TB Reduction Among Non- Thai Migrants (TBRAM) Project

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

World Vision
มูลนิธิศุภนิมิตแห่งประเทศไทย

2009 Year 2 Annual and Phase 1 Report
World Vision Foundation of Thailand
Supported by the Global Fund to Fight AIDS, Tuberculosis and Malaria

About the Cover:
Many communities that World Vision works with lie on the border areas between Thailand and Myanmar whereas the border may or may not be visible. This community lives by the coastal area where Myanmar is visible and easily accessible to cross. Mobility of the migrant TB patients has proven to be one of the biggest challenges for an effective TB control among migrants.

About the Photo above:
Cured migrant TB patients with their WVFT TB counselors.

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

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

Writers: Mary Grace T. Gayoso, Jaruwaree Snidwongse, PhD
Contributing Writers: Nang Sarm Phong, MD
Editors: Mary Grace T. Gayoso, Jaruwaree Snidwongse, PhD
Lay-out & Design: Wittawat Suttipongkeat

© 2010 World Vision Foundation of Thailand
All rights reserved. This publication may be quoted, reproduced, or translated, in part or in full, provided that the source is properly acknowledged and a written consent is secured from World Vision.

World Vision
มูลนิธิศุภนิมิตแห่งประเทศไทย

ARC INTERNATIONAL

Table of Content

2009 Year 2 Annual and Phase 1 Report
World Vision Foundation of Thailand

Message from the **PR Manager**

This report is both a Year 2 and a Phase 1 report of the TB RAM Project which intends to summarise the efforts made by all partners, both by World Vision Foundation of Thailand and by the American Refugee Committee in Phase 1.

Initially, during the proposal writing process, when I knew nothing about TB, a friend and advisor once told me that a TB control project is like a cookie-cutter project – meaning that it should not be very difficult in implementing as TB is an old disease and there are many tools and information available on TB. Such statement lulled me into believing that implementation of such kind of project should not be much of a problem. What he did not tell me was that, it is a cookie-cutter project if it is in a normal setting (i.e. to implement a TB project among the country's own population) but when it comes to a migrant setting, many issues posing as challenges may or may not be a main issue among the Thai population.

As people in TB control know, TB as a disease already has its own stigma and discrimination. In a setting where the migrants are non-Thais and are long-term mobile visitors – almost residents in the country with a long history with its neighbouring countries – the project's Sub-Recipients (SRs) found themselves facing double discrimination at the least. One is for being a TB patient, and another is for the patients being migrants themselves. In this project, we as implementers cannot deny certain amount of discrimination posed against the migrants, which resulted to lack of or barriers to access to care. However, in this gloomy scenario, we also found some silver linings among the people we work with. The SR staffs had been putting so much effort into identifying and collaborating with various stakeholders, including the business owners, police officers, and health and TB officers at various levels. The effort to gain trust in the community and the patients had also paid off despite various challenges along the way.

In this report, I am very proud to give you some human faces of the TB control project and not just facts and figures because at the end of the day, it is the individual lives that we touch - to allow them to heal and get cured from this disease. I myself had shed tears when hearing stories of patients and how much they had suffered. At the same time, I had been bewildered by stories of kindness and the endeavor that the staff or the volunteers went through just to ensure patients' adherence.

We had the privilege of acquiring the assistance of our new friend from World Vision Regional Office, Grace Gayoso, who wrote this document for us in a very short period of time. I'd also like to acknowledge and salute all the colleagues at the Principal Recipient (PR) & SR levels, those from the Regional Office, and to all the government health officers, who had been contributing the most to the success of the project in the past two (2) years. Most of all, I would like to take my hats off to the migrant communities and the patients for ensuring that their selves, their friends, and their loved ones would be cured of this disease through their own efforts.

Jaruwaree Snidwongse Na Ayuddhaya
Principal Recipient Manager

Highlights of **TB RAM**

World Vision Foundation of Thailand and its partner, American Refugee Committee (ARC) has stirred up TB control efforts among migrant populations despite various challenges surrounding the migrant setting. Community-based DOT is not currently a norm in Thailand. By building on the experiences in Social Mobilization among migrants in previous migrant health projects,TB RAM project had trained and retrained at least 2,500 Migrant Health Volunteers each year to disseminate information and act as DOT partners.

The Migrant Health Workers and Volunteers had spurred the interest of the community members and saved more lives through TB education. Both Migrant Health Volunteers and the community members had referred more than 5,000 suspects, where year 2 received 3 times more suspects referred compared to year 1. Within two years, the communities had identified almost 700 of the suspects who had been suffering with the disease.

142 Community Health Posts were established across the 6 provinces to provide a space for the migrant communities to access information and TB verbal screening services provided by the volunteers. Many of these health posts were provided by the business owners of the migrant workers after successful local-level advocacy efforts had paid off. Sputum samples were collected at the health posts and referred to the government hospitals for laboratory examination.

Many volunteers had been given the great responsibility of becoming DOT partners, providing Anti-TB medicine to TB patients on a daily basis. Many methods had been devised to ensure treatment completion including provisions of nutrition and food packages for patients who could not work and had no money. Sometimes a new job or an accommodation had to be found for the patient to allow him to stay put for at least 6 months to complete the treatment. Overall treatment success rate for TB positive patients had been 85%, right on the WHO standard, a number not easily achieved for a highly mobile population.

Advocacy events were organized to increase awareness of TB at both national and provincial levels. Bangkok Metropolitan Administration was the key partner for advocating a national campaign in 2009. In the provinces, provincial campaigns and community-level activities went alongside to create a fun space for learning about TB. Concerts, drawing competitions, sports, drama, and many other activities were organized in the 6 provinces with the government and community as their partners. Staff and volunteers went from house-to-house to distribute IEC materials and posters in the communities, to advocate both Thais and migrants.

Year two was also a crucial year for the project. From the 2-year success of the project with high grading from GF, WVFT has successfully secured the Phase 2 grant to continue its efforts for the next three years. A new partner has also been recruited as a Sub Recipient for Phase 2, Kwae River Christian Hospital. The hospital, with its long TB control experience with GF Round 1 would provide a strong partnership to both WVFT and ARC.

Migration, TB, and the Economy:
The Thailand Experience

The migration phenomenon

Crossborder migration is not uncommon in Thailand. The country's strategic location, sharing borders with Myanmar, Laos, Cambodia, and Malaysia, has made cross-border migration easy. In Kraburi District in Ranong province, Thailand and Myanmar are separated only by a 200-meter wide river. In some of the areas, the distance can even be as narrow as 10 meters (American Refugee Committee, 2009). People coming from Myanmar can even reach Thailand's Kanchanaburi province by foot (Suksiri, 2007). Thailand's relative affluence within the region and its growing economy also makes it an attractive destination for migrants from neighboring countries seeking better life (World Vision Foundation of Thailand [WVFT], 2008).

Among all of Thailand's neighboring countries, Myanmar shares the longest border with the country. Such shared border runs 2400 km long and cuts through ten provinces of Thailand (Clarke, 2009). With Myanmar sharing most of its border with Thailand and with its long history of migration, it is not surprising that 80% of the approximately 2.5 million migrants in the country are from Myanmar (WVFT, 2008). Political, economic, and social instability; poverty, bad debts, and lack of employment opportunities have led many Myanmar migrants to relocate to Thailand despite high risks involved for staying illegally (Clarke, 2009; Suksiri, 2007).

Thailand's economic growth has also contributed to such migration phenomenon. The country is tagged as the fourth richest nation in Southeast Asia in relation to per capita income following Singapore, Brunei, and Malaysia, and its per capita GDP is seven times higher than its neighboring countries such as Myanmar, Cambodia, and the Lao People's Democratic Republic (Sciortino and Punpuing, 2009). This economic growth led to the boom of various sectors such as fishing, manufacturing, construction, and agricultural industries such as in rubber plantations and palm oil farms, thus requiring an increase in demand for both skilled and unskilled labor. According to Urbano, Myanmar is "conveniently…a plentiful source of cheap, pliant labor for the Thai industry" (as cited in Clarke, 2009).

Thailand's experience of affluence and the increase in Thai education levels further contributed to human resource shortage in low skilled jobs since it was observed that many of its citizens are avoiding what was coined as the 3D jobs – dangerous, dirty, and disdained (Clarke, 2009; Sciortino and Punpuing, 2009). Consequently, only the migrants accept these kinds of jobs despite lower wages and poor working conditions since what they will earn is still relatively higher than what they will earn in their own countries (Sciortino and Punpuing, 2009).

Migrants: Movers of economic growth

The impact of migrants, both legal and illegal, to the Thai economy cannot be denied. According to the 2009 report of the International Organization for Migration (IOM), the migrants' contribution to the Thai economy is 1.25% or US$2 billion of the US$177 billion Thai GDP in 2005 (Sciortino and Punpuing, 2009). Typically living in border regions, most migrants works in fishing and fishing industries, rubber and palm oil plantations, and construction in the southern part (Ranong, Phang Nga, Phuket, and Chumporn), and in factories in the northern part (Tak and Kanchanaburi). Such industries are dependent on migrants for labor to be able to thrive and maintain economic prosperity.

According to Urbano, "The ILO observes that labour intensive industrialization has been integral to Thailand's growth, and the influx of migrant workers has enabled Thailand to maintain a labour force to support its economic development" (as cited in Clarke, 2009). As one business owner in Ranong province puts it, "If Myanmar laborers were to leave altogether, the business dependent on them would collapse in no time" (Amayun, 2009).

Pholphirul and Rumnuaykit (2007) noted that the cheap labor provided by the migrants enhances the competitiveness of the Thai economy since employing migrants can achieve an equal level of productivity with that of Thai workers but at a much lower unit labor cost. Such trend on dependence on low-skilled migrant labour is expected to continue especially with the regionalization of the Thai economy and the ageing of the Thai population (Sciortino and Punpuing, 2009).

Vulnerability to TB and other diseases

Despite the global economic crisis which led to considerable loss of jobs especially to migrant workers, and as job opportunities in Thailand for migrants becoming scarce due to oversupply of migrants, the migration trend from Myanmar to Thailand for employment remained unchanged (WVFT, 2008). The number of migrants is continuously growing but most of them are unregistered and illegal. The high cost of registration, which is unaffordable for migrant workers receiving below minimum wage, deters them from applying. To date, an estimate of 1.3 million migrants are unregistered (Sciortino & Punpuing, 2009). Being illegal means having no access to basic services and to legal and social protection, and restriction in movement. Invisibility is the key to their survival. As such, most migrants usually just stay within the border or the designated area of employment, not complaining on their poor working and living condition for fear of arrest and deportation.

Migrants and their families usually stay in unsanitary conditions (usually near industrial wastes, trash, and other debris) and in poorly ventilated, crowded rented rooms or in quarters provided by employers making them more susceptible to parasitic and infectious diseases. Their poor resistance to diseases is further aggravated by their to exposure to excessively long working hours, usually more than 12 hours of continuous work (Sciortino & Punpuing, 2009).

Current health data available indicates that in areas where there is concentration of migrants, transmission of communicable diseases like TB is intensified (WVFT, 2008). In the 2006 data of the Ministry of Public Health, most of the migrants treated suffered from infectious diseases such as TB and Sexually Transmitted Diseases (Sciortino & Punpuing, 2009). Unfortunately, most migrants are ineligible for government funded healthcare due to their illegal status.

In addition, the risk of getting arrested for traveling to the health facility and of getting fired at work prevents most migrants from seeking healthcare and from disclosing their illness. Having no social protection, lacking knowledge on disease transmission and lacking access to health services make such migrants TB vulnerable populations.

Non disclosure and non-treatment of TB could lead to infecting other migrant workers and the Thai community and this poses grave consequences not only to the health of both migrant workers and the Thai community where they are hosted but also to the survival of the industries dependent on the productivity of the low-skilled migrant workers. Thus, there is a need to focus on assisting this migrant population, who has been greatly contributing to the economy, to access the needed and deserved TB care.

Healthy migrants, healthy Thailand

Health is seen as the essential factor in sustaining human and societal development. National development cannot be achieved by a country that has an unhealthy population. As such, ensuring a healthy populace has always been part of the development agenda. In Thailand, migrant workers have become an important part of its population, evidently contributing to the economic prosperity that the country is experiencing. Migration will continue especially with the growing global economic demands. Consequently, dependency on low-skilled migrant workers will remain. Migrant workers are movers of the economy but unfortunately are not provided enough protection and access to basic services such as TB care, which would have enabled them to increase their work productivity. Indeed, as one author on migration and health puts it, achieving the country's aim of a "Healthy Thailand" will unlikely be achieved without having healthy migrants.

References

Amayun, M. (2009). Reduction of TB morbidity among non-Thai migrants in six borders and adjacent provinces: Midterm evaluation report. Unpublished report to the project TB Reduction Among Non Thai Migrants (TB-RAM). Bangkok: World Vision Foundation of Thailand.

American Refugee Committee (ARC). (2009). TBRAM project annual report: year 2. Unpublished report to the project TB Reduction Among Non Thai Migrants (TB-RAM). Bangkok: Author.

Clarke, M. (2009). Over the border and under the radar: can illegal migrants be active citizens. Development in Practice, 19(8), 10641078.

Pholpirul, P. & Rukumnuaykit, P. (2007). Economic contribution of migrant workers to Thailand. Unpublished report to the project Health Relates Issues Among the Thailand Myanmar Border: A Synthesis Body of Knowledge.

Sciortino, R. & Punpuing, S. (2009). International migration in Thailand 2009. Bangkok: International Organization for Migration.

Suksiri, U. (2007). Human trafficking cycle and patterns in Thailand. Bangkok: World Vision Foundation of Thailand.

World Vision Foundation of Thailand (WVFT). (2008). TB-RAM project annual report: year 1. Unpublished report to the project TB Reduction Among Non Thai Migrants (TBRAM). Bangkok: Author.

Fast Facts

- Thailand ranks 18th globally for having high TB burden. (Global Tuberculosis Control WHO Report 2009)
- Every year, 14,000 people in the country die of TB. (Global Tuberculosis Control WHO Report 2009)
- TB, malaria, and sexually transmitted diseases (STDs) are in the top ten causes of morbidity and mortality among migrants in Thailand. (Annual Epidemiological Surveillance Data, Ministry of Public Health, 2006)
- TB is the top fifteen causes of mortality and morbidity among Myanmar migrants in Thailand. ("Overview of Thai/Myanmar Border Health Situation, 2005" WHO Thailand Border Health Program Department of Disease Control, MOPH)
- According to the Ministry of Public Health, only 16% of the migrant population has access to clean water and less than 50% to adequate sanitation, including latrines, and waste disposal. ("Review of Health Issues Along the Thai-Myanmar Border", Report to the Border Health Program of WHO, 2007)
- Unsanitary and overcrowded living and working environments also contribute to the poor health of migrant workers and their families. Many lack access to latrines, safe water for washing and drinking, and means of disposing of solid waste. (International Organization for Migration, 2009)
- 80% of the total migration in Thailand is from Myanmar. (International Organization for Migration, 2009)
- Migrant labour has contributed US$ 2 billion of the US$ 177 billion Thai GDP in 2005. (International Organization for Migration, 2009)
- Thailand is the largest destination country in the sub-region for, mainly low-skilled, migrant workers from Cambodia, the Lao People's Democratic Republic, and Myanmar. (International Organization for Migration, 2009)
- An estimated two million irregular migrant workers from Myanmar, Cambodia and the Lao PDR are now believed to be present in Thailand. (International Organization for Migration, 2009)
- The number of unregistered migrant in Thailand is estimated at 1.3 million. (International Labour Organization, 2007)
- Fear of employer, bonded labour, and insecure illegal status makes many migrants workers stay in abusive situations. (International Organization for Migration, 2009)

IMPACT OF MIGRANTS REGISTRATION ON THE TBRAM PROJECT

The Thai government conducts the migrants' registration annually wherein migrants register to acquire work permit, enabling them to work legally in Thailand. This event also greatly affects the TBRAM project implementation. It is the time of the year when TB case detection is very high since undergoing a medical checkup is part of the registration process. As such, many migrants are discovered to have TB. Good news indeed! However, it is also during this time when TB case finding is very low for the TBRAM project. Why? Since most of the illegal migrants during this period are either in hiding or on-the-run especially with the government verifying the identities of migrants. Thus, no one dares to seek care or refuses to be referred to health centers for diagnosis and treatment for fear of imprisonment or deportation.

The highly transient nature of such migrants, combined with non-access to health care for fear of being deported, is conducive to increased TB morbidity and mortality.

TB Reduction Among Non-Thai Migrants (TBRAM) Project: Crossing borders, removing barriers

Tuberculosis (TB) is one of the major public health problems in Thailand. Globally, the country ranks 18th among all high TB burden countries. Despite the country's substantial investment in implementing TB control activities which include the Directly Observed Treatment Short course (DOTS) strategy, its treatment success rate is still below the global target of 85% due to high default and mortality rates, and incomplete reporting from health care providers (WHO, 2009). Annually, between 47,000 and 56,000 persons are diagnosed with TB and reported to the country's National TB Program (NTP). However, the NTP receives reports on case finding, sputum conversion, and treatment outcomes only from health services under the supervision of the Ministry of Public Health (MOPH). Therefore, the actual number of cases with the TB disease may be higher because of failure to diagnose or report TB from non-MOPH facilities, such as clinics or private hospitals.

Migrants are at particular risk to TB. As the population movement is common in Thailand along the Myanmar border, it creates the largest public health problem. At least 1.3 million Myanmar migrants who are living illegally in the country are at risk to such disease. The highly transient nature of such migrants, combined with non-access to health care for fear of being deported, is conducive to increased TB morbidity and mortality. Being a mobile population, completing a minimum of 6-month TB treatment regimen is difficult for them to do. This failure to complete treatment makes them susceptible to drug-resistant strains of TB.

Currently, there is an uncertain number of TB burden among migrants in Thailand. Since the mobility of the migrants neither allows access nor surveillance to include the migrant population in the country TB database, it is difficult to gauge the actual TB burden in the country.

As a response to this growing concern of improving the health of migrants, the TBRAM project was born.

What is the TBRAM project?

The TB Reduction Among Migrant (TBRAM) project is a 5 year project funded by Global Fund to fight AIDS, TB, and Malaria (GFATM), a grant-making organization based in Geneva, Switzerland created in January 2002 that aims to dramatically increase resources available to fight these three killer diseases in the world.

World Vision Foundation of Thailand (WVFT), a Christian humanitarian organization, was designated as both the Principal Recipient (PR) and Sub-Recipient (SR) for this project. As a PR, WVFT is responsible for disbursing the project funds and monitoring the project implementation. WVFT has a long history of working with migrant communities in the borders of Cambodia, Laos, and Myanmar, allowing it to foster the relationship and expertise needed to handle the sensitivities arising from working with migrant communities. As an SR, it will be doing the actual implementation of the project in the field. Collaborating with WVFT as an SR is the American Refugee Committee (ARC), a non-profit, nonsectarian, international humanitarian organization providing opportunities and expertise to refugees, displaced people, and communities. It has been providing assistance to refugees and migrants in Thailand since 1979.

The goal of the project is to reduce TB morbidity among non-Thai migrants in six provinces in Thailand. It aims to deliver the following services:

1. Increase case detection and treatment success rate among non-Thai migrants by expanding quality TB services which includes (a) providing patient support, and (b) doing community TB care.

2. Empower non-Thai communities to reduce their TB burden through public awareness. Public awareness is done through conducting advocacy, communication, and social mobilization (ACSM) activities in the communities.

3. Ensure coordinated TB/HIV care for non-Thai migrants by developing a service delivery system.

4. Increase the capacity of implementing agencies among non-Thai migrants on project monitoring and evaluation, and program management and supervision.

ACSM is the main strategy in this TB prevention and control project among migrants. The TBRAM project collaborates with government organizations (GOs), non-government organizations (NGOs), public health staff, hospitals, village leaders, and business owners in providing a healthy and enabling environment for migrants with TB. It works with the migrants, through the community health volunteers called the Migrant Health Volunteers (MHVs), in educating the community on TB and available TB care and services, in referring TB suspects to health facilities, and in acting as DOTS treatment partners to TB patients. It provides health information and counseling to TB patients through established health posts, and also provides them financial support for TB diagnosis and treatment, nutrition, and transportation in visiting health facilities. The project also develops behavior change communication (BCC) materials, mostly in written in Myanmar, to complement the community education sessions. Lastly, it also builds the technical capacity of its staff, MHVs, and public health staff in effectively managing TB care.

Who does the project serve?

The project works closely with border communities, with particular focus on those in the Thailand Myanmar border, their leaders, and others with influence to educate and encourage them to take part in anti-TB efforts. It targets non-Thai communities since they are seen as the TB vulnerable population.

Provinces	WVFT	ARC	Toatal Migrants	Total Thais	Total Targets
	Districts				
Ranong	Muang	Kraburi	21,000	69,000	90,000
Phang Nga	Kuraburi	Kapong	12,800	21,000	33,800
	Takuapa				
	Taimuang				
Phuket	Muang		20,000	269,000	289,000
	Katu				
Chumporn	Muang	Tasae	12,800	24,000	36,800
	Paknam langsuan				
Kanchanaburi		Sangklaburi	35,400	103,000	138,400
		Tongpapoom			
Tak	Maesot		33,000	31,000	64,000
Total	9 districts	5 districts	135,000	517,000	652,000

Table 1: TBRAM Project's covered areas, districts, and corresponding migrant

Where does the project operate?

TBRAM covers six provinces namely Ranong, Phang Nga, Phuket, Chumporn, Kanchanaburi, and Tak with WVFT and ARC handling 9 districts and 5 districts, respectively (see Table 1). High concentration of migrants is located in these provinces sharing border with Myanmar (see Figure 1). Of the total 500,000 population in these areas, 26% are migrants.

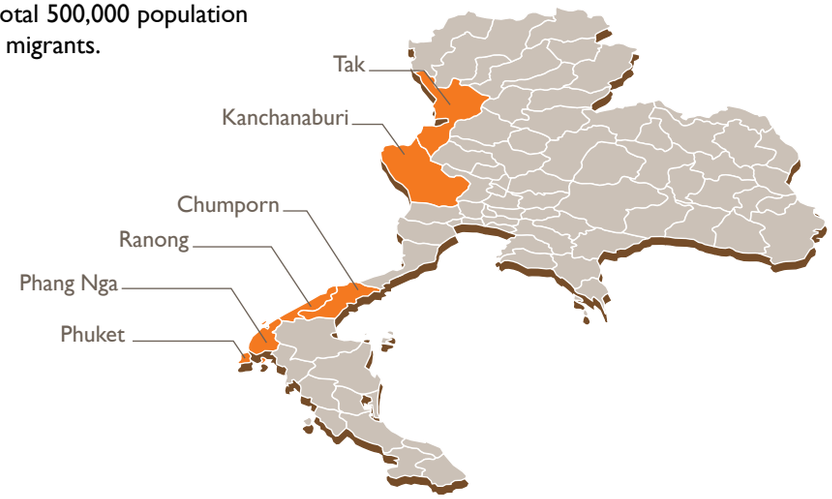


Figure 1: Map showing the the TBRAM project sites

REFERENCE

World Health Organization (WHO), (2009). Global Tuberculosis Control 2009 Report.

WHAT ARE HEALTH POSTS?

Health posts are structures built through the community's initiative. It can range from homes of community members, either that of Thais' or migrants', to any available space in the migrant workers' workplace provided by the business owners. Though it may be a small space, the health post has been giving big benefits to the migrant community. TB screening for people who show TB symptoms is being done here. It is also a community resource since it has become a place for conducting health education, a meeting area for community health volunteers, TB network groups, and self-help groups; a center where people can get TB and other health information, a venue to refer people suspected of TB and to collect sputum from them, and it has even become a recreational area for the community especially those health posts which has a library.

Health posts are structures built through the community's initiative. It can range from homes of community members, either that of Thais' or migrants', to any available space in the migrant workers' workplace provided by the business owners.

In Ranong province, the migrant community established the Thai U Dawn health post inside a concrete mix belching plant. Interestingly, most of its health volunteers are women who were responsible for managing the health post and handling the daily activities from giving TB information to the community to helping people suspected of TB in going to a nearby World Vision clinic or health center. At present, the community is considering of having income generating activities to be able to sustain the health post even after the TBRAM project ends. Indeed, the health post is a testimony of community participation and empowerment.

The 2-year **Fight Against TB**

Achieving results in doing advocacy, communication, and social mobilization in TB prevention and control among migrants

Advocacy, communication, and social mobilization (ACSM) strategies has always been documented as vital in TB prevention and control. The World Health Organization has consistently placed great value in the ACSM approach for TB control.

Since it started, the TBRAM project has been using the ACSM strategy to assist in reducing TB among non-Thai migrants. The following sections show the project's victories for the past two years.

Advocacy

Generating support for a healthy and enabling environment for both legal and illegal migrants with TB needs collaboration with various key players in the communities such as the district government officials, public health staff, community leaders, immigration and police officers, and the community leaders hosting the migrants.

WVFT and ARC have already established working group meetings with district administration offices, public health offices, and NGOs regularly discussing possible cooperation between GOs and NGOs, handling patient referrals, and managing healthcare services for TB/HIV patients. This led to an organized flow of referral of TB patients between the SR's Service Delivery Point (where recording and reporting of TB suspects occur) and the government hospitals (where diagnosis and treatment are done). In Maesot district, the project partnered with the Maesot government hospital in installing a Myanmar speaking medical officer in its TB clinic to better assist in diagnosing migrant TB patients within the hospital. In the same area, a Memorandum of Understanding (MOU) was made with the Mae Tao clinic to share TB/HIV care services for the migrants. In Sangklaburi, a patient referral agreement was made with a private hospital called the Kwai River Christian Hospital (KRCH). With this agreement, migrant TB patients coming to KRCH can be referred to the project in the area to receive support for diagnosis and treatment cost.

Various formal and informal meetings were also held with community leaders and business owners of different industries to educate them on TB and the importance of TB control among their workers. An example of a successful cooperation with a business owner is in Takuathung, Phang nga. The Petch Thalang Group Co., Ltd. and the Songchai Rubber Wood factory have allowed the project to conduct TB suspect screening activity within the plantation. Such meetings have also resulted to the development of 142 health posts within migrant communities in the project sites, allowing migrants to have access to TB information, screening, and counseling.

Since there is no enabling policy environment for migrants in Thailand, unregistered migrants can be arrested by the police if found traveling beyond their designated areas. As such, unregistered MHVs are not able to work as volunteers in community activities or act as DOTS treatment partners. Acting on this concern, the project met with the police in the districts and an agreement was made with the police that the project will provide them with information about the migrant volunteer (name, address, and picture), who will then be protected from being arrested.

At the national level, the PR represents itself in the Country Coordinating Mechanism (CCM) Technical Committee on TB lobbying for increase in government's cooperation to include the migrants' health information to the existing TB system. Also, WVFT initiated a cross-border coordination meeting with World Vision Myanmar at Yangon in May 2009 to discuss possible collaborations in addressing this health issue across borders.

With these various advocacy activities, referral system was organized, screening and referral of TB suspects among migrants became possible, resources to cure migrants TB patients were shared, increased awareness on both TB and the project occurred, and health posts were established to the advantage of the migrant workers and their families.

Communication

Communication refers to creating awareness and behavior change among target populations and improving interpersonal communication between TB patients, their families, and health care providers.

For the past two years, the TBRAM project have organized and conducted various TB education sessions in the health posts located in the migrant communities and in the workplace. These were done in partnership with the MHVs, the public health teams, and the hospital and local health center staff. One MHV, who speaks Myanmar, regularly facilitates such TB education session to migrant workers in rubber plantation companies located at Klongkian Khok-kloi and Thayu subdistricts.

To aid the MHVs in educating the migrant communities on TB, various BCC materials were developed such as brochures, stickers, posters, and flipcharts. To date, a total of 306,718 BCC materials have been developed and distributed in the health posts. To be understood by the migrants, most of the materials were written in Myanmar. To further improve its future development of BCC materials and implementation of communication strategies, a Knowledge, Attitude, and Perception (KAP) survey on TB was done last 2008 in the project sites. Results of the KAP survey will be used in developing appropriate TB messages and materials to the community.

Also acting as TB treatment partners, MHVs were provided trainings on counseling in addition to other trainings given to them such as how to do TB screening, sputum collection, referral of TB patients, recognizing side effects, reducing stigma, and doing household contact screening.

Celebration of World TB Day and World AIDS Day in the project sites also increased the migrant communities' awareness on TB, its consequences, and on TBHIV co-infection. Migrants learned TB concepts through unique and creative activities such as quiz and drawing contests, sports competition, entertainment programs, and TB exhibits.

Social Mobilization

At the core of the TBRAM project are the identification and organization of health volunteers among migrants, called the MHVs, who will be responsible in identifying, screening, and referring TB patients for diagnosis and treatment, and in acting as treatment partners to these TB patients. To date, a total of 47 MHV networks have been formed. With such important responsibilities, they were given various training to be able to effectively communicate TB concepts to the community and to correctly identify and refer TB suspects.

In addition to the MHVs, government facility based service providers were also mobilized to collaborate with the project in developing, producing, and installing protocols in referring, registering, and tracking TB patients. As a result, a Standard Operating Procedure (SOP) manual was developed, which will be followed by all sectors involved in TB care among migrants at the community level. There were also small network groups created within hospitals composed of the hospital doctor, the TB coordinator known as Mr. TB., a TB clinic staff, and the project staff. This is a collaborative effort between the hospital and project. The aim of such network is to update the team on the status of the TB patients under their care, share new TB information, and coordinate with the community health center and the community leader on the status of the TB patient once discharged from the hospital.

As a result of the ACSM initiatives, a total of 5,052 TB suspects were referred for diagnosis of which 8% were diagnosed to be new smear positive. Treatment success rate of all TB patients enrolled for treatment is on average at 85%. Further, increase in referrals, case detection, and enrollment has increased on average of 50% from Year 1 to Year 2 of the project implementation (see Table 2).

Implementing the TBRAM project is not without challenges, especially with the high mobility of the population making treatment compliance and conduct of follow up tests difficult. However, doing the ACSM strategy has been an important initial step for the project to achieve its goal of reducing TB morbidity among migrant workers.

Indicators	Year 1		Year 2		Total Achievement
	Target	Achievement	Target	Achievement	
No. TB suspects referred	1,170	1,172	5,016	3,880	5,052
No. new sm+ cases detected	59	106	250	343	449
No. of new sm+ cases enrolled	38	106	208	298	404
Sputum conversion rate	>80%	92%	>80%	87%	89%
Treatment success rate	58%	86%	80%	84%	85%
No. of HP developed	39	81	73	61	142
Training of MHVs	2,550	2,487	1,480	2,800	5,287

Table 2: The TB-RAM Project's key indicators and achievements

PLAYING OF NATIONAL ANTHEM EQUALS TIME FOR TB TREATMENT

Ma Thandar, 28 years old, will never forget the Thai national anthem – her TB treatment was dependent on it.

Ma Thandar had just quitted work from a fish factory in Bangkok due to her deteriorating health when she moved at Pak Num Chumphon with her sister. She was diagnosed with a respiratory disease during the registration period for migrant work permit. Having no money, she just bought cough medicines at a local drugstore which did not help in improving her condition. Fortunately, she met Yin Mg, a migrant health volunteer of World Vision who assisted her in undergoing diagnosis for TB and in availing the free TB treatment. With the support of her husband, she continuously drank her medicines despite experiencing some side¬ effects. Every day at 6PM, she met her treatment partner at the beach to take her medication, which was difficult for her back then since she does not own a watch and thus, cannot track the time if it is already 6PM. At first, she asked for the time from strangers walking in the streets but she realized that she could wait for the Thai national anthem to be played to know the time. Since then, she marked the playing of the Thai national anthem as her time for medication. Not surprisingly, she finally got cured of TB on October 2009. Truly, if there is a will, there is a way.

Through the Years: A Quick Glance at the Project in 2 Years

FY1 - 2008

- 26-30 Nov — SR Orientation By PR
- 9 Oct — SR SGA MoU Signed
- 14 Nov 07 — SR 1st grant Disbursement
- 1 Oct 07 — PGA Signed & Grant Implementation Starts
- 31 Oct 07 — PR 1st grant Disbursement
- Dec 07 — PR/ SR Study Visit-India
- 15 Feb 08 — PR Q1 PU/ DR
- Apr 08 — Baseline survey training and collection
- June 08 — Microsropist Training BTB
- Sept 08 — R&R training BTB
- Oct 08 — TB RAM Annual project Review
- 20 Jan 08 — SR Q1 report
- 24 Mar 09 — World TB Day Advocacy
- Jul 08 — Migrant Health Conference

PR/ SR Joint meeting: Production of R&R forms, IEC Materials, SOP, training materials

FY2 - 2009

- 31 Mar 09 — Phase 2 Renewal
- 24 Mar 09 — World TB Day Advocacy
- Feb 09 — Phase 2 Indicator Preparation Meeting
- 9-13 Mar 09 — Phase 2 Preparation with WHO & PR DDC
- 26 Mar 8 Apr 09 — Mid-term Evaluation

Touching Lives, Making a Difference

Three individuals share their stories on how the TBRAM Project affected their lives

"I am an MHV."

Migrant health volunteers may not be health professionals but their role cannot be ignored in community TB prevention and control

Migrants in the context of the TB RAM Project are not simply the TB patients or the project's beneficiaries. Most of them also wanted to help their fellow migrants and have decided to become a migrant health volunteer, or more known as an MHV. One such migrant is 33-year old Ko Win Za Oo.

Ko Win works as a tiling mason in a construction company in Phuket, Thailand. As an undocumented migrant in the past, he faced so many hardships from receiving very poor wage and being discriminated, to being arrested by the police. He took many odd jobs, like being a gasoline station attendant, just to earn money. Seeing the difficulties, sacrifices, and discrimination that migrants face and experiencing it first-hand have led Win to volunteer in helping migrants.

Ko Win's sense of volunteerism started when he was very young. At a young age, he already wanted to help poor people and eventually, as an adult, he realized that the most effective way of helping the poor is by working with a team in a non-government organization. He believes that he can serve more poor people by joining such organization rather than doing it alone.

His opportunity came when he learned about the TBRAM project during a World TB Day commemoration in his worksite. As an MHV, he enjoys assisting and referring migrants with TB to WV clinics, hospitals, and health centers, and organizing community trainings. Win has always been willing to help beyond the regular call of duty – from driving a person with an emergency case to the clinic using a rickshaw to giving shelter to a TB patient.

Ko Win is only one of the many MHVs in the TBRAM Project. The MHVs are the movers in the migrant community doing the most important initial step in TB prevention and control – finding TB cases. With such importance of the role of MHVs and also the importance of ensuring the quality of TB cases to be referred to the health centers, the TBRAM Project built the capacities of these MHVs by providing basic trainings on TB case detection, TB signs and symptoms, referral process, treatment compliance, and handling side-effects of TB drugs in patients. Gaining such skills has empowered them to initiate TB prevention and control activities and knowing that they are doing something valuable in the community has boosted their confidence.

With the help of MHVs, a total of 5,052 migrants were referred for TB diagnosis. Eight percent of those referred proved to be positive with TB.

MHVs are not health professionals yet in their own selfless ways, they have touched and saved many lives. For Win, living his life as a volunteer and knowing that he is able to help his fellow migrants even through simple ways is priceless. Truly, being an MHV is something to be proud of.

The TB Patient

Ma Kaykhine, 25 years old, and her family have barely enough to survive the cost of everyday living in KhaHlaine village in Myanmar. Determined to help her family, she left her village to work at a wool factory in Maesot, Thailand.

Living as an illegal migrant worker is difficult. Ma Kaykhine lives together with 20 other people in a very small and crowded room inside the factory barracks. Such crowded condition and poor ventilation has led to infectious diseases among the workers. During this time, Ma Kaykhine suffered continuous coughing for a month. But despite her worsening condition, she did not dare go to the clinic for fear of police arrest. She tried both traditional medicines and available drugs but her coughing just worsened.

"I also felt loss of appetite, weight loss, aches and pains, and could not work anymore," she said, "even my roommates were scared… and tried to stay away from me."

It was an uncle from the factory that helped her to sought help from a foundation, which then introduced her to project staff Ko Nay Oo. She then learned how to collect her sputum and how to cover her nose and mouth while coughing. On May 29, 2008, she was diagnosed as TB positive.

"I felt very sorry. I was afraid of dismissal from work if the employer found out about my disease," she lamented.

Fortunately, one of her roommates agreed to be her treatment partner. With the help of the TBRAM project, she right away started treatment 5 days after release of her results.

"I have never dreamt of an organization that helps people like me, without registration and money, for treatment in Thailand," Ma Kaykhine exclaimed.

She remembered Project staff Nay Oo who educated her and her treatment partner on the possible side effects of the drugs, provided them with pamphlets on TB, and visited her at least once a week.

Ma Kaykhine was not spared from the side effects of the drugs. She always felt dizzy and coughed a lot. Her friends knew she had TB and stayed away from her for fear of getting the disease. Despite the physical and emotional pain, Ma Kaykhine took her medicine daily as directed, determined to get cured.

Throughout the course of her treatment, Ma Kaykhine always looked forward to the patients' gathering, a monthly activity where TB patients shared their difficulties and problems with each other. It is also the time where nutritional support such as rice, oil, canned fish, and noodles are given them.

"I cried for joy when I got those things. I lack money that time since I cannot work back then," she said.

Ma Kaykhine also gained much knowledge on TB through the trainings she has received. Since then, she had been sharing her knowledge and experience on TB with others. Her friends in the factory started calling her as the TB teacher. Factory workers started to approach her once they are suffering from cough.

By November 2008, Ma Kaykhine got cured of TB. She gained 10 kg after the treatment and was teased as Shin Guan Gui, a famous Myanmar cartoon character who is a fat lady.

"I felt so much grateful to the project as they help me get cured of the disease and cared for me like a family. I am thankful for the health care they give to Myanmar migrants,"

Ma Kaykhine shared.

With many blessings she received from the project, Ma Kaykhine believed that TB patients like her can help other migrants simply by sharing her knowledge on TB.

"Until now, I share my TB knowledge wherever I am, and as much as I can," she concluded.

The Project Staff

Khin Win, as a Frontline Social Networker (FSN) for the TBRAM project, begins pedaling her bicycle at 7:30 am to be able to reach the office by 8:30 am. She starts her day with a prayer and then continues with her usual daily activities as scheduled – facilitating meetings and trainings of the migrant health volunteers, taking care of TB patients, doing follow ups with TB treatment partners, counseling people suspected of having TB, monitoring health posts, and accomplishing and checking health data.

At first glance, it seems to be a typical day for any worker but being an FSN helping migrant worker is not an easy job.

"There are misunderstandings due to language barrier, which lead to difficulties," said Khin Win.

Most of the migrant workers, both the health volunteers and those with TB, do not speak Thai and instead speak Karen, Myanmar, and Mon. With the right information as the key to addressing the many TB misconceptions among migrant workers, having to communicate with them in their own language, FSNs like Khin Win who comes from the same community help to reduce this obvious barrier.

The mobility of the migrants also poses a challenge for FSNs, who need to constantly monitor those migrants diagnosed with TB to ensure that they gain the right TB information, receive nutritional support, and drink their medicines daily for six months.

Khin Win remembered one of her patients who left home and moved to a far away farm hut.

"My patient Naing gave me a lot of inconveniences during the treatment…but I have great concern [for] him to acquire TB knowledge and nutritional support during a patient gathering. So I went to his hut [asking] him to join the patient gathering," recounted Khin Win.

Little did she know that she would forever remember that day. Khin Win went to Naing's hut after work. Since it was the rainy season during that time, she passed through mud and pools of water, and even slipped and fell on the way. On her way back home, she was even questioned by a group of homeless people along the way of where she was heading.

"I was frightened [since] I never had that that kind of experience in my life before. I was sick the next day…I [will] never forget that day," confessed Khin Win.

But despite such ordeal, she felt much fulfilled.

"Now, my patient was cured and could work again [and] now leads a somewhat comfortable life. I feel deeply pleased to see that," said Khin Win.

Khin Win's passion in improving the health of the Myanmar migrants and determination in gaining their confidence has pushed her to continue with her work with the TB-RAM project despite the challenges that the work demands. Her constant interaction with them taught her to understand the problems that the migrants face.

Her empathy for migrants was unmistakable as she said,

"They face so much difficulties and I want to help them as much as possible, in every way possible… [even] when there is no project, I will help them as much as I can."

For Khin Win, the fulfillment of seeing the migrants get cured of TB outweighs the difficulties she faces as an FSN.

Walking through rough terrains: **Overcoming challenges in reducing TB among migrants**

Implementing any project among migrant workers in Thailand is not exactly a walk in a park. A TB control in a normal setting is considered a challenge by most National TB programmes even in Thailand wherein being 18th out of 22 ranking for having high TB burden is still something to consider. Attempting a quality TB project among a non-Thai migrant setting faces more challenges on top of the challenges already being faced by TB projects in a non-migrant setting. Many of the factors below contribute to the difficulties in ensuring high treatment success rate and case detection in TB control.

• **Lack of reliable epidemiological TB data among migrants –** This is the first challenge in designing a TB project when the prevalence and incidence of TB among migrants is relatively unknown. The project had to collect data from all health facilities in the areas just to be able to calculate the number of migrants with positive smear results in the past three (3) years. This is to be able to extrapolate the future situation for Phase 2.

• **Mobility –** Seasonal and non-seasonal movements of migrant workers resulted to high rates of patients not completing TB treatment, especially if appropriate attention was not given. The staff had to devise many strategies to limit mobility of patients once the medicine is provided. Examples of strategies included finding a new job for such patients that allows them to stay put for 6 months, or finding ways to provide DOT to fishermen diagnosed with TB who are on boats for long months.

• **Lack of freedom of movement of migrant workers –** This seems like a contrast to the previous bullet point. The reality is that, once the migrants work in certain areas, it is difficult for them to travel outside their work areas due to fear of getting arrested by the police. This situation challenges the community-based referral approach for TB since the migrant volunteers cannot refer either TB suspects or sputum samples without fear. As such, Migrant Health Workers (MHWs) or front line staff had to collect sputum samples in lieu of the migrant volunteers since the former are not restricted in their movements compared to the volunteers.

• **Difficultly accessing communities –** Migrant workers in Thailand consist of those who are legally and illegally residing in the country. Since the issue on illegal migrants is a sensitive one, gaining access to these communities requires patience & perseverance from staff, and trust from both community members and business owners.

• **Exploitation suffered by migrant workers –** The fortune of migrant workers lies at the mercy of the business owners or their employers. In many situations, migrant workers are not treated with the highest standards intended for workers. They become more unfortunate if the business owners find out about their TB symptoms or medication and are not sympathetic with them due to stigma and discrimination. Many patients would not reveal their TB status due to fear of being expelled from their rented homes or their jobs. Many patients would sneak out very early in the morning (e.g. 5 am) just to meet with their DOT partners to take medicine for fear of being seen by others.

• **Low government support –** TB control among migrants is aligned with the National TB Programme strategy. However, during the actual implementation of a TB control project, it is still difficult to gain both the trust and the support of the government due to the following reasons: (1) lingering doubts of some government official on the effectiveness of a community-based DOT approach despite numerous evidence on its success, and (2) the project's target population or beneficiaries are non-Thais. Thus, continuous evidenced-based advocacy at the national, provincial, and local level and dissemination of the project's successes can help in gaining such trust and support from the government.

• **Language difficulties faced by and with community members –** As mentioned in this report earlier, there are many ethnic languages spoken and ethnic differences among those from Myanmar. Selecting the appropriate frontline staff that could both communicate fluently and identify themselves with the communities is one of the key aspects in reaching to the target groups.

• **Difficulty of attracting appropriate staff –** Implementing a TB project in a migrant setting is already very challenging. Add to this the technical skills required from the human resource implementing such kind of project. Both the challenges and the need for technically skilled staff have posed great difficulties for the project in recruiting the appropriate staff, who should also be both Thai and Myanmar-speaking. Further, it is also vital to do continuous recruitment, train staff, and provide such staff with timely and appropriate advice.

• **Difficulty of attracting and maintaining long-term funding –** Without a reliable TB epidemiological data, attracting funding is a challenge on its own. The more difficult part is maintaining a long-term funding and at the same time advocating to the government to provide a sustainable solution and system on healthcare for both documented and undocumented migrants. It is important to educate donors and make them understand that a 5-year approach may not be enough to gain long-term support from the government.

• **Difficulty of cross-border collaboration in referring TB patients –** The government cross-border referral system has not been established yet to assist TB patients in Thailand returning to Myanmar. Therefore, many patients who could be considered simply as "transferred out*" ended up being "defaulters" (those who did not finish their treatment) since the systematic referral system is not in place. Thus, most referrals occurred through an informal route – either via the assistance of the migrant health volunteers or the patient's relatives on the other side.

These challenges may or may not be unique to migrant settings existing in other countries. However, it is important to take note that the challenges among these migrant workers are not identical to those "refugee" migrants wherein the settlements or refugee camps would restrict their movements, and wherein other social or political issues may not intervene in the TB control efforts.

These issues were not raised to weaken the spirits of those currently implementing or still planning to implement a TB project using a similar approach but rather, these issues were shared for the benefit of future projects to be able to achieve better outcomes.

Transferred out = Patient who has been transferred to another DOT recording and reporting unit and for whom the treatment outcome is not known.*

BUSINESS OWNERS TURNED TREATMENT PARTNERS

Most business owners in Chumphon and Takuatung provinces hire migrant workers for their plantation. Through regular dialogue with these plantation managers, who learned the project's sincere intentions of improving their workers' health, community health posts were established within the plantation.

Further, the business owners encouraged their own employees to become volunteer health workers. One example is the Vitchipan Palm Plantation in Thasae, Chumphon. It has been operating for 20 years, having approximately 350 legal migrant workers. Initially, the managers were hesitant of the pr oject especially with the sensitive issue on reporting illegal migrants. But through regular consultation between the project staff and the plantation managers, a good relationship was established which led to the managers' strong support for all project activities conducted within the site. As a result, the managers even offered one of its newly constructed housing units for employees to become a health post (serving as a Secondary Service Delivery Point) to cater basic TB services. Further, a second space intended for community activities was constructed – all expenses paid by the plantation.

Looking Back, Moving Forward

Looking back in the past two and a half years in the preparation and implementation phase of TB-RAM, there were a few things that the project should have included to ensure its success. These may not be a comprehensive list but it had been identified both as key lessons learned and as recommendations for future projects.

1. Ensuring political commitment – collaborating and planning with the government at various levels

A TB project differs from an HIV prevention project mainly because of the more structured system of TB control within the government. Planning and collaboration with the government at various levels should occur prior to writing the project proposal to ensure clear understanding and commitment of government officials coming from various levels. Without this vital collaboration, the project can be slow to start and difficult to implement since the project relies on the government's TB control system and services.

2. Identification of roles, responsibilities, and expectations of partners at various levels

The project felt that it could have accelerated its implementation and success on TB control efforts if roles, responsibilities, and expectations of different partners and stakeholders had been identified, written down, and sealed through Memorandums of Understanding (MoUs) or Terms of References (ToRs). After implementing the project, the government, PRs, and SRs at various levels realized that they are not clear on each other's roles and responsibilities and ended up having different expectations of one another. Roles and responsibilities of different partners could be added into the National TB Programme Strategy, which could then be streamlined to all levels.

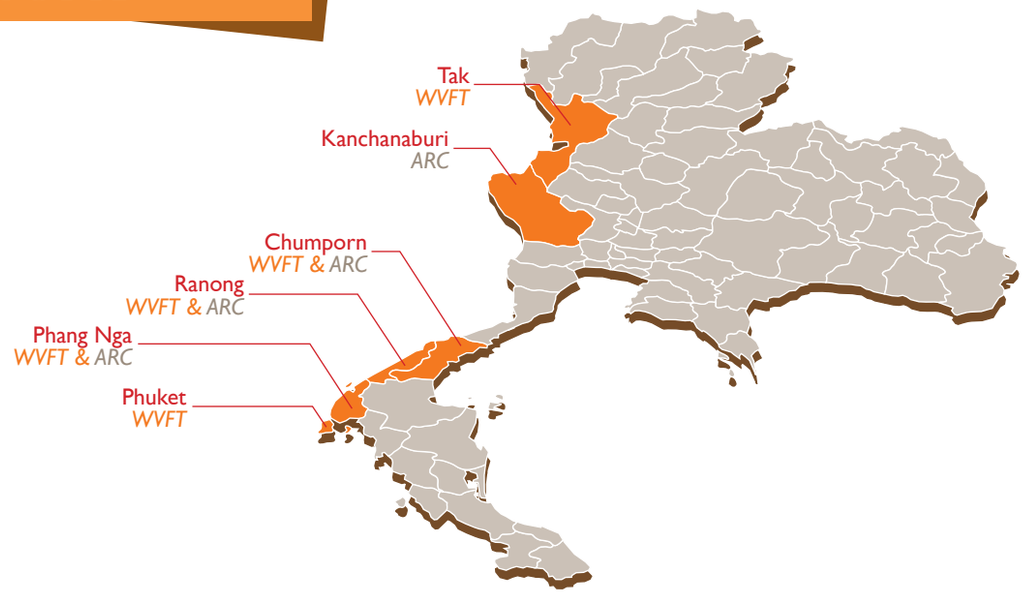
3. Having a clear advocacy plan

Different levels of advocacy require different tactics. In order to achieve impact through advocacy, a 5-year advocacy plan with specific indicators should have been formulated to ensure smoothness in doing advocacy. Stakeholders and partners should have been identified and contacted. Further, the advocacy plan can be shared to partners and stakeholders to develop synergy and create more voices during advocacy processes. Currently, the advocacy plan is carried out annually and in which the advocacy results could not be measured in long term and achievement may not be clearly summarized. As a result, the achievements from these 1-year advocacy plans may not have matched the resources invested by the project.

4. Doing proper baseline – both epidemiological and social baseline for migrants

It has been consistently cited that there is very little epidemiological and social data on TB at the national and local levels on migrants. With good planning, the budgets and technical assistance for a proper surveillance and baseline system on migrant populations provided by recognized technical agencies would benefit both the project and the country in implementation and future planning of TB projects.

Where Our Partners Work



WVFT: World Vision Foundation of Thailand
ARC: American Refugee Committee

TB RAM project
Principal Recipient office

World Vision Foundation of Thailand
582/18-22 Sukumvit 63 Klongtoey Wattana
Bangkok 10110 Thailand
Tel: +66-2-381-8863-5