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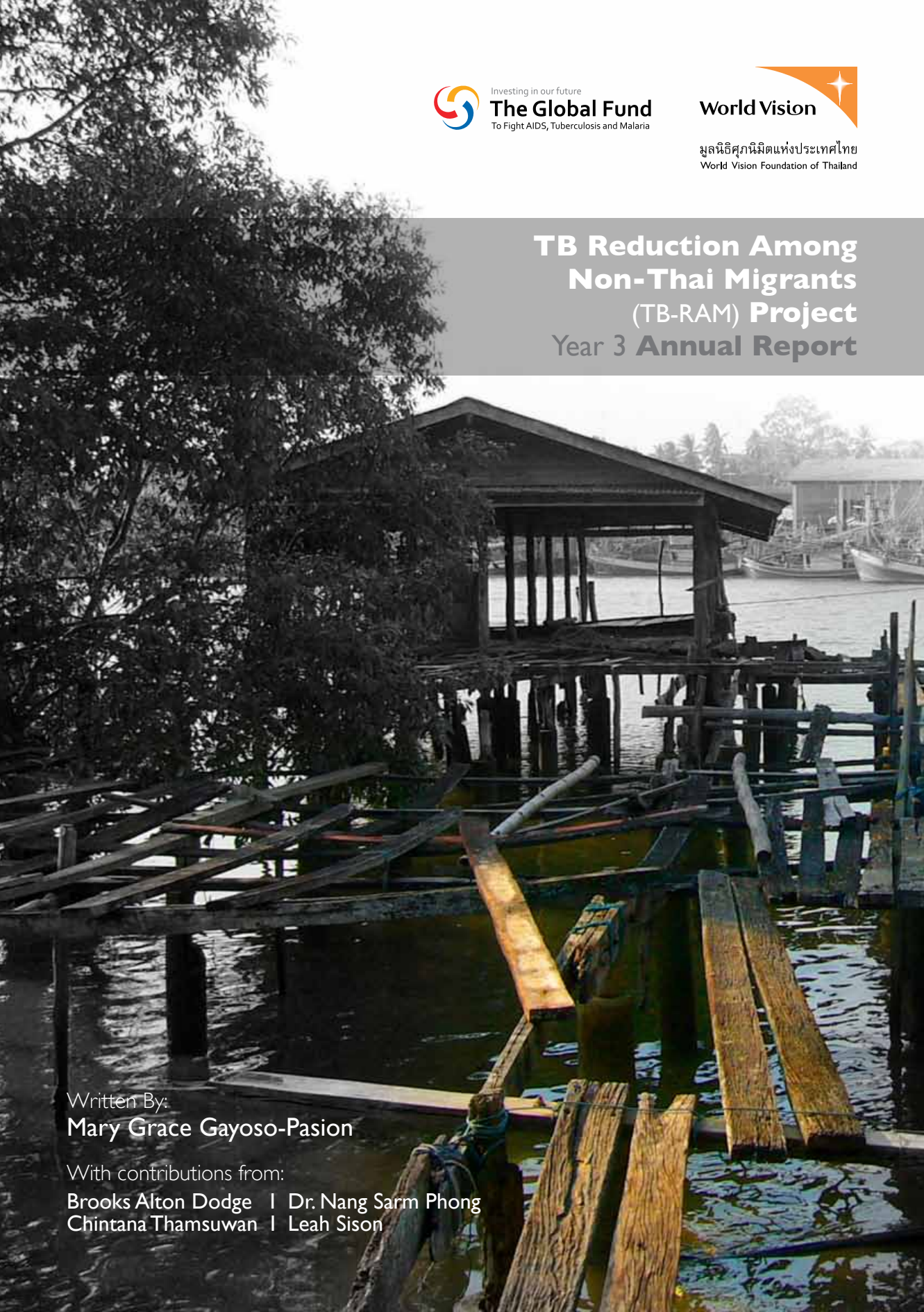
World Vision Foundation of Thailand

TB Reduction Among Non-Thai Migrants (TB-RAM) Project Year 3 Annual Report



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With contributions from:
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Table of Content

About the Cover

Many communities that World Vision and its implementing partners works with lie on the border areas between Thailand and Myanmar, and the borders are not always a visible demarcation. This is one of the fishing piers in the city of Ranong, Ranong Province, where Myanmar migrants work and where SR-WVFT implements its community-based work.

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.

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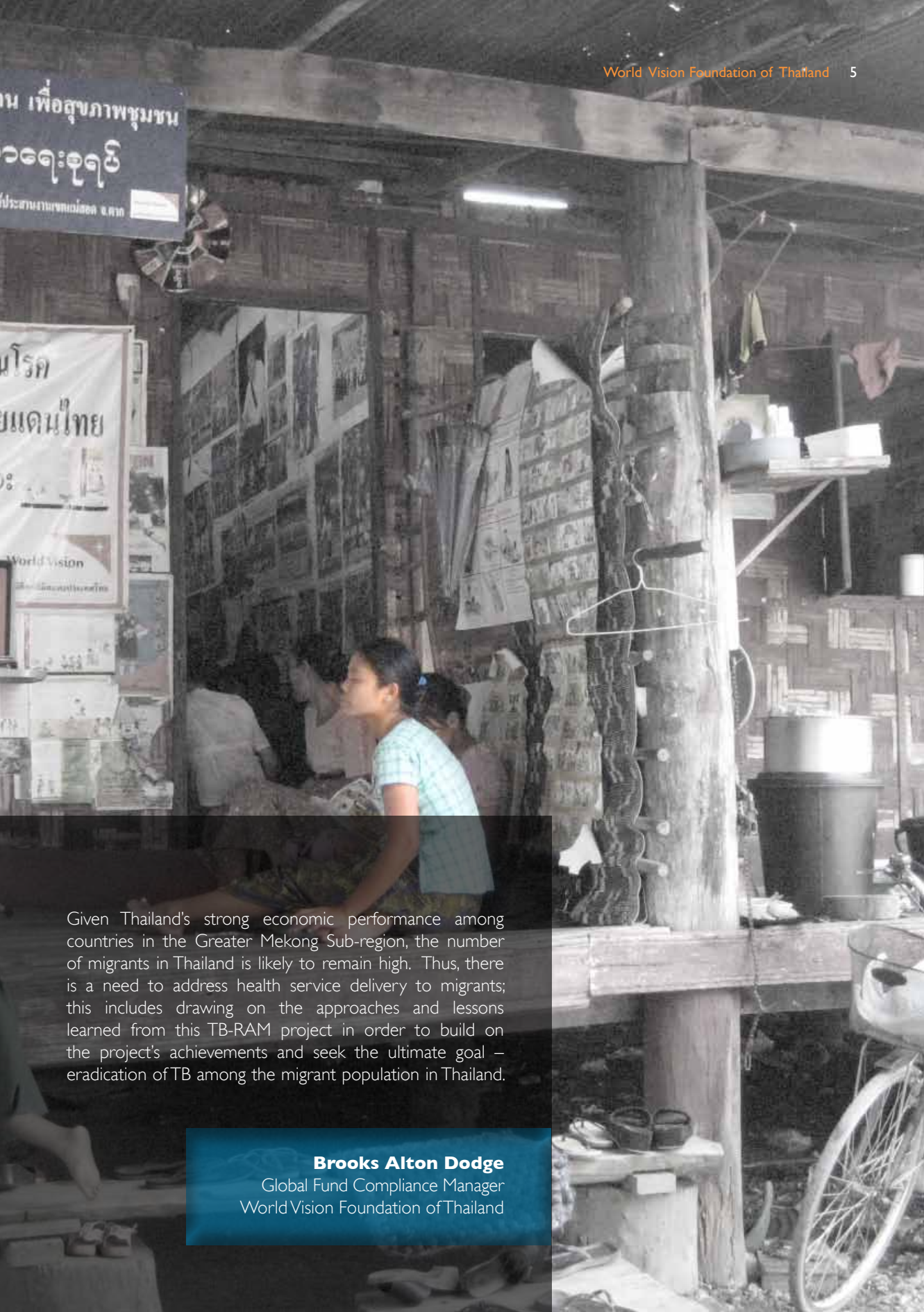
Message from the PR Manager

There is an increasing number of migrants who are relocating to other countries in search of better lives. According to the UN report, Trends in total migrant stock, 2008 revision, the number of international migrants in the world increased from 150 million in 2000 to 214 million in 2008. For Thailand, there is a demand for labour that needs to be filled in order to sustain the country's level of economic growth. As a result, there are an estimated 2.5 million migrants in Thailand and 80% of the migrant are from Myanmar. Among the Myanmar migrants, only one third of them were registered.

With mobility of persons across countries comes the increased potential for the spread of infectious disease; migrant communities are often found in crowded and unsanitary locations that are susceptible to infectious disease. The health of migrants in a country becomes an important factor to address at the national level, not only for the prospects of healthy workers to participate in the labour market but also from the standpoint of the long term public health environment in the country.

The TB-RAM Project implement by World Vision Foundation of Thailand (Principal Recipient) serves the migrant communities in 6 provinces of Thailand, and has achieved some significant results in regard to TB reduction among the migrant population in Thailand. This achievement has been possible through the hard work of the Sub-recipients that have tapped into the migrant communities themselves, as well as from the support of key stakeholders, such as the Department of Disease Control (Ministry of Public Health - MoPH), local immigration department, police department, the public health staff, hospitals, village leaders and business owners. This annual report, covering the third year of the project, highlights the results in reducing the incidence of TB through the achievement of the project's indicators and through the project's social mobilization as well as other innovative approaches. The report also points out the many challenges in working to address the TB burden among the migrant population. These approaches and challenges are informative not only to other projects that target TB health among migrants but also to Thailand's public health and TB reduction strategy.



Given Thailand's strong economic performance among countries in the Greater Mekong Sub-region, the number of migrants in Thailand is likely to remain high. Thus, there is a need to address health service delivery to migrants; this includes drawing on the approaches and lessons learned from this TB-RAM project in order to build on the project's achievements and seek the ultimate goal – eradication of TB among the migrant population in Thailand.

Brooks Alton Dodge
Global Fund Compliance Manager
World Vision Foundation of Thailand

Executive Summary

The TB-RAM project has successfully passed the 3rd year of its implementation in September 2011. In order to provide enabling environment for migrants, the TB-RAM project has been using the Advocacy Communication and Social Mobilization (ACSM) approach. The project works closely with border communities, and collaborates with government organizations (GOs), non-government organizations (NGOs), public health staff, hospitals, village leaders, and business owners in order to strengthen the community system.

This year, the project established 74 community health posts in the six provincial project sites. Health posts are the places where the migrants are able to conduct TB screening and sputum collection. Moreover, migrants can gather in the health posts to participate in activities and to access health-related information.

The uniqueness of the project comes from helping migrants identify capable migrant health volunteers (MHVs). During year 3, the project trained a total of 3,760 MHVs. By increasing the capacities of MHVs, these MHVs are able to support the project through the following ways: raising TB awareness of the migrant community, TB screening, and referring TB suspects for diagnosis and treatment. Lastly, they also serve as TB treatment partners.

As a result of the ACSM approach, a total of 6,996 suspects were referred for diagnosis, 347 of whom were diagnosed to be smear positive. Out of 347 smear positive cases, 316 cases were enrolled to receive TB treatment. The project's treatment success rate for the smear positive cases was at 89%.

In addition to presenting the project's achievements in year 3, the annual report examines the project's new and innovative methods to better serve TB health among migrants. These include the addition of a new sub-recipient, the development of contextualized Behavior Change Communication (BCC) materials, the impact of the National Tuberculosis Program (NTP) new guideline for HIV testing, and the linking of TB and malaria activities at the community level. Furthermore, the annual report includes insights on the project from different stakeholders to give an understanding of the broad commitments required in implementing the project. Lastly, the report discusses the project's 3-year journey, which has not been without challenges such as high mobility of the population, different ethnic languages, high staff turnover rate, and increased detection of TB-HIV co-infected patients. Nevertheless, the project implementation using the ACSM and community-based methodology has proven to be an important initial step in reducing TB illness among migrant workers in Thailand.

TB-Reduction Among Non-Thai Migrants (TB-RAM) Project: An Overview

THE PROJECT

The TB Reduction Among Migrant (TB-RAM) 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 that was created in January 2002 and aims to dramatically increase resources available to fight these three high mortality diseases in the world. The project completed its Phase I in September 2009. The end of TB-RAM Project's Phase I results included the following: 5,052 people suspected with TB were referred for examination, 449 people were detected to be positive with TB through smear examination[1], and there was a treatment success rate of 85% among those cases enrolled for TB treatment. Further, 142 health posts[2] were established and a total of 5,287 migrant health volunteers (MHVs) were trained to do TB screening, referral, and to act as treatment partners *(see Table 1)*. The project's remarkable performance in achieving its targets and managing its finances led Global Fund to continue its funding for Phase 2, which ends in September 2012.

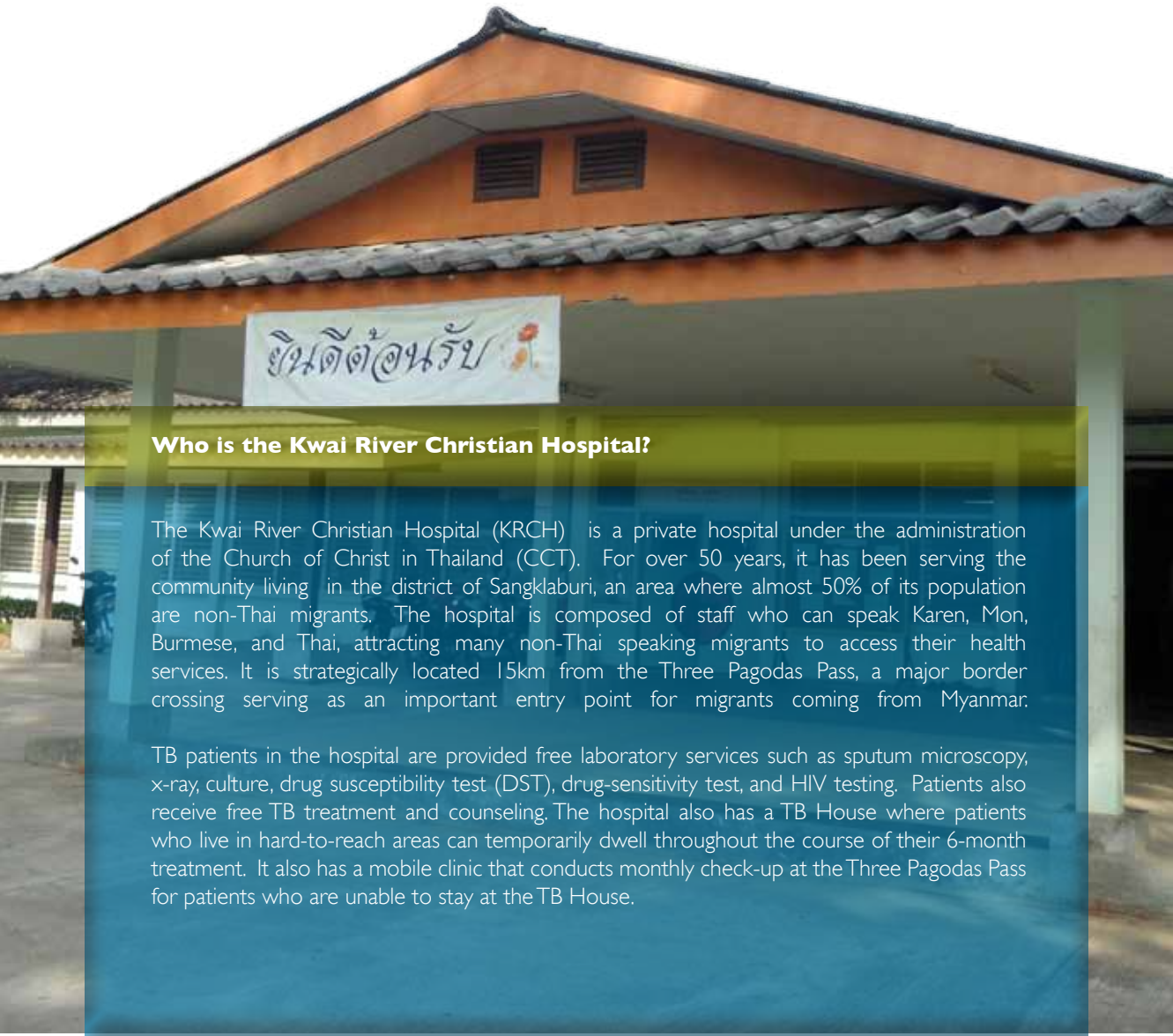
TB-RAM Project Indicators	Year 1		Year 2		Total Achievement
	Target	Achievement	Target	Achievement	
No. TB suspects referred	1,170	1,172	5,016	3,880	5,052
No. new sm+ cases detected	59	106	250	343	449
No. of new sm+ cases enrolled	38	106	208	298	404
Sputum conversion rate	>80%	92%	>80%	87%	89%
Treatment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

Table 1 : The TB-RAM Project's Phase 1 key indicators and achievements

[1] **Smear examination** is a process wherein a sample from a TB patient's sputum is spread on a glass slide and stained for cytologic examination and diagnosis under a microscope.

[2] **Health posts** are structures built through the community's initiative, where TB screening for people who show TB symptoms is undertaken. It has also become a place for conducting health education, a meeting area for community health volunteers, TB network groups, and self-help groups, and a center where people can get TB and other health information.

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 along with Thailand's Department of Disease Control (Ministry of Public Health), WVFT is responsible for disbursing the project funds and monitoring the project implementation. 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, non-sectarian, international humanitarian organization providing opportunities and expertise to refugees, displaced people, and communities. It has been providing assistance to refugees and migrants in Thailand since 1979. Beginning Phase 2, a new SR joined the project, called the Kwai River Christian Hospital (KRCH) *(see inset box).*



Who is the Kwai River Christian Hospital?

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

TB patients in the hospital are provided free laboratory services such as sputum microscopy, x-ray, culture, drug susceptibility test (DST), drug-sensitivity test, and HIV testing. Patients also receive free TB treatment and counseling. The hospital also has a TB House where patients who live in hard-to-reach areas can temporarily dwell throughout the course of their 6-month treatment. It also has a mobile clinic that conducts monthly check-up at the Three Pagodas Pass for patients who are unable to stay at the TB House.

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.

THE STRATEGY

ACSM is the main strategy in this TB prevention and control project among migrants. The TB-RAM project collaborates with government organizations (GOs), non-government organizations (NGOs), public health staff, hospitals, village leaders, and business owners in providing a healthy and enabling environment for migrants with TB. It works with the migrants through the community health volunteers, called the Migrant Health Volunteers (MHVs); the MHVs serve to educate the community on TB and available TB care and services, refer TB suspects to health facilities, and act 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 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.

THE BENEFICIARIES

The project works closely with border communities, with particular focus on those along 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 in Thailand.

THE PROJECT SITES

TB-RAM covers six provinces namely Ranong, Phang Nga, Phuket, Chumporn, Kanchanaburi, and Tak, with programs in a total of 18 districts. Table 2 shows the distribution of districts among WVFT, ARC, and KRCH. There is a high concentration of migrants located in these provinces that share their border with Myanmar *(see Figure 1)*. For year 3, the project serves an estimated 236,000 migrants living in these areas.

Provinces	Districts					Migrant Population	
	WVFT		ARC		KRCH		
	Phase I	Phase II	Phase I	Phase II	Phase II	Phase I	Phase II
Ranong	Muang	Muang	Kraburi	Kraburi		21,000	29,805
Phang Nga	Muang	Kuraburi	Takuatung	Takuatung		12,800	23,982
	Takuapa	Takuapa					
	Taimuang	Taimuang					
Phuket	Muang	Muang				20,000	7,472
	Kathu	Kathu					
		Thalang					
Chumporn	Muang	Muang	Thasae	Thasae		12,800	24,138
	Lang Saun	Lang Saun					
		Tako					
Kanchanaburi			Sangklaburi	Sangklaburi	Sangklaburi	35,400	65,180
			Tongpapoom	Tongpapoom			
Tak	Maesot	Maesot				33,000	85,307
TOTAL POPULATION COVERAGE						**135,000**	**235,884**

Table 2: TB-RAM Project's covered areas, districts, and corresponding migrant population

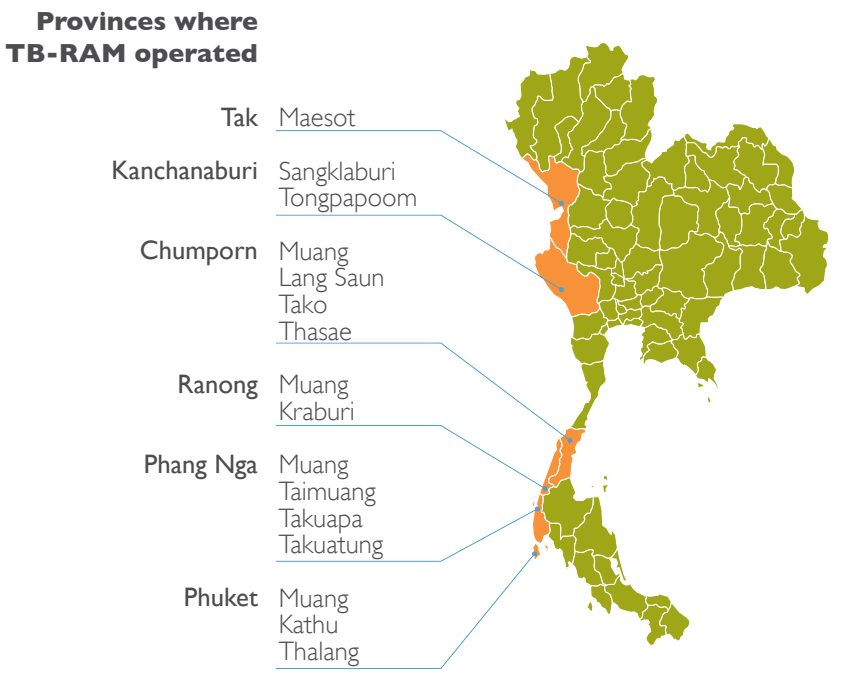


Figure 1: Map showing the TB-RAM project sites

Progress Report:
The Year That Was For The TB-RAM Project

Since it started in 2007, the TB-RAM project has been collaborating with various entities ranging from government organization and other NGOs to migrant communities and business owners. It has been using the ACSM strategy to generate health care support for migrants, to create enabling environment for migrant TB patients, to educate migrant communities on TB, and to collaborate with MHVs in detecting, referring, and caring for TB patients. It has assisted TB patients by providing them with financial support for TB diagnosis and treatment, nutrition, and transportation in visiting health facilities, and by also giving them psychosocial support through the monthly TB patient gatherings.

To improve its implementation and services, the project invested in building the staff's skill and capacity in the following: TB screening and case management, TB/HIV counseling, TB monitoring and supervision, quality recording and reporting, financial and project management, and project monitoring and evaluation. It has also built MHVs skill in TB screening, sputum[3] collection, household contact screening, community mobilization, and participatory learning and action. Also, the project educated them on key TB information and on the importance of the Directly Observed Treatment Short-course (DOTS) in curing TB.

THE REPORT CARD

After implementing its strategies and improving its work through new initiatives, how did the TB-RAM project perform as it entered Phase 2? The following table highlights the project's achievements in relation to its key objectives for Year 3.

PBF no.	Indicator	Y3 Plan	Y3 Achievement
1.1	Case Notification : Number of new smear-positive patients notified in the target migrant population	400	347
1.2	Number of TB suspects including household contacts referred for TB screening	6,600	6,996
1.3	Number of new smear positive TB cases supported to receive TB treatment	360	316
1.4	Number of enrolled TB patients among migrants receiving PITC and result of HIV test.	450	497
1.5	Treatment success rate: Number of new smear positive TB cases among the migrant populations that are registered who are successfully treated.	80%	89%
1.6	Number of community health posts supported to provide TB information, counseling, care and services.	95	74
2.1	Number of migrant health volunteers trained/retrained as DOTS partners, TB/HIV counseling and referral, and community-based interventions.	1,950	3,760

Table 3: The TB RAM Project's Key Indicators and Achievement

[3] **Sputum** is a matter coughed up and usually ejected from the mouth, including saliva, foreign material, and substances such as mucus or phlegm, from the respiratory tract (2009 The American Heritage Dictionary of the English Language 4th Ed.)

TB Case Referral

The project was able to refer a total of 6,996 TB suspects[4], which is 6% over the intended target of 6,600. The increase in referrals may be attributed to the project's expansion of coverage. It has expanded to two districts in Phang Nga province, one district in Phuket, and one district in Chumporn. Currently, the project is serving 235,884 migrants compared to only 135,000 migrants during Phase 1.

Another contributing factor is the joint outreach activities of ARC, KRCH, and the district hospital in the Three Pagodas Pass, a major border crossing accessible from both Thailand and Myanmar, which enabled active TB case finding and screening of household contacts[5].

Also, the decision of one of the SRs to integrate the community activities of its Global Fund TB and Malaria projects led to cross-referrals. Interestingly, in the World Vision project areas, 80% of the referrals came from the community.

Smear Positive TB Case Notification[6]

Out of almost 7,000 TB suspects referred, 347 were notified to be new smear positive TB patients. This figure is 13% shy from the target of 400. New TB smear positive patients are those identified as positive with TB through a sputum smear examination – the primary diagnostic procedure used to identify pulmonary TB. The low identification of new smear positive patients has been, in part, affected by limitations set by some district hospitals. In one district , the schedule for receiving TB suspect referrals for examination is only once a week. Further, the hospital laboratory is only accommodating four persons for smear examination in a week.

Meanwhile, in another district, household contacts suspected with TB were not sent for sputum examination but were only under observation. This kind of TB referral system contributes to a reduced level of cases notification every quarter. And, there is concern in one district over the quality of the sputum specimen being submitted, thus hindering proper and timely diagnosis of TB suspects. However, the project was able to address the issue by applying innovative techniques, as well as coordinating with the district hospitals and building awareness of project objectives.

Other factors affecting low case notification includes the seasonal rain towards the second half of Year 3 and the increase of migrant arrest that created difficulty for TB suspects to reach the district hospitals for examination.

Treatment Success Rate

Good news! Most of the migrant TB patients enrolled for TB treatment under the project were cured. The treatment success rate for Year 3 is at 89% exceeding the project's target of 80%. This is a significant achievement for TB control given that the project's target beneficiary is a mobile population. Although the 6-month TB treatment compliance continues to be a challenge, the high treatment success rate can be attributed to the efforts of using community-based DOTS wherein a migrant volunteer or a family member becomes the patient's treatment partner, as well as the strong follow-up mechanism on treatment compliance, and the good collaboration with the local district hospitals.

[4] **TB suspects** are those people who are exhibiting TB signs and symptoms.

[5] **Household contacts** are those people that a TB patient may have contact with, who could also be carrying the TB bacteria.

[6] **Smear positive TB case notification** means that smear positive TB is diagnosed, and a diagnosed smear positive TB patient is notified by the project for DOTS service.

HIV Testing and Counseling of TB Patients

A total of 497 enrolled TB patients were provided with HIV testing and counseling. This is 10% higher than the project's target of 450. The Thai government's guideline mandating all public health facilities to provide HIV testing and counseling to all TB patients has assisted the project in achieving more than its target. However, there is more work to be done, such as advocating to some district hospitals who failed to follow such guideline. With this initiative, the project discovered that around 13% of all enrolled new smear positive TB patients were co-infected with HIV, an alarmingly high percentage. Accordingly, these TB patients co-infected with HIV or who are suffering from opportunistic infections were referred to appropriate health facilities or NGOs.

Establishment of Health Posts

As described in the section of the TB-RAM Project overview, health posts have become important places within the migrant community where TB screening, sputum collection, and TB education are conducted. This year, the project managed to establish 74 health posts out of the target of 95. There was a delay in the approval of the procurement plan which consequently delayed the procurement activities in the project sites, including the purchases needed to set up health posts. Nevertheless, the health posts were established with the assistance of the community and the business owners. At times, business owners or employers pro-actively share materials to establish the health posts.

Training of Migrant Health Volunteers

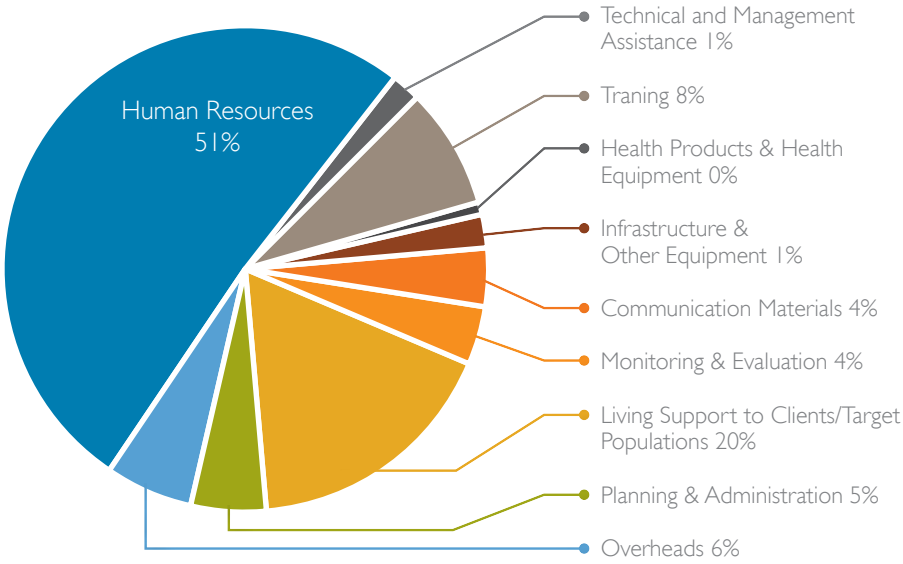
The project has achieved almost 200% of its target in relation to training a total of 3,760 MHVs. The over achievement is due to the project's expansion of coverage, therefore resulting in a need for more volunteers. More importantly, this is due to the mobile nature of the migrants. The migrant's high-mobility (either seeking new or better job opportunities, or moving to escape arrest) led to high drop-out rate among MHVs and the subsequent need to train new MHVs to replace drop-out volunteers.

WHAT'S THE FINAL SCORE?

Over-all, the project was able to achieve more than its targets for most of the indicators despite the many challenges that it faced, such as migrant arrests and the inherent mobile nature of the target population. For Year 3 alone, almost 7,000 TB suspects were screened for TB and a total of 540 migrant TB patients have been supported for treatment, around 60% of whom are smear positive TB patients. The project has achieved an 89% treatment success rate – a remarkable performance given that the World Health Organization's (WHO) recommended success rate is 85% for the general population and 80% for the migrant population. Such success would not have been possible if not for the sustained effort in mobilizing more than 1,500 MHVs, establishing over 100 health posts since Phase 1, and organizing 50 migrant volunteer network groups to reach the migrant communities in the six provinces covered by the project.

TB-RAM Project's Financial Report Card

For FY2010, the TB-RAM project funded by Global Fund has total consolidated expenditures of $1,351,166. Out of this amount, fifty-one percent was spent on Human Resource. This represents 114 staff from World Vision (both PR & SR), 37 staff from ARC and 14 staff from KRCH. Competent and dedicated staff collaborate 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. On the other hand, low retention rate and high staff turnover have also been part of the challenge.



Living support to clients and target populations has the second largest share of the total project expenditures, representing 20%. The uniqueness of the project comes from helping migrants (non-Thai communities) identify capable migrant health volunteers (MHVs). The project serves an estimated 236,000 migrants living in six provinces namely Ranong, Phang Nga, Phuket, Chumporn, Kanchanaburi, and Tak, with programs in a total of 18 districts.

The project has also invested on building the capacity and skills of both the staff and MHVs in TB screening and case management, TB/HIV counseling, TB monitoring and supervision, quality recording and reporting, financial and project management, and project monitoring and evaluation. It has also built MHVs skill on TB screening, sputum collection, household contact screening, community mobilization, and participatory learning and action. For year 3 alone, seventy-four health posts were established with the assistance of the community and business owners. Various communication materials were also initiated for public awareness. Public awareness is done through conducting advocacy, communication, and social mobilization (ACSM) activities in the communities.

What's NEW? Phase 2 Begins with New Approaches and Fresh Ideas

With the TB-RAM Project being able to successfully achieve its targets during its Phase I implementation, it received funding to move towards implementing Phase 2 for the next three years. However, continuing the project to its third year is more than simply repeating the intervention that proved successful in the initial phase. Rather, it is continuing to improve upon its previous work by building on its successes, applying lessons learned, and persistently finding the appropriate approaches to achieve the project goals. Such was the case in Year 3 as it explored new initiatives to better assist the TB care needs of migrants.

WELCOMING A NEW MEMBER TO THE TB FAMILY

The start of Phase 2 is also a new beginning for Kwai River Christian Hospital (KRCH), the newest SR to join the TB-RAM Project. KRCH is a private hospital serving non-Thai migrants in Sangklaburi District, a migrant-populated area, for over 50 years (see the TB-RAM Project overview section for more information on KRCH). With KRCH being facility-based, it complements the existing approach of other SRs who are doing active case finding through household visits, community health education, and training migrant health volunteers in detecting and referring possible TB patients. The presence of KRCH also provided more options for TB patients as to where they would like to have their treatment – in KRCH's TB House or in their own respective homes.

TB LEARNING MADE EASY

To support the project's communication strategies, a Knowledge, Attitude, and Practice (KAP) survey was conducted in 2008. Results of this survey, together with the lessons learned in producing information materials during Phase I, were used to develop appropriate TB messages and to improve the

Behavior Change Communication (BCC) materials for migrants. To date, there are four kinds of BCC materials developed that target different stakeholders in the migrant communities: TB patients, migrant health volunteers, treatment partners, and business owners/employers. Such materials include posters, comics, flipcharts, notebooks, and calendars. The pre-tested materials provided to migrants are in Myanmar, which contain mostly illustrations, and use simple, basic texts to accommodate those who are not able to read. In addition, each page of the notebooks provided to business owners and employers contain TB facts to educate them on TB and the migrant workers.

FROM VOLUNTARY TO MANDATORY

In 2008, the Thai government, through its National Tuberculosis Program (NTP), released a guideline entitled Provider-initiated HIV testing and counseling (PITC) for tuberculosis patients, mandating all public health facilities to provide HIV testing and counseling to all TB patients for free. Implementation of the guideline began in 2009, closely aligned with the start of TB-RAM Project's Phase 2. This mandate has assisted the project in increasing its number of enrolled TB patients among migrants receiving PITC and HIV test results. In Phase 1, HIV testing and counseling of TB patients was only on a voluntary basis. Armed with the new guideline and with continuous advocacy to district hospitals, the project was able to encourage the provision of PITC to all enrolled TB patients in the project's coverage area. By the end of the project's Year 3, a total of 497 enrolled migrant TB patients received PITC and their HIV results – 10% higher than the project's target of 450. This shift from voluntary to mandatory HIV testing and counseling resulted in providing information on the percentage of TB-HIV co-infection among migrant TB patients. The challenge remains, however, to ensure that the TB patients detected with HIV receive proper treatment.

THE MARRIAGE OF TB AND MALARIA

One of the SRs decided to integrate the community activities of its Global Fund TB Projects – the TB project and the Malaria project. This integration resulted in cross-referrals, contributing to TB notification. In Kraburi district, a suspected Malaria case was brought to the Malaria post for screening and was also screened for TB, resulting in a confirmed TB case. This approach is resource effective and beneficial for both the project and the migrants – the projects benefits from efficient case detection, while the patients benefit from being educated on both TB and Malaria.

These new initiatives have supported the project in achieving specific targets. But more importantly, these initiatives provide opportunities on how to better serve the target migrant population and address their needs.

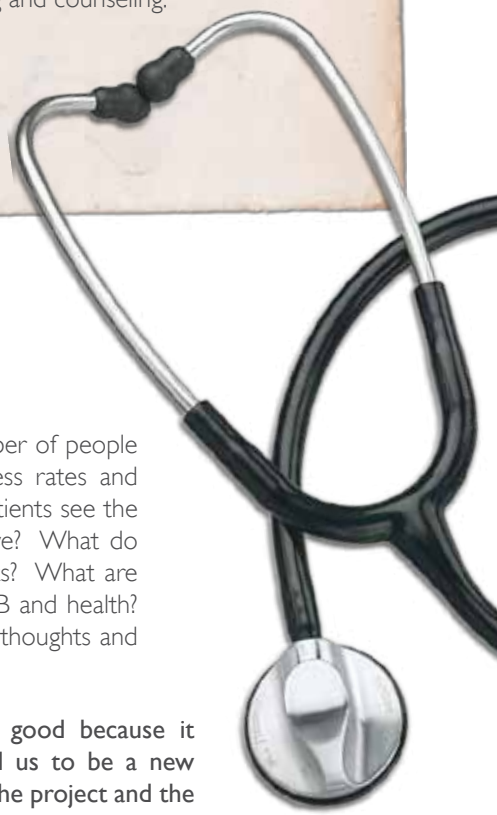
(Left)
This comic explains in an entertaining way the TB signs and symptoms that migrants should know.

I have TB, I have HIV:
The rise of TB-HIV co-infection among migrants

The release of the Thai government's guideline mandating public health facilities to provide free HIV testing and counseling to all TB patients brings good new and not-so-good news. The good news? Information on the percentage of TB-HIV co-infection among migrant can now be gathered and migrants would be able to receive free service on HIV counseling and testing. The not-so-good news? There is no standard of procedure yet on what to do next once a migrant TB patient is detected with HIV. Based on the information gathered by the TB-RAM Project, around 13% of the new smear positive TB patients were co-infected with HIV, an alarmingly high percentage.

TB patients co-infected with HIV do not just suffer the physical pain of having the disease but also have to deal with double stigma. Ko Myint (not his real name), a 33-year old migrant fisherman, was diagnosed with TB. The project supported him with food during the course of his treatment and his wife was supportive in taking care of him. Just before the end of his TB treatment, he was diagnosed with HIV that prompted his wife to leave him.

Ko Myint is only one of the many migrant TB-HIV patients suffering from such pain and stigma. With the rising incidence of TB-HIV co-infection among migrants, a system and a policy must be put in place on how to treat TB patients also diagnosed with HIV. The healthcare service to migrants must not stop at simply providing HIV testing and counseling.



He said, She said: Voices from the Field

Figures have been recorded, targets have been achieved, number of people suspected of TB referred was counted, and treatment success rates and sputum conversion rates were calculated - but how do the patients see the project? What do public health partners think of this initiative? What do the staff feel as they do their daily work in helping TB patients? What are the MHVs thinking as they educate their fellow migrants on TB and health? Let us listen to these voices from the field as they share their thoughts and experiences of having been part of the TB-RAM Project.

"TB Project for migrants [is] good because it helped us to live and changed us to be a new person. I really want to thank the project and the staff that helped us in many ways…So with the help of God, if I am able, I plan to help others who need my help the same way that they helped me when I was sick."

Chart
Migrant TB patient, Saiyok Sub-district
Sangklaburi District, Kanchanaburi Province

"There were some difficulties of being a volunteer. I participated in the group [who] collected donation from community members then distribute these donations to TB patients, HIV patients…those who had terminal illness. The community misunderstood me. They used to ask me 'Who are you talking about health?' and 'Why are you collecting money?' If people told me bad things, I easily forget it once I see the patient. The well-being of the patient motivates me to be a volunteer."

Daw Win Mu
Migrant Health Volunteer
Paknam Lang Suan District, Chumporn Province

"The most unforgettable experience of working in the TB project is seeing the smiles after the patients have completed their treatment, are cured, and are able to return home to their family. I am so glad and happy to have the opportunity to help people who are very sick and desire to live again."

Supawaree Saisangklapontiti
TB-RAM Project Staff
Sangklaburi District, Kanchanaburi Province

"It is because of my utmost concern that health is very important to [ones'] quality of work and to the worker's life. No matter how workers want to work for the company but if they have health problems, they will not be able to work well and it will affect [their] income, which will bring family problems. On the other hand, if they have good health, it will make [them] work more, [have] better income and happiness in their life."

Smit Pornprasi
Human Resource Manager
Vitchipan Palm Plantation
Tha Sae District
Chumporn Province

"The incidence of TB has increased among migrant groups over the last 2 years. Thanks to the work of the NGO groups, these new migrants receive quicker health services and treatment. The majority of these patients are of working age, which [is in] contrast with Thai TB patients, who are mostly elderly…Clear policies need to be provided by the government, particularly to the migrant factory workers, on the necessity of completing TB treatment."

Khun Kedruthai Setthakorn
Provincial TB Coordinator, Provincial Health Office
Kanchanaburi Province

"I really thank the project because I got cured from TB and [was] allowed to participate as a DOTS partner to help migrants. I can easily understand [their] suffering and their feelings as a TB patient. I promise to be an efficient DOTS partner if there are patients that I could serve."

U Tin Hlaing
Migrant TB patient Maesot District,
Tak Province

"The Global Fund [project] supplements the existing healthcare system of the government because it is taking care [of] migrants, who are difficult to be reached and are out of the healthcare system."

Lersak Satapan
The Chief of Wiakadi Health Center
Sangklaburi District, Kanchanaburi Province

"I find my job challenging as each patient has different needs during the course of their treatment. Patients find it hard to support themselves during treatment and this often leads to non-compliance…I feel frustrated that I do not have enough money to help them…I want to do the best for the patients and wish for all patients to be healed."

Sureepon Damrongpanwan
TB-RAM Project Staff
Sangklaburi District, Kanchanaburi Province

MHV Diary: A Sneak Peak at a Community Health Volunteer's Life

Throughout the course of the project, most of the referrals for TB suspects were from the migrant health volunteers (MHVs). They have also been a big contribution to the treatment success rate for Year 3 as 63% of the MHVs are treatment partners to TB patients. It cannot be denied that the MHVs are vital in doing community-based DOTS and in bringing TB care closer to TB vulnerable groups, particularly the migrants.

Fifty-five year old Daw Khin Htwe, who is working as a tailor, is only one of the many MHVs who have helped many migrants and saved lives from simply giving TB information and assisting them to receive examination and treatment. Let us take a look at the life of Khin as she tells her story as an MHV during an interview with a TB-RAM Project staff.

Q: When did you arrive in Thailand?

Khin

On 29th July 1997

Q: Why did you come to Thailand?

Khin

In Myanmar, I used to sell vegetables in the morning and take clothing order in the evening at a tailor shop. I have five children and I want them to be educated. I do not want them to lead a life like me. I worked hard, but no success…Then one of my friends told me if I want my children to attend schools, I should go to Thailand where there are better opportunities than in our village. So I came to Thailand.

Q: Can you describe your life as a migrant worker?

Khin

To tell you the truth, the migrant workers' life is difficult. They work for jobs that pay less and those jobs that most people will not do or cannot want to do. Frankly, they have no rights at all. No security, no health care. To share an example, there had been a police arrest in our community. They search illegal migrants even to their homes. Women, including pregnant women, were frightened and hid in the forests and farms. The factory owners told workers that the factory will be closed for one week, that they could not live there, and to find other places. They said, "That is your fate." We just could not say anything.

Q: Why did you volunteer to be an MHV?

Khin

Project staff came to our community and they explained the projects being done. The projects are for migrants. I was happy to know that. If you ask migrants about the diseases like HIV, AIDS and TB, they will say that they do not know anything about them. They have to work full time from morning until night and they have no health knowledge. I want to help them so I ask if it is ok if I serve as a volunteer and now I am an MHV.

Q: What do you do as an MHV? What activities do you do?

Khin

As an MHV, I collect sputum samples of TB suspects in the community, arrange for taking chest x-ray, and inform project staff of updates whenever necessary. I also ensure continuous drug supply to the patients, do follow-up with patients, consult with doctors, support and check the DOTS partner's daily records, and ensure DOTS to patients. If there are drug side effects, I also inform the appropriate persons. I also take part in project activities such as MHV trainings, and monthly meetings. I help in community activities like in the MHV network meetings. I come in time whenever I was assigned work for the activities.

Q: Can you describe your life as an MHV?

Khin

The life of an MHV is very simple. We are not business people. We help people. We always help migrants in terms of health. If there are needs that the projects could not provide, I ask other organizations to help them. I try my best to assist in solving their difficulties. I always provide help out of empathy.

Q: What do you like the most in your work as an MHV?

Khin

I like taking down records. I also get lots of knowledge.

Q: What is your most unforgettable experience as an MHV?

Khin

It was the day when I help a patient called Poe Kar. My son's friend came to our home and inquired how to collect sputum samples. I told him to take three sputum samples including one early morning sample. Not long after, the TB suspect came to my house bringing with him his belongings and the sputum cups I gave him. He said that his house owner forced him to move out. He moved to seven places within two months since the neighbors force him to move out because they could neither eat nor sleep by his disturbing cough. So he came with no other options. With tears in his eyes, he begged me to allow him to stay in our home for two months and to take treatment. I encouraged him and allowed him to stay, but I told him that he needs to follow my words. His honest response of saying yes with a trembling voice makes that day unforgettable for me.

Q: What do you know about TB before becoming an MHV?

Khin

I do not have knowledge about TB before. I could not help my friend, who lived next door, suffering from TB. I could not direct them to which organization to ask for help, or how to prevent transmission, and so on. I could not help to get treatment because I have no information. I was also afraid of TB infection. They say that you can die of it.

Q: How do you perceive or see people with TB before becoming an MHV?

Khin

I was scared of TB patients before becoming an MHV. I was afraid of being infected. If I contract the disease, I think I will surely die.

Q: Has becoming an MHW changed your knowledge on TB? How?

Khin

I get to know TB from the project. I felt very pleased. Now I know that TB infection can be cured, that not every TB patient dies, and that you need to follow the doctor's advice. The treatment is also free of charge. It is also remarkable that DOTS strategy can cure TB infection.

Q: Has becoming an MHW changed your perception on people with TB? How?

Khin

I am no longer scared of TB patients after becoming MHV because I now know how to prevent TB. If I did not learn how TB was transmitted, I will discriminate them…isolate them. But now, I know the ways of prevention like putting on mask cover, covering the mouth and nose when coughing or sneezing, not spitting sputum carelessly, and to dispose sputum correctly. I always tell the patients to practice them to avoid transmission.

Q: What motivates you to continue working as an MHV?

Khin

My family always encourages me to continue to work as a MHV. Another reason is I want to help migrants with their health problems out of sympathy.

Q: What are your dreams? What are your plans in life?

Khin

I am now getting old. We cannot forecast fate. I will continue to contribute my effort out of compassion to the project if I do not die before the project ends. I will work until the project finishes. If I have to go back to Myanmar, I will still help migrants even after the project. My dream is to see my children educated. Also, I want to have a happy and united family, and to provide a good shelter for my children to live together. As a Buddhist, I want to practice meditation, take peaceful shelter of Buddha teaching.

MA NGE : WHOM THE MIGRANTS CALL FOR HELP ON HEALTH

Ma Nge has been living in Ranong province for more than 10 years, beginning her life in Thailand as a migrant worker. Being able to save money, she is now a housewife and lives a better life than the kind of life she used to have in Myanmar. Having spare time on her hands and the desire to help her fellow migrants, she decided to become a migrant health volunteer.

Health Post in Ranong

For the past two years, Ma Nge received training on TB and HIV from the TB RAM Project. To be able to help more migrants, she transformed her room to become a health post where community health activities can be done and where migrants can go to if they need information or help on health. She even initiated collecting donations from neighbors to be able to help poor migrants with poor health.

At present, she is a treatment partner to an 18-year-old fisherman residing near her room. Since the patient has to go early for work, she even visits the patient at 5am to ensure he takes his medicine.

Ma Nge is not only educating the community on TB and HIV but also has been actively giving information on reproductive health issues such as family planning and ante-natal care. She has also started organizing a community savings scheme for the community to have funds for any emergency.

With volunteers like Ma Nge, TB and HIV care can indeed be brought closer to vulnerable groups such as the migrant communities.

Challenges and Lessons Learned

Despite the project creating new initiatives to improve its case detection, treatment success rate, project management, and service to migrants, it continues to face challenges that have consequently slowed down its journey towards achieving its goal of reducing the TB incidence among non-Thai migrants.

MOBILITY OF MIGRANTS

Non-Thai migrants in the project's coverage areas are inherently mobile due to any of the following reasons: to seek better job opportunities, to escape arrest and deportation, or to find a new job in another area after completion of work within particular period of time. This highly transient nature of migrants and the migrants' preference to work and receive wage (which they will be unable to do during treatment) contribute to TB patients not completing the TB treatment; this makes them susceptible to drug-resistant strains of TB, and the potential for a rise in Multi-Drug Resistant (MDR) TB cases. With this kind of population, supervisory visits to patients are essential to aid in the patient's improved understanding of the importance of treatment compliance.

Further, such mobility makes it difficult to retain and recruit MHVs. Previously trained MHVS are moving out while new migrants are coming in. To minimize the decrease of case referrals and detection, some of the project sites have had the MHVs collaborate with Thai health volunteers in conducting both community and screening activities.

There are also types of work that require greater movement, such as those in construction. Once the construction project is done, migrant workers abandon the site and move to another construction work. Consequently, the health post established in these project sites are left to function as a repository of BCC materials for migrants; however, no TB screening and referral is being done anymore since most of the migrants have moved out.

ACCESSING HARD TO REACH COMMUNITIES

The remote geographic location of some migrant communities also makes referral of TB cases and follow-up on examination and treatment difficult, affecting the project's performance on

case referrals and case notification. There is no regular public transportation in some areas and some communities can only be reached by walking for days. This also contributes to higher spending on transportation cost in order to send TB patients back and forth to the hospitals for treatment and follow-up examination. Having a good program design, which includes careful selection of project sites and development of realistic site selection criteria, must be done at the beginning of any project.

LANGUAGE BARRIER BETWEEN VOLUNTEERS/HOSPITAL STAFF AND MIGRANT TB PATIENTS

Most of the Myanmar migrants do not speak Thai and they speak different ethnic languages such as Karen and Mon. Such language barrier prevents some migrants from seeking appropriate care and discussing their symptoms and illness to either Thai-speaking volunteers or to health staff. Also, this often leads to misunderstanding of migrants on TB messages. Selecting the appropriate frontline staff, who can speak the migrants' language and identify with the migrant communities, is necessary to be able to reach this TB vulnerable group. Fortunately, all staff of the new SR can speak Karen and Mon, which has encouraged migrants to access their healthcare service. Also, the new BCC materials developed were written in Myanmar for easier understanding by the migrants. Such materials must be culturally sensitive and contextualized to be fully accepted by the target communities.

MISSED OPPORTUNITIES IN TB DIAGNOSIS

In one of the project sites, the hospital's schedule for receiving TB suspect referrals for examination is only once a week. The hospital's laboratory can only accommodate 3 suspects (total of 9 sputum samples) for smear examination in a week, which has caused a delay in identifying and treating possible new smear positive patients, and resulted in a low case notification and the possibility of more people getting infected with TB. To address this concern, the project trained its staff in sputum smearing to be able to accommodate TB suspect referrals, who were excluded from the 3 suspects per week ceiling of the district hospital. Meanwhile, in another district, sputum samples will instead be sent to a private clinic near the hospital for examination provided that the clinic will submit the result to the district hospital.

Constant coordination and collaboration with the district hospitals on proper TB management has been essential in detecting TB patients and providing them with appropriate care.

LOW RETENTION RATE OF PROJECT STAFF AND DISTRICT HOSPITAL STAFF

There is a fast turn-over rate of project staff. Work overload, inability to cope with high work expectations, mismatched work experience with current job skills, better work opportunities, and the approaching end of the project – these have led some project staff to resign from their work. A limited human resource overstretches the capacity of the remaining project staff and hampers smooth project implementation. Also, capacity building costs will be high since there is a need to train the newly recruited staff. To achieve better project performance, it is crucial to find the best means to timely recruit the appropriate and qualified staff in the right position within an effective organizational structure, and to retain them for the long-term.

Meanwhile, there are also regular turn-over of government staff at the community level. Usually, rotation in work assignment among public health doctors occurs. A public health doctor will only be working for two years in a particular area and then will be transferred to another area. Therefore, the project staff will need to start from the beginning in building

relationship with the new doctor and educating him on the project, as the commitment and support of this doctor and the public health staff in the district hospital are vital to the project's success.

TREATING TB-HIV CO-INFECTED PATIENTS

Since the Thai government has already released the guideline mandating public health providers to give HIV testing and counseling to all TB patients, more cases of TB-HIV co-infection are now being detected. Information is now available on possible TB-HIV co-infection among migrants. However, proper care and treatment must be provided to the TB patients co-infected with HIV in order to holistically serve the migrant population. Currently, TB patients still face the stigma of having the disease and TB-HIV co-infected patients face the double stigma of having both diseases. Given this reality, the project needs to strengthen its community awareness efforts in order to generate positive support and understanding for those migrants with TB and for those migrants who are co-infected.

There are always challenges in implementing projects; however, with constant collaboration among project implementers, regular discussion of issues and concerns, and sharing and developing new ideas and strategies to help in improving project delivery and serving the migrants, the difficult feat to reduce TB incidence among migrants will be a lighter weight to carry.

Former Fisherman TEACHES TB to Migrant Fishermen

For 10 years, he has been working as a migrant fisherman. But for the last 5 years, he is working as a TB RAM Project staff teaching TB to migrant fishermen.

Nyan Lin is a project staff in Chumphorn province. Being a fisherman before, he understands the kind of life fishermen lead and their very mobile nature, which creates difficulty in educating them on TB.

"Most of the migrants had no knowledge on health. Most of the male migrants use their life in drinking or sexual pleasure. They did not even know about their rights to seek healthcare," exclaimed Nyan Lin.

Given the knowledge and skills he has learned as a project staff, he now organizes group sessions teaching migrants on health, life skills, and how to set life goals.

For Nyan Lin, "I like the most being a trainer and a counselor because [I am] interested to preach to people and to help patients in solving their problem.

Further, with his ability to speak Myanmar, he assists in translating the illness that a migrant is experiencing upon visiting a hospital.

"I was being a bridge between [the] migrants and [the] hospital staff [in] solving health problems," he shared.

Nyan Lin already travelled a long way from being a migrant fisherman to a social worker, trainer, and counselor. Despite the challenges he faced with his work, he perseveres in giving knowledge and TB care to patients. He believes that migrant TB patients are worth working for.

"The gratitude of the former patients motivates me to continue with my work," he concluded.

Migrant Health Volunteers meeting in Maesot

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