensure the availability of a quality, accessible health service system including health promotion, disease prevention and control, health care and treatment, and rehabilitation.
2. Support for alternative health insurance coverage schemes.
3. Support primary health care services in migrant communities to encourage participation from migrants and communities in self and family health care.
4. Strengthen and coordinate multi-sectoral collaboration at all levels, including government, local administrative organization, private sector, NGOs, and local, national and international Community Based Organizations (CBOs).
5. Develop the migrant health information system with linkages to other databases so that data can be used for planning, monitoring and evaluation of public health results at all levels.
6. Develop an efficient and effective migrant health management system.

¹³ This Migrant Health Strategy was developed by the working committee, comprised of public health officers and relevant agencies from policy and implementation levels including both government and non-government organizations since 2005. Following a series of workshops, the drafted strategy preceded through a public hearing with representatives from government and non-government sectors from every province of Thailand attending the 1st National Migrant Health Conference 5-7 July 2006. The working committee revised the drafted strategy and presented the updated version of the strategy to all stakeholders in October 2006. On 3 November 2006, the draft was revised once again in order to be endorsed for application as a guide for the development of migrant health activities.

Strategies

1. Migrant health service system
2. Health insurance scheme
3. Participation of migrants and communities in self and family health care
4. Development of information system
5. Management system

Strategy 1 : Migrant health service system

Goal : Public and private health facilities provide quality, comprehensive and accessible health services in accordance with conditions and limitations of the population.

Key Performance Indicators

1. Percentage of health facilities that provide health services to migrants without communication barriers.
2. Percentage of health facilities that provide health promotion and disease prevention to migrants both in the community and at health facilities.
3. Proportion of migrants receiving health promotion and disease prevention services.

Methodologies

1. Develop a friendly service system and reduce communication barriers by using appropriate mechanisms.
2. Develop a health promotion system, active disease prevention and control including occupational health and safety.
3. Promote living conditions of migrants according to the principles of environmental health.
4. Develop in-country and cross-border migrant referral networks for appropriate treatment by establishing a referral coordination center.
5. Strengthen the capacity and attitude of public health personnel as well as the public health workforce in accordance to demands for the workload.
6. Develop and promote migrant health workers to support migrant health services.

Strategy 2 : Health insurance scheme

Goal : Migrants who are registered according to the cabinet resolution or holding a Tor Ror 38/1 have universal health coverage

Key Performance Indicators

1. Percentage of registered labor migrants who have health insurance.
2. Percentage of dependents of registered labor migrants who have health insurance.
3. Availability of other health care systems for other groups of migrant populations.

Methodologies

1. Strengthen the coordination, monitoring and auditing systems of the migrant health insurance scheme for migrants and dependents who are registered according to the cabinet resolution or holding a Tor Ror 38/1.
2. Promote understanding of health insurance entitlements, particularly among employers and migrant populations.
3. Develop alternative health care systems for other groups of migrants in accordance to local contexts.
4. Integrate a system for collective monitoring and coordination systems among relevant organizations and employers in order to increase the coverage of health insurance among migrants.

Strategy 3 : Participation of migrants and communities¹⁴ in self and family health care

Goal :

1. Migrants, together with their host communities, can take care of their own health as well as the health of the community.
2. Communities that host migrants consistently implement joint health care activities¹⁵.

Key Performance Indicators

1. Percentage of communities that have representatives in the form of health volunteers, workers, leaders (such as migrant health volunteers, migrant health workers, migrant health leaders), or Migrant Community Health Posts.
2. Number of participatory health promotion activities conducted by the community.
3. Number of vaccine-preventable disease outbreaks among migrants and the incidence of major communicable diseases or severe diseases in the community such as diarrhea, tuberculosis, avian influenza in humans, sexually transmitted infections, and AIDS, etc.

Methodologies

1. Promote and support Migrant Community Health Workers and Volunteers / Migrant Health Leaders through appropriate position employment policies.
2. Strengthen the capacity of Migrant Community Health Workers and Volunteers, and Migrant Health Leaders in self, family and community health care
3. Promote learning networks and support the work of Migrant Community Health Workers and Volunteers, and Migrant Health Leaders including coordination with Thai Village Health Volunteer networks.
4. Promote a supportive participatory, system, and the positive attitude of networks including government, private sectors, the Thai population, entrepreneurs and local administrative organization on providing primary health care to migrant communities.
5. Establish the Migrant Community Health Post as deemed appropriate within the local context.

¹⁴ “Community” herein refers to the geographical areas where migrants are living together or the workplace establishment where migrants live. It can be categorized by the responsibilities of the organization or component of community which also includes both Thais and migrants who live in the same community

¹⁵ “Health care activities” herein refers to health knowledge in accordance to tradition and culture, environmental hygiene, health promotion, disease prevention and control, primary care, and rehabilitation.

Strategy 4 : Development of information system

Goal : Accurate and up-to-date migrant health information is available, accessible and connected to other databases that can be used in planning, monitoring and evaluating health activities at all levels.

Key Performance Indicators

1. Number of migrant health information centers at provincial and central level.
2. Number of persons / organizations that utilize the information at the migrant health information center.

Methodologies

1. Develop an information system to link with relevant databases of other sectors.
2. Allocate a budget to support the information system.
3. Establish a migrant health information system at provincial and central levels.
4. Promote the dissemination and use of migrant health information in planning, monitoring and evaluation.
5. Establish a structure for migrant health information management in the form of a committee that comprises relevant agencies including both government and private sectors.

Strategy 5 : Management system

Goal : Efficient and effective management system is established in order to support the implementation of the Migrant Health Strategy.

Key Performance Indicators

1. Number of policies at all levels that support migrant health activities.
2. Number of migrant health work plans that are developed with participation from all sectors.
3. Number of public health agencies at local and central levels that have migrant health management structures established and persons responsible appointed.
4. Amount of the budget contributed from various organizations to support migrant health activities.

Methodologies

1. Promote an integrated policy and work plan for migrant health activities.
2. Establish a migrant health management committee that comprises relevant government and private sectors.
3. Manage the migrant health insurance budget to support effective migrant health activities.
4. Establish supporting mechanisms including sufficient budget and/or resource allocation from all sectors to serve migrant health management.
5. Support migrant health monitoring and supervision according to the government inspector system or other similar system.

Note : The original strategy document is only available in Thai language. This English version is translated from the Thai version. Should there be any discrepancies in the two versions; the original Thai version should be used as an official reference.

Annex 4. Background Information on Migrant Community Health Workers

Scope of Work

The key role of the Migrant Community Health Workers is to assist public health personnel with implementing migrant health service activities. This includes the whole process of community health development. In summary, they primarily conduct the following tasks:

- ❑ Conduct community health assessments including community and migrant population mapping and baseline surveying;
- ❑ Assist public health personnel to develop IEC tools and materials in migrant languages;
- ❑ Conduct community outreach to deliver health education, information and communication activities to promote migrants' health related knowledge, awareness and practices through face-to-face and small group discussions as well as the large scale campaign;
- ❑ Provide basic health consultation, prevention, care, and referral to migrants mainly through the mobile clinic organized by the public healthcare providers, community/home visit, and health post service;
- ❑ Provide medical translation/interpretation for migrant patients and the Thai care providers;
- ❑ Provide basic service to improve community sanitation such as vector control;
- ❑ Assist the District Surveillance and Rapid Response Team to conduct infectious disease outbreak investigation and control as required.

Minimum Requirements

Below are minimum qualification requirements of Migrant Community Health Workers.

- ❑ A primary education (six years) or higher.
- ❑ Ability to speak Thai and one or more of the relevant migrant languages.
- ❑ Ability to read and write one or more of the relevant migrant languages.
- ❑ Ability to read and write Thai is preferred but not required.
- ❑ To ensure the sustainability of the Program, a Thai national with the same ethnicity as migrants is preferred. However, in the settings where individuals with such qualifications are not available, registered migrants from the same ethnicity of the migrants in the target communities can also be considered.

Capacity Building for Migrant Community Health Workers

Throughout the Program period, Migrant Community Health Workers receive a series of formal and informal capacity building opportunities. These do not only include public health topics but rather a series of various issues and procedures for community health development, which mainly include the following:

- ❑ Following recruitment, an initial training is provided to Migrant Community Health Workers for 10 days. The training manual and materials were developed by the public health personnel who are part of the MHP team. The training is delivered by public health personnel, visiting trainers, and IOM technical staff who are keen on capacity building process. The training covers several basic health issues as well as essential techniques for their initial tasks such as community mapping and interview techniques for migrant data collection.

- ❑ During the first year of Program implementation, Migrant Community Health Workers receive two-three days training on additional topics on a quarterly basis. These mainly include public health issues, how to approach communities, presentation and facilitation skills, development of IEC materials, counseling skills, etc.
- ❑ In following years, Migrant Community Health Workers continue to receive training on a quarterly basis. The training addresses both additional public health issues that are necessary for their work as well as emerging diseases such as Avian and Human Influenza and Pandemic Influenza Preparedness. In addition, Migrant Community Health Workers may also receive refresher training on the topic or skill areas where they still require further improvement to be able to effectively perform their assigned tasks.
- ❑ On a monthly basis, the local MHP teams organized meeting to review achievements and lessons learned from the previous month as well as to develop a detailed workplan for the following month according to the annual workplan. At the monthly meeting, Migrant Community Health Workers may also receive a half-day refresher training on specific topic upon their request.
- ❑ In addition to the formal training, Migrant Community Health Workers also receive several informal capacity building opportunities. For example, they receive day-to-day, on-the-job training and mentoring from their mentors who are public health personnel. They also participate in the regular team meeting, annual program review, and the bi-annual National Migrant Health Conference.

Note : Migrant Community Health Workers with Thai nationality are given priority employment by local health authorities and facilities to avoid misconduct as well as to ensure the Program sustainability. However, this kind of Migrant Community Health Workers is very limited in number and only exists in a few implementation sites such as Tak Province. Therefore, there is still a huge need for the MOPH to receive external donor support for this purpose, at least for the next few years until the MOPH develops formal systems to train and hire Migrant Community Health Workers.

Annex 5. Background Information on Migrant Community Health Volunteers

Scope of Work

The key role of the Migrant Community Health Volunteers is to assist the public health personnel as well as Migrant Community Health Workers in implementing migrant health service activities. This mainly includes;

- ❑ Dissemination of health information and IEC materials.
- ❑ Dissemination of related information such as mobile clinic schedules.
- ❑ Participation to large scale campaigns such as health information campaign, vector control campaign, community sanitation and waste management campaign.
- ❑ Being peer educators for community health information either at their community housing or in workplaces through the health information corners.
- ❑ Serve as an element to the migrant health referral networks by coordinating with public health facilities for referral or directly accompany migrant patients to the networked health facilities.

Minimum Requirements

Below are the minimum requirements for the qualifications of the Migrant Community Health Volunteers.

- ❑ Ability to speak one or more of the relevant migrant languages.
- ❑ Being long-term residents of the target communities to avoid frequent turn over.
- ❑ Willingness to participate in the Program activities on a voluntary basis without set compensation.
- ❑ Being trusted and selected by the target communities.

Capacity Building for Migrant Community Health Volunteers

The Migrant Community Health Volunteers also received a series of capacity building opportunities in a similar fashion as the Migrant Community Health Workers but at a lower frequency with less detail. These mainly include:

- ❑ Two-day initial training from the MHP team members on basic health issues such as first aid, personal hygiene, maternal and child health, community sanitation and communicable diseases control and prevention.
- ❑ Periodically, the Migrant Community Health Volunteers receive two one-day training semi-annually on topics that are necessary to perform their tasks, either new or refresher training. The purpose of the periodic training is not only to strengthen their knowledge and skills as a Migrant Community Health Volunteer, but the training is also considered a good incentive as well as networking opportunity for them. During training, Migrant Community Health Workers also participate in assisting the trainers to organize the training as well as to provide translation service. This also allows Migrant Community Health Workers to meet and network with Migrant Community Health Volunteers.



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