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A Situation Analysis on Health System Strengthening for Migrants in Thailand

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Supported by World Health Organization and European Union

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FOREWORD

The World Health Organization identified the six building blocks of a health system that include service delivery, health workforce, health information, medical procurements and technology, health financing, and leadership and governance. Health system strengthening is, consequently, defined as the improvement of these building blocks as well as management of their interactions in the way that brings up with equitable and sustained betterment of health services and health outcomes.

Recently, the number of population residing in Thailand without Thai nationality was estimated at over three millions. This consists of the majority who are migrant workers and dependants from Myanmar, Cambodia and Laos, and other groups of the non-Thais including ethnic minorities, stateless persons and displaced persons. Despite the recognition of a successive Thai health system under the universal coverage schemes for the Thais, migrants and non-Thais remain vulnerable to various health risks, insufficient coverage for the protection and access to health services. Given the large number of these populations, strengthening of Thailand's health system in corresponding to the concerns is inevitably crucial, requiring supports and collaborations among all relevant stakeholders.

As an important step of the attempt, this report aims to provide an identification and gap analysis on the current situations of health system for migrants in Thailand. Desirable attributes of each health system building blocks, defined by the WHO, those remain unachieved to

ensure greater coverage and access to quality health services of migrants is a basis for the analysis. It is our hope that the information and findings of this report are useful as an input for understanding the situations of health system for migrants in Thailand, and also guide appropriate way forwards to health system strengthening policies and strategies to ensure the better health outcomes for all in Thailand.

Associate Professor Dr. Sureeporn Punpuing
Director, Institute for Population and Social Research
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FOREWORD

There is growing recognition that the health of Thai citizens is inextricably related to the health of the estimated 2-3 million migrants residing in their communities. Economic, human rights, and public health imperatives all point to the need to ensure that migrant populations have access to quality health services. Nevertheless, there are substantial challenges to reaching this goal of health security for migrants.

Generating sustainable solutions to the complex and dynamic problem of providing health security for migrants in Thailand will require comprehensive systemic approaches, appropriate policy guidelines, and practical programs to overcome both financial and non-financial barriers. Previous researchers have provided useful reviews and analysis of various health challenges facing migrants, particularly regarding major communicable diseases such as HIV, TB, and malaria. These reports consistently demonstrated that, although as a group, migrants are primarily a young, healthy population, the nature of their mobility, their living conditions, the hazards of their occupations, and their often limited access to health care increases their risk for developing both communicable and non-communicable diseases. While these research efforts have increased our understanding of migrant health, most have focused on specific diseases or programs without examining the overall health systems context or requirements for a more efficient network of services.

Both in Thailand and globally there is increased understanding that achieving major health goals will require interventions which include

strengthening health systems as a whole. WHO has championed the concept of health systems as comprising six inter-related building blocks: service delivery; health workforce; information; medical products/ vaccines/technologies; financing; and leadership and governance. While Thailand has utilized this approach to some extent to address the challenges of its overall health system, there has been a gap in applying this approach to migrant health services. Overall improvements in the performance of a health system are dependent on the system's capacity to address particular needs of specific vulnerable groups as well as the general population in order to have an impact on the health outcome for the entire community.

As one contribution to understanding the health needs of migrants, WHO, with support from the European Union, has collaborated with the Institute for Population and Social Research (IPSR) to undertake an analysis of health system strengthening needs for non-Thais in Thailand. Utilizing the building block approach of WHO, IPSR has conducted extensive document reviews and interviews with public health experts to provide a comprehensive look at each functional aspect required for providing services. Gaps and key constraints are thoroughly examined for each building block. Most importantly, the report also provides critical analysis and recommendations for how each component could be strengthened.

IPSR has made a major and timely contribution for addressing the health needs not only of migrants, but the Thai population in general. This compilation of data and related analysis should prove useful to public health policy makers as well as program managers responsible for health care delivery at all levels.

Dr. Maureen Birmingham
WHO Representative to Thailand

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Without kind supports and assistance, both directly and indirectly, from the following individuals and organizations, this report would not have been possible. The authors would like to express sincere appreciation and thanks to Associate Professor Dr. Sureeporn Punpuing, Director of Institute for Population and Social Research, Mahidol University, for her guidance and supervision throughout the study and report making. Our appreciation also goes to Associate Professor Dr.Kritaya Archavanitkul, Mr. Andy Hall, and Associate Professor Dr.Wathinee Boonchalaksi for their kindness in providing invaluable information and insightful comments about updated situation of migrants in Thailand in the aspect of health. Special thanks go to Ms. Ploychompoo Sukustit for kind assistance on proofreading throughout the paper.

We would like to thank the Raks Thai Foundation, the Global Fund (Thailand) and the PHAMIT network for organizing a meeting on "The Challenges and Potential of Health System Strengthening for Non-Thais, Migrants, and Dependants" held during September 26-27, 2011. This meeting had gathered the relevant stakeholders, from public and private sectors, national and international organizations, who had also provided a wide range of information, opinions and perspectives toward the issue. Their inputs were very useful and crucial for the completion of this report.

Last but not least, the authors wish to express gratitude and thanks to the World Health Organization (Thailand) and the European Union for financial support. Without their support, this study and the report would not have been accomplished. Our specific appreciations go to Dr. Asheena Khalakdina, Ms. Aree Moungsookjareoun and Dr. Brenton Burkholder who initiated the study, provided support and meaningful guidance for the study. Finally, we would like to thank Mr. Suwanna Sangsuwan, Ms. Sushera Bunluesin, and Ms. Charuwan Charupum for their kind assistance on logistics and administrations of the study project.

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CONTENTS

Contents (Con't)

List of Tables

List of Tables (Con't)

List of Figures

List of abbreviation

ACHIEVED	Aligning Care and Prevention of HIV/AIDS with Government Decentralization to Achieve Coverage and Impact
ACSM	Advocacy, Communication and Social Mobilization
ARC	American Refugee Committee
ART	Antiretroviral Therapy
AMI	Aide Medicale Internationale
BHP	Border Health Program
BOE	Bureau of Epidemiology
CBO	Community Based Organizations
CCM	Country Collaboration Mechanism
CHAMPION	The Comprehensive HIV Prevention among MARPS by Promoting integrated Outreach and Networking Program
CMHI	Compulsory Migrant Health Insurance
DDC	Department of Disease Control
DFID	Department for International Development
DOPA	Department of Provincial Administration
ECAT	Enhancing HIV Related Care and Treatment for HIV Mothers and Their Partners
FSW	Female Sex Worker
GF	Global Fund
GFATM	The Global Fund to Fight AIDS, Tuberculosis and Malaria
HSS	Health System Strengthening

List of abbreviation (Con't.)

ID	Identification number
IDU	Inject drug user
IOM	International Organization for Migration
IPSR	Institute for Population and Social Research
IRC	International Rescue Committee
KAP	Knowledge Attitude and Practice
MARPS	Most at Risk Populations
MHIS	Migrant Health Information System
MMC	Mahidol Migration Center
MOI	Ministry of Interior
MOL	Ministry of Labor
MOPH	Ministry of Public Health
MOU	Memorandum of Understanding
MMP	Migrants and Mobile Population
MSM	Men who have sex with men
MW	Migrant Worker
NGO	Non-governmental organization
NV	Nationality verification
PCM	Provincial Coordinating Mechanism
PR	Principle Recipient
PHA	People Living with HIV/AIDS
PHAMIT	Prevention of HIV/AIDS Among Migrant Workers in Thailand Project

List of abbreviation (Con't.)

RCC	Rolling Continuation Channel
RFT	Raks Thai Foundation
RH	Reproductive Health
TB	Tuberculosis
TBBC	Thailand Burma Border Consortium
TBCA	Thailand Business Coalition on AIDS
TFR	Total Fertility Rate
TUC	Thailand U.S. CDC Collaboration
VCT	Voluntary Counseling Testing
UNGASS	United Nations General Assembly Special Session
UC	Universal Coverage
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization
WVFT	World Vision Foundation of Thailand

Executive Summary

This study aims to provide a situation and gap analysis on the health system strengthening (HSS), particularly for non-Thais in Thailand. The analysis is based on the WHO's health system building blocks framework. Findings are contributed to initial assessment of the situation and identification of problems and gaps related to the issues to be addressed, which are expected to serve as an input for the development of an application to the GFATM Round 11 on HSS for Non-Thais Living in Thailand.

The study is a research-based activity. Document reviews and interviews with local experts and academic who have expertise and experiences in working with the issue on migrant health in Thailand are key methods used. Key material for the analysis also comes from output of the meeting on "The Challenges and Potential of Health System Strengthening for Non-Thais, Migrants and Dependents" organized by the Raks Thai Foundation with collaboration from the Global Fund (Thailand) and the PHAMIT network during September 26-27, 2011.

I. Backgrounds of the Migrants and Migrant Health

- **Migrants in Thailand**

The migrants, or the non-Thais, scoped in this study include 4 categories as follows.

1) Migrant workers and dependants from the three neighboring countries (Myanmar, Cambodia and Laos): This group of low-skilled workers (and dependants) includes both regular and irregular migrant workers.
2) Ethnic minorities: This group refers to documented non-Thais who prior to 2004 issued identity card with a 13-digit identification number starting with "6" or "7".
3) Stateless/rootless persons or persons without civil registrative status: This group refers to persons who have been living in the country for a long time or since they were born but not recorded in the national registration system until the implementation of the registration survey by the DOPA, the MOI in July 2005.
4) Displaced persons: This category refers to "displaced persons" residing in "9 temporary shelters" located in the 4 provinces along the Thailand-Myanmar border, plus an ethnic Shan residing in Chiangmai province.

As the majority in terms of quantity and the most problematic ones in terms of migrant health, migrant workers and dependants from Myanmar, Cambodia and Laos are set as the targeted groups in this study.

HSS

Number of migrants in Thailand

Migrant categories	13 digit ID No. (civil/residential registration)	Source (1)	Source (2)
Migrant workers and dependants from Myanmar, Cambodia and Laos	Start with "00"	Totally 2,581,360 from 6 registrations: • In 2004: 1,161,013 • In 2006: 256,899 • In 2007: 12,479 • In 2008: 96,708 • In 2009: 1,054,261 • In 2009 (migrants' dependants): 5,317	Totally 2,455,744 (in February 2010)
Ethnic minorities	Start with "6" and "7"	323,084	303,610 (of which 233,811 and 69,799 are the minorities not born in Thailand and the children of the minorities not born in Thailand, respectively)
Stateless/rootless persons or persons without civil registrative status	Start with "0"	218,538 (including residents awaiting nationality, children and students without registrative status who came to live in Thailand before 18 January 2005, and rootless persons without registrative status)	210,182 (including undocumented long-term migrants from neighboring countries, undocumented hilltribe members and Thai descendents who are not recorded in the birth registration system and de facto stateless persons)

Migrant categories	13 digit ID No. (civil/residential registration)	Source (1)	Source (2)
Displaced person	Start with "000"	138,076 in 9 temporary shelters along Thailand-Myanmar borders in 4 provinces; Mae Hong Son (4), Tak (3), Kanchanaburi (1), Ratchaburi (1)	143,315 (April, 2011) (at the end of 2010 the number was 141,076; consisting of 95,330 persons registered by the MOI and estimated 45,746 persons unregistered)

Source (1): The number of migrants is on the basis of civil/residential registration in April 2011 from Bureau of Registration Administration, Department of Provincial Administration (DOPA), cited in Bussayarat Kanchanadit, (2011)

Source (2): The estimated number of migrants in Thailand cited and summarized by Supang, (2011) and Suchada and Bongkot (2011) in International Migration in Thailand (IOM, Huguet and Chamratrithirong, 2011); Mahidol Migration Center (MMC) Newsletter 2nd Edition

- **Migrant workers and dependants from Myanmar, Cambodia and Laos**

A large number of these migrant workers, of which the majority around 80 percent is from Myanmar, have been residing, mobilizing and working in Thailand for a long time. Many of them, entered into the country illegally and, consequently, not officially recognized both in terms of residential and working status. Policies for administration and management of these groups of migrants and their dependants were without concrete direction and standard practice until 2001 when the Committee on Illegal Migrant Workers Administration was established,

and once again in 2004 when working guidelines for solving illegal migrant workers problem were introduced holistically in 2 stages.

Stage one: Semi-regularization of irregular migrant workers. With attempts to balance tensions of national security concerns, economic necessity and demand of local employers for additional low-skilled labor; the procedure was to allow irregular or illegal migrant workers to work legally one to two years in the country under an amnesty program before repatriation. Stage two: Migrant worker regularization framework. The framework was introduced to "legalize" the status of illegal migrant workers and allow them to work for a certain period of time under two methods. The first method is "nationality verification" or NV of the registered (but illegally entered) migrant workers who are already in Thailand by enabling them to obtain legalized status through the process by means of temporary passport or certificates of identity. The second method is importation of workers directly from neighboring countries. These two methods were conducted under a memorandum of understanding (MOU) between the Thai government and the government of each neighboring country (Myanmar, Cambodia and Laos).

Presently, defined by legal working status, migrant workers from the three countries are broadly classified into 3 groups. The first group is the regularized workers with a work permit who entered the country illegally but are allowed to work legally under the cabinet resolution. The second group is the regular workers with a work permit legally entered the country under the MOU either through NV process or direct importation from the home country. The third group is irregular migrant workers who illegally entered the country, have not registered with MOI and a valid work permit from the MOL.

In August 2011, regular migrant workers of the 3 nationalities with work permit account for 1,565,600 workers. This number consists of 1,036,212 workers of the first group as mentioned above; 529,388 workers of the second group or those who completed the NV (465,941 workers) and imported from the home country under the MOU (63,447 workers). The number of the last group or irregular migrant workers is then estimated at around 1 million.

- **Migrant health in brief**

The diseases surveillance in foreigners of the Bureau of Epidemiology (BOE) reported numbers of foreign patients at Thai health facilities to increase from 19,599 in 2001 to 44,552 in 2010, of which more than 70 percent are migrant workers from Myanmar, Cambodia and Laos. The number of foreign patients who were migrant workers reported in this surveillance is, nevertheless, estimated to be much lower than the actual number owing to a huge number of irregular migrant workers without work permits and health insurance who could not access care at health facilities when needed.

Patterns of sickness and prevalent diseases among foreign patients are not so different from Thai patients. Somehow, emerging disease such as “Malaria” and “Tuberculosis” are still found with more prevalence rate among foreign patients compared to Thai patients. By comparing the prevalence between Thai and foreign patients, it was found that the prevalence of malaria among the foreign patients was approximately 26 times of the Thais living in the same locale; STI infection was over 8 times; leprosy was about 4 times; and TB was about 2 times (Krittaya, 2007 cited in Bhassorn and Narisara, 2011).

From a survey in 2011 (Wathinee, et al. 2011), compared to the Thais, average times of both outpatient sickness and inpatient sickness (that needed to be admitted into a hospital) in a year was found lower among migrant groups. Anyway, when asked about times of sickness needing rest at home in average, it was found higher among migrants than the Thais. To some extents, this implies less access to care or treatment that needs hospitalization in a facility of migrants than the Thais, resulting in more times of sickness needing rest at home but fewer times of inpatient sickness of the migrants.

Considering care seeking behavior of migrants when falling sick the last OP sickness, a large percentage reported do nothing and self-medication by buying medicine from a drug store. Another majority utilized care at a public hospital and health center. From the same survey, 50-70 percent of migrant outpatients and inpatients, reported have no entitlement to any health welfare or insurance scheme. Constraints that would prevent migrant workers from going to receive care or health service at a health facility when falling sick included: having no legal identification card or the health card was a key constraint, followed by reasons of time-consuming, far distance to a facility, language and fees charged. These selected figures are reflecting some evidence on difficulties and constraints faced by migrants in accessing needed health care and services which was caused by either financial factors or non-financial factors.

On reproductive health and family planning, major problems are identified to be a high number of children born to migrant workers and ethnic groups. The estimated number of children born to Myanmar migrant workers each year was at 2,000 in average (Bhassorn and

Narisara. 2011; p.40). The actual number of birth, nevertheless, was suspected much under-reported. Estimated by Prasartkul. et al., the number of births to migrant workers was somewhere in the range between 42,000 and 98,000 births in 2010. The TFR among migrant workers was more than two times higher than the Thais at 3.6. So was those of the ethnic groups which in average at 2.3 in 2010 (NESDB and UNFPA. 2011; p.20-21).

- **Master plans and health strategies on migrant health in Thailand**

The Ministry of Public Health (MOPH) by Bureau of Policy and Strategy of the Permanent Secretary Office has developed and officially launched the first Border Health Development Master Plan 2007-2011 in 2007. The plan was aimed to improve the quality of life and health of border populations, including migrants. The second Master Plan for the period of 2008-2012 has already been drafted and on the process of its finalization.

Apart from the Border Health Development Master Plan, the National Master Plan for HIV/AIDS Prevention, Care and Support for Migrants and Mobile Population (MMP), 2007-2011 was developed and launched officially in 2007 by the Department of Disease Control with aims to reduce new HIV infected people among MMP and increase the quality of life of the HIV infected MMP.

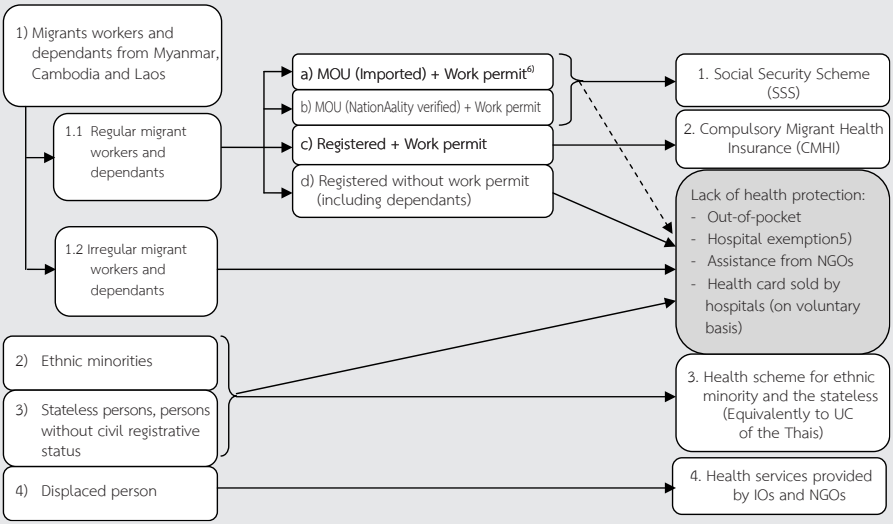
There is also the Migrant Health Strategy which has been developed by a working committee in collaboration with relevant government and non-government agencies and was drafted in 2006-2007 by the

Department of Health Service Support, Ministry of Public Health. The strategy was targeted on migrant populations which refer to migrant workers, their families and dependents, who are Myanmese, Laotian, Cambodian and other nationalities. This includes those who have been registered with the Ministry of Interior (with a 13-digit identification number) and those who have not been registered (no 13-digit identification number), as well as ethnic minorities living in Thailand. However, displaced persons from civil conflict who are residing in the temporary shelters are not included as target population in this strategy.

Noticeably, master plans and health strategy in relevance to the improvement of migrant health and health system for migrants in Thailand have provided importance and emphases on nearly all the six building blocks of health systems according to the WHO's framework; especially service delivery system, health information system, human resources, financing and health scheme for migrants, management and governance. However, to date, evidence and information available to monitor implementations and evaluation of performances as well as outcome, as identified and expected by the plans and strategies, are still limited and insufficient.

- **Coverage of health insurance**

Health insurance or benefit schemes by categories of the migrants



Considering the entitlement to health welfare or insurance scheme, migrants who are still uninsured and lack of health protection include the following groups:

a) Regular migrants workers (and dependents) who have,
   - completed NV or were imported under the MOU but failed to register with the SSS
   - registered with the MOI but not applied for a work permit and not enrolled to the CMHI

b) Irregular migrant workers (and dependants), or those who have not registered with the MOI and the MOL

c) Ethnics minorities, stateless/rootless persons, persons without civil registrative status who are not covered by the health scheme under the Cabinet resolution on March 23, 2010
d) Displaced persons who escaped from or lived outside the shelters

II Recent programs on migrant health

- **Border Health Program (BHP)**

The Border Health Program was initiated in 2001 by the World Health Organization (WHO) Thailand with supports from the DFID. The program in the beginning was a 2–year project which later on extended to the end of 2007. It was aimed to improve health situation with focus as well on humanitarian aspects of the population living along the Thai-Myanmar border with targeted geographical areas in ten provinces. These areas consisted of communities of the Thais, the non-Thais including both regular and irregular migrant workers, their spouses and children, and displaced persons registered in the nine UNHCR-run temporary shelters. Particular target was placed on the health of vulnerable groups such as irregular or non-registered migrant workers and their dependants and migrant living outside the shelters.

- **Programs supported by GFATM**

Since 2004, many interventions and initiatives under programs on fighting AIDS, TB and Malaria in Thailand have been supported by the GFATM. To date, most of the supported programs are the three disease-specific interventions with identified targets on particular groups of the population, especially the high-risk population and the vulnerable

groups including migrants. Reviews of those programs in Global Fund Round 1 to Round 10 is summarized and provided in the report.

- **Migrant Health Program: Healthy Migrants, Healthy Thailand**

The Migrant Health Program was an initiative under the collaboration among the Ministry of Public Health (MOPH), the International Organization for Migration (IOM) and the World Health Organization (WHO) which started in 2003. To develop an innovative and sustainable model of basic health provision for migrants, both the regular and the irregular, and their families, the program was undertaken with close coordination from local health authorities and relevant facilities. Implemented areas were focused on those with migrant-rich communities and villages along the Thai-Myanmar border. Primarily, the program was first launched in 2003 in Tak (3 districts) and Chiangrai (3 districts), then expanded in 2004 and 2005 to cover the following geographical areas; Chiangrai (4 districts), Tak (3 districts), Ranong (Muang district), Samutsakorn (Muang municipality), Phang-nga (4 districts). The program's ultimate goal was contributed to the Healthy Thailand policies of the government. Overall objective was to provide assistance and supports to the government in improving health knowledge, awareness, practices and access to needed health care among migrants and their Thai host communities through the provision of a comprehensive, participatory, sustainable, and cost-effective migrant health. Six strategies were identified and undertaken to achieve the objective: 1) Strengthening the capacity of relevant counterparts at all levels; 2) Increasing access to migrant-friendly health services; 3) Developing a sustainable MHP model that can be replicated elsewhere; 4) Strengthening collaboration among key stakeholders; 5) Facilitating the development and supporting the implementation

of positive migrant health policies; and 6) Strengthening community preparedness and response to potential disaster and/or disease pandemics.

III. Key constraints and gaps for HSS for migrants in Thailand

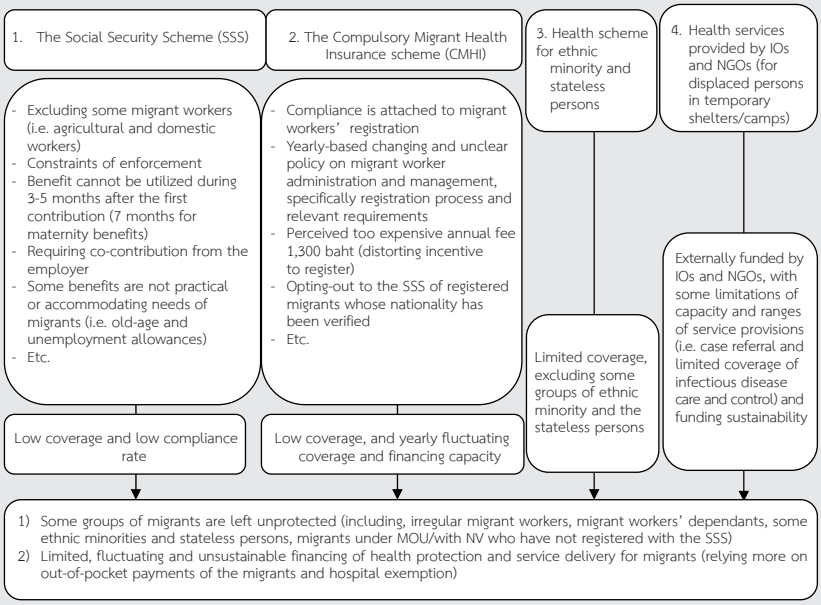
Summarily, in the aspect of "access", obstacles and barriers faced by migrants in accessing safety and quality health services can be identified into the financial and non-financial ones in table below.

List of obstacles/barriers of accessibility to health services of migrants

Financial factors	► Lacks of health insurance and protection, and entitlement to public welfare/ assistance ► Accordingly, inability to pay for services and related expenses (i.e service fee, transportation costs)
Non-financial factors	► Illegal status (both residential and working statuses), resulting in fears of being arrested or abused refraining them from accessing needed health services ► Geographical factors (particularly, remoteness) and inability to access health facilities of some migrant groups (i.e. seafarers and highly mobilizing migrants) ► Inability to communicate (i.e. language barriers) and some health belief affecting health and care seeking behaviors ► Lacks of knowledge, information, awareness on rights and protection entitled to (for those with health insurance/ the SSS) ► Retained work permit and health card by the employer ► Time constraints (i.e. time spent for utilizing care and transportation, not allowing work-hours)

In the aspect of "coverage", particularly coverage of health protection and insurance scheme among migrants, key constraints to be highlighted are on limited coverage and unsustainable financing capacity of the existing health schemes and programs for each migrant group. These constraints and consequences are depicted in a simple diagram below.

Limited coverage and unsustainable financing capacity of the existing health schemes and program for migrants



For HSS for migrants in this report, identifying constraints and gaps is grounded on the World Health Organization (WHO)'s health system framework for each building block - including service delivery, human resource and workforce, health information, medicines and technology, health financing, and leadership and governances.

- **Building block 1: Service delivery**

1) Incomplete coverage of health insurance scheme, and uneven benefit coverage entitled under each exiting scheme
2) Inaccessible services/ inaccessibility of target migrant groups
   - Long distance to facilities, and restricted movement of (some) migrants
   - Inflexible work-hours, time consuming care utilization
   - For those covered by health insurance: Fixed to access only at registered facilities, and exclusion of private hospitals. This is against nature of high mobility among migrant workers
   - Insufficient outreach activities and proactive service provisions
3) Constraints to efficiency, safety and quality of services delivered
   - Negative attitudes of service providers
   - Communication barriers
   - Limited capacity of facilities and constraints of case referral
   - Fragmented and uncoordinated service provisions to unreached migrants
   - Discontinuity of service provision (i.e. for TB patients) caused by high mobility of migrants

- **Building block 2: Human resource**

1) Inadequate human resources (quantity) i.e. Number and mixes of staff/personnel
2) Unresponsiveness (quality and capacity) caused by;
   - Negative attitudes of service providers
   - Problems with awareness, understandings and doubts of service providers on rights that the migrants are entitled to (including human rights, legal rights and rights entitled by health insurance)
   - Communication barriers
3) Needs of supporting health workforce for service provision to migrants; i.e. Migrant Health Workers (MHWs), Migrant Health Volunteers (MHVs), interpreters, etc.

- **Building block 3: Health information**

1) Lacks of sufficient information of migrant population, especially irregular migrant workers and dependants (demographic and health profiles; i.e. health status and determinants, morbidity, care seeking behaviors)
2) Data from routine health information system is scarce, usually attached to information system of the Thais, fragmented and unable to represent the whole picture of migrants (only some reachable groups), inaccurate with data errors caused by rush work and manual errors, inefficient and difficult to identify migrants and their status.
3) Routine information system is quite centralized with insufficient coordination from other relevant stakeholders, especially local authorities

4) Existing data about migrants is incomparable from different sources, consequently, not utilized effectively in generating useful information.
5) Lacks of monitoring and evaluation mechanism on the performance of health system for migrants
6) Insufficient IT and technical supports. At operating level, strengthening health information system of migrants is not given yet priority.

- **Building block 4: Medical procurement**

1) Constraints of health insurance coverage and benefit provided (i.e. AZT for HIV infected migrant mothers is not covered for those without insurance). For those with health insurance, some treatments are not covered within the benefit packages (i.e. ART, hemodialysis)
2) Obstacles/barriers in accessing health services of the migrants and of the "service delivery" building block
3) Some vaccines are not provided; i.e. Japanese B, Hepatitis B vaccines

- **Building block 5: Health financing**

1) Constraints of limited, fluctuating and unsustainable financial resources and pooling of existing health insurance for migrants and external funding:
2) Uneven coverage of health benefits under existing health insurance, and fragmented administrative body of existing funds (i.e. CMHI, SSS, Health benefits for ethnic minority and stateless persons)

3) Huge reliance on out-of-pocket payments and hospital exemptions
4) Yet pooling from additional potential financing sources, especially local administrative authorities, private sectors beneficial from migrant workers
5) Lack of monitoring and evaluating mechanism on financing performance and efficiency (for the whole system and for each health fund)

- **Building block 6: Leadership and governance**

1) Unclear recognitions of the migrants' rights (especially, in aspects of "health", of irregular migrant workers and dependants) among policy makers and relevant stakeholders due to controversy between the principles of national security (reflecting on legal contexts and immigrant laws), economic security of the nation, and human rights of migrants
2) Lacks of "appropriate migrant health policy" due to limitations of health information, and "national guidelines" for service provisions to migrants, resulting in variation of service practices and management
3) Insufficient multilateral/multi-sectoral/multi-level/integrative collaboration among relevant stakeholders (including governmental organizations, NGOs, IOs, private or business sector, local administrative agencies, donors, academic institute, medias, communities and also migrants themselves)
4) Constraints of health insurance governance
   - Ineffective enforcement, especially the low compliance rate of migrants under MOU (imported and NV) to the SSS
   - Enrollment to health insurance (of the CMHI and the SSS) which is attached to registration, work permit, and NV process
   - Inefficiency due to inappropriate financing mechanism

5) Lacks of monitoring and evaluating mechanisms on the achievements and constraints of the "Master Plan for Border Health" and other relevant migrant health policies
6) Inefficient administrative and management system of health system for migrants due to limitations of health information

IV. Recommendations for HSS for migrants

Particular recommendations for strengthening of each building block of the health system for migrants are provided as follows:

Service delivery

- Comprehensive interventions on maternal and child health
- Intensive provisions of health education, promotion and prevention, knowledge and awareness of entitled health rights to encourage accessibility and service utilization of the migrants, through regular outreach activities with collaboration from networks of local health providers
- Promoting the concept of "migrant-friendly health services"
- Appropriate service delivery system for different contexts and settings (i.e. rural and isolated, urban, workplace, and cross-cutting setting) of migrants. This can be done by scaling-up or replicate migrant health services from program implementation approaches and good practices developed by the Migrant Health Program

Human resource/workforce

- Advocacy for capacity-building and empowering MWHs and MHVs through the legalization of their employment status, provisions of standardized training and skill development; with a recognition of necessity for specific language interpreter in health facilities, and outreach activities to migrants

Information

- Development of integrative information system, with target on irregular or undocumented migrants
- Strengthening the routine migrant health information system to produce complete and reliable information relevant to health determinants and health status of migrants, and health system performance for "evidence-based" policy advocacy, planning and guiding direction

Medicines and technology

- Coverage of AZT, ARV for HIV infected migrants
- Universal provisions of medicines and vaccines necessary for caring and preventing specific infectious diseases (i.e. HIV infected migrant mothers, TB, Japanese B and Hepatitis B vaccines) which is unconditioned by the migrants' status
- Collaboration from drug stores and private clinics in migrant-rich communities

Financing

- Additional financing sources to assist health facilities burdened with "hospital exemption" for poor migrants/uninsured migrants (i.e. government subsidy/budget, contributions or funding from local administrative authorities, and private or business sector)
- Expansion of CMHI or development of additional insurance schemes on a compulsory-basis to cover irregular migrant workers and dependants, and expansion of benefits for "occupational health" and "work injury compensation"
- Revised SSS which accommodates better needs and contextual status of migrants, to induce more incentive and higher compliance rate among MOU migrant workers

Leadership and governance

- Development of "National Agenda" and "Official Policy" on migrants and migrant health issues on a "long-term" basis with collaboration from all relevant stake holders
- Development of "National guidelines" for service provisions to migrants
- Management of health insurance and financing on "area-based approach" (rather than "issue-based approach") as migrant groups in each area have different contexts.
- Effective enforcement on health insurance enrolment of the migrants
- Expansion or imitation of existing initiatives and activities that are successfully implemented in pilot areas
- Advocacy for research-based/evidence-based/lesson-learned policy making, cross-cutting disseminations of existing information from routine data and survey results
- Monitoring and evaluating mechanism in assessing each building block of health system for migrants
- Empowerment and capacity-building to local administrative authorities and community leaders on public health for migrants
- Appropriate health system management (of all building blocks) which can accommodate the "high mobility" or migrants

A Situation Analysis on Health System Strengthening for Migrants in Thailand

I
Introduction

II
Backgrounds of the
Migrants and Migrant Health

III
Recent programs
on migrant health

IV
Key constraints and gaps
for HSS for migrants
in Thailand

V
Recommendations
for HSS for migrants

I
Introduction

Part 1:
Introduction

According to the National Population and Housing Census in 2010, the population living in Thailand stands at around 65.4 million in total. Out of this, 3.3 million are non-Thai nationalities. This number, especially, of those migrants coming from neighbor countries including Myanmar, Cambodia and Laos are estimated to be much higher than the number recorded.

Even though Thai health system is known globally as a success with universal health care coverage for all Thais, the health system for the non-Thais living and working in the country is underdeveloped and weak. The Country Coordinating Mechanism (CCM) Thailand has decided to submit a proposal to the Global Fund for HIV, TB and Malaria (GFATM) under the health systems strengthening (HSS) platform for Round 11. A situation/gap analysis is therefore required of the current situation.

This study aims to provide a situation and gap analysis on the health system strengthening (HSS) needs particularly for non-Thais in Thailand. The basis of the analysis is based on the WHO's health system building blocks framework. This study is expected to serve as an input for the development of an application to the GFATM Round 11 on HSS for non-Thais living in Thailand. Specifically, the study's objective is to produce a report on the situation analysis of health system strengthening for non-Thais living in Thailand. The findings are contributed to initial

assessment of the situation and identification of problems and gaps related to the issues to be addressed.

The study is a research-based activity for the express purpose of providing background analysis to be incorporated into the Global Fund Round 11 HSS proposal to be submitted by the CCM Thailand. Document reviews and interviews with local experts and academic who have expertise and experiences in working with the issue on migrant health in Thailand are key methods used. Activities include (i) gathering and reviewing relevant national policy and strategy documents, data, information and studies on migrant health issues in Thailand; (ii) interviewing some experts and academic who have expertise and experiences in working with the issue on migrant health in Thailand for relevant views and opinions; and (iii) conducting the situation and gap analysis on Health System Strengthening for non-Thai populations living in Thailand, based on health system building block framework. Additional source of information which is another key material for this situation analysis comes from output of the meeting on "The Challenges and Potential of Health System Strengthen for Non-Thais, Migrants and Dependents" organized by Raks Thai Foundation with collaboration from The Global Fund (Thailand) and the PHAMIT network during September 26-27, 2011.

Hereafter, defined on a basis of the nationality, the "non-Thais" are referred as the "migrants" which specifically include migrant workers and dependants who moved to Thailand from the three countries (Myanmar, Cambodia and Laos), displaced persons in temporary camp/ shelters located in Thailand, ethnic minorities and stateless persons living in the country but having not acquired Thai nationality. However, as the majority in terms of quantity and the most problematic ones in terms of migrant health, migrant workers and dependants from

Myanmar, Cambodia and Laos are set as key targeted groups in the analysis.

The report consists of 5 main parts including this part which is the introduction. The second part reviews basic backgrounds of the migrant groups respecting numbers, identification, recent policies towards, and issues relevant to the migrant health in the country; i.e. brief health profiles, national master plan and strategies, health protection and insurance to migrants, financing and health information. The third part, then, gives a short summary with some lessons learned from selected previous programs supported by the Global Fund and other agencies in order to improve the situation of migrant health and access to health care of the migrants in the country. From the reviews and situation analysis, key constraints and gaps to be fulfilled surrounding HSS for migrants based on the WHO's health system building block framework are identified in the fourth part. The last part provides recommendations and suggested advocacy for the HSS for migrants.

This part contains sub-topics illustrating basic information and backgrounds about migrants and situations of the migrant health in Thailand. On the first area, focus is placed on the group of migrant workers and their dependants from the three neighboring countries (Myanmar, Cambodia and Laos). Brief chronicle, progress and challenge of the national policies towards administration and management of this group of migrants are provided. On the second area about migrant health, the sub-topics include migrant health profile in brief, relevant national master plans and health strategies towards migrant health, coverage of existing health protection or health schemes for the migrants, and migrant health information system.

II
Backgrounds of the Migrants and Migrant Health

Part 2:

Backgrounds of the Migrants and Migrant Health

2.1 Migrants in Thailand

As mentioned earlier, the term "migrants" is defined on the basis of nationality which is equivalent to the "non-Thai" population, but with a specific scope. In this report, the migrants are classified into 4 categories as follows.

1) Migrant workers and dependants from the three neighboring countries (Myanmar, Cambodia and Laos): This group of low-skilled workers (and dependants) includes both regular and irregular migrant workers. The regular workers refer to the workers with work permits while the irregular workers refer to those without work permits. Approximately, the number of migrant workers and dependants is estimated to be at around 2.5 millions[1] . In August 2011, the number of regular migrants workers from the three countries who possess a work permit from the Ministry of Labor

[1] According to Suchada and Bongkot (2011; p. 134), this number was reported to be 2,455,744 in February 2010. Out of this, 1,444,803 are irregular migrant workers.

(MOL) stands in total at 1,565,600; of which 63,447 and 456,941 legally entered into the country under the nationality verification (NV) process and a memorandum of understanding (MOU) process, respectively. Another 1,036,212 entered into the country illegally but got registered under the cabinet resolution to get a work permit and work legally (Source: Office of Foreign Worker Administration – Work Permit). Hence, the rest which is around 1-1.5 million is estimated as a number of irregular workers (and dependants) those are working in Thailand without a legal status. Migrant workers who had ever registered with the Ministry of Interior (MOI) since 2004 to get a legal residential status on 1-year basis would get a 13-digit identification number starting with "00".

2) Ethnic minorities: This group refers to documented non-Thais who prior to 2004 issued identity card with a 13-digit identification number starting with "6" or "7". This group since then has been issued a card with an entitlement as "Persons without Thai Nationality" which are classified into 2 sub-categories. The first one (ID number starting with "6") includes those minorities who were not born in Thailand which account for 233,811. The other category (ID number starting with "7") includes children (who were born in Thailand) of the migrants who were not born in Thailand which account for 69,799 (Suchada and Bongkot, 2011, p. 132). Then, the number of this group of migrants is estimated to be at 303,610 with a possible range to 323,084, according to another data source from the residential registration database of the Department of Provincial Administration (DOPA) (Bussayarat, 2011).

3) Stateless/rootless persons or persons without civil registrative status: This group refers to persons who have been living in the country for a long time or since they were born but not recorded in the national registration system until the implementation of the registration survey by the DOPA, the MOI in July 2005. As of this survey, these migrants was registered and provided a 13-digit identification number staring with "0" and currently entitled as "a person without civil registration status". This group also includes de facto stateless/rootless persons or persons possessing a nationality but their right to the nationality is not recognized by the state where they reside in. The stateless/rootless may be provided Thai nationality if they can prove that they have been living in the country for more than ten years continuously. The current number of migrants in this category is at around 210,000-220,000.

4) Displaced persons: This category refers to "displaced persons" residing in "9 temporary shelters" located in the 4 provinces along the Thailand-Myanmar border, plus an ethnic Shan residing in Chiangmai province. These persons, sometimes recognized as refugees, escaped from political violence or suppression against ethnic minorities in Myanmar and registered by the MOI with assigned 13- digit identification number starting with "000". The provinces where the shelters located in are Mae Hong Son (4 shelters), Tak (3 shelters), Kanchanaburi (1 shelter) and Ratchaburi (1 shelter). According to the database of United Nations High Commissioner for Refugees (UNHCR), the number of the registered population of displaced person in all shelters was at 131,549 in

2006 which has declined to 95,330 in 2010 due to resettlement to the third countries. Estimated by the Thailand Burma Border Consortium (TBBC), which is a group of NGOs working on the provision on supplies and services in the shelters, there are still 45,746 unregistered persons at the end of 2010 making the population of displaced persons in total stand at 141,076 (cited in Supang, 2011; p.178). The most updated number of displaced person in the 9 shelters and ethnic Shan in Chiangmai from the TBBC is presented in Table 2.1.

Table 2.1 Displaced persons from Myanmar in Thailand (April, 2011)

Location (provinces and districts) in Thailand	Displaced Persons from Myanmar
Chiangmai: Wieng Heng (Ethnic Shan)	**625**
Mae Hong Son	**51,478**
Ban Mai Nai Soi	14,193
Ban Mae Surin	3,648
Mae La Oon	15,740
Mae Ra Ma Luang	17,897
Tak	**79,492**
Mae La	45,706
Umpiem Mai	17,885
Nu Po	15,901
Kanchanaburi: Ban Don Yang	**4,127**
Ratchaburi: Tham Hin	**7,593**
Total	**143,315**

Source: TBBC (as of April 2011), in MMC Newsletter 2nd edition (2011)

In fact, the non-Thais currently residing or working in Thailand cover more than these 4 groups. It includes foreigner workers who are professional, skilled and semi-skilled labors working in Thailand and their dependants; other temporary stay, students, foreigners overstaying visas, and also migrant workers from other neighboring countries who migrated to live and work in Thailand (i.e. from Vietnam, Bangladesh or China)[2]. However, in order to scope down this study and the analysis, only the 4 groups of the non-Thais (or migrants) as listed above are targeted with the most emphasis on the first group; or migrant workers and their dependants from Myanmar, Cambodia and Laos.

Table 2.2 summarized the residential identification number assigned by the MOI, and approximate numbers of the migrant in each category from the most recent reference.

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2 Rough details and figures of these groups of the non-Thai population are available in Huguet and Chamratrithirong (2011)

Table 2.2 Number of migrants in Thailand

Migrant categories	13 digit ID No. (civil/residential registration)	Source (1)	Source (2)
Migrant workers and dependants from Myanmar, Cambodia and Laos	Start with "00"	Totally 2,581,360 from 6 registrations: - In 2004: 1,161,013 - In 2006: 256,899 - In 2007: 12,479 - In 2008: 96,708 - In 2009: 1,054,261 - In 2009 (migrants' dependants): 5,317	Totally 2,455,744 (in February 2010)
Ethnic minorities	Start with "6" and "7"	323,084	303,610 (of which 233,811 and 69,799 are the minorities not born in Thailand and the children of the minorities not born in Thailand, respectively)
Stateless/ rootless persons or persons without civil registrative status	Start with "0"	218,538 including residents awaiting nationality, children and students without registrative status who came to live in Thailand before 18 January 2005, and rootless person without registrative status	210,182 (including undocumented long-term migrants from neighboring countries, undocumented hilltribe members and Thai descendents who are not recorded in the birth registration system and de facto stateless persons)

Table 2.2 : Number of migrants in Thailand (Con't)

Migrant categories	13 digit ID No. (civil/residential registration)	Source (1)	Source (2)
Displaced person	Start with "000"	138,076 in 9 temporary shelters along Thailand-Myanmar borders in 4 provinces; Mae Hong Son (4), Tak (3), Kanchanaburi (1), Ratchaburi (1)	143,315 (April, 2011) (at the end of 2010 the number was 141,076; consisting of 95,330 persons registered by the MOI and estimated 45,746 persons unregistered)

Source (1): The number of migrants is on the basis of civil/residential registration in April 2011 from Bureau of Registration Administration, Department of Provincial Administration (DOPA), cited in Bussayarat Kanchanadit, (2011)

Source (2): The estimated number of migrants in Thailand cited and summarized by Supang, (2011) and Suchada and Bongkot (2011) in International Migration in Thailand (IOM, Huguet and Chamratrithirong, 2011); Mahidol Migration Center (MMC) Newsletter 2nd Edition

2.2 Migrant workers and dependants from Myanmar, Cambodia and Laos

According to the National Population and Housing Census in 2010, out of the 65.4 million of total population residing in Thailand, 3.3 million is the non-Thai nationality. As mentioned, of this number of non-Thai population, low-skilled migrant workers (from Myanmar, Cambodia and Laos) both regular and irregular ones and their dependants are estimated account for around 2.5 million, making them the major group that this study will focus on.

A large number of these migrant workers, of which the majority around 80 percent is from Myanmar, have been residing, mobilizing and working in Thailand for a long time. Many of them, entered into the country illegally and, consequently, not officially recognized both in terms of residential and working status. Policies for administration and management of these groups of migrants and their dependants were without concrete direction and standard practice until 2001 when the Committee on Illegal Migrant Workers Administration was established, and once again in 2004 when working guidelines for solving illegal migrant workers problem were introduced holistically in 2 stages.

Stage one: Semi-regularization of irregular migrant workers. With attempts to balance tensions of national security concerns, economic necessity and demand of local employers for additional low-skilled labor; the procedure was to allow irregular or illegal migrant workers to work legally one to two years in the country under an amnesty program before repatriation. Stage two: Migrant worker regularization framework.

The framework was introduced to "legalize" the status of illegal migrant workers and allow them to work for a certain period of time under two methods. The first method is "nationality verification" or NV of the registered (but illegally entered) migrant workers who are already in Thailand by enabling them to obtain legalized status through the process by means of temporary passport or certificates of identity. The second method is importation of workers directly from neighboring countries. These two methods were conducted under a memorandum of understanding (MOU) between the Thai government and the government of each neighboring country (Myanmar, Cambodia and Laos).

The policy chronicle towards the administration and management of migrant workers from the three countries in Thailand since the early of 1990s is summarized in Table 2.3.

Table 2.3: Summary of policy for administration and management of migrant workers from Myanmar, Cambodia and Laos

Year	Related policy
1992-2000	- Beginning of migrant management system under the Cabinet Resolution - Open registration and allow for employment worker in specified area and designated sectors - Policy was firm to control and not to promote an increase in the number of migrant workers through the continuous use of suppressive, arrest and deportation. The employers, migrant workers and those involved with the process in bringing in

Table 2.3: Summary of policy for administration and management of migrant workers from Myanmar, Cambodia and Laos (Con't)

Year	Related policy
	or hiring illegal migrant workers would be charged with crimes. - Under the Cabinet Resolution in 2000, migrant workers could work in 18 types of employment in 37 provinces (10 border provinces, 18 fishing/ fishing related provinces and 9 industrial provinces).
2001	- Formulation of Committee on Illegal Migrant Workers Administration (or "Alien Labor Management Committee"), attached as an internal unit to the Department of Employment, Ministry of labor - The Cabinet Resolution required "illegal" migrant workers in every area and all typed of employment to report to the government and register.
2002	- Renewal of migrant worker registration for one more year - Signed MOU with Lao PDR (October 2002)

Table 2.3: Summary of policy for administration and management of migrant workers from Myanmar, Cambodia and Laos (Con't)

Year	Related policy
2003	- Renewal of migrant worker registration for more year with reduction in types of employment allowed - Signed MOU with Cambodia (May 2003) and Myanmar (June 2003)
2004	- The Cabinet accepted the working guidelines for solving problem holistically in 2 stages: Stage one was to allow illegal migrant workers to work temporarily in the country before repatriation; and Stage two was to "legalize" the status of illegal migrant workers and allow them to work for a certain period of time. - Registration of migrant workers and issuance of 13 digit ID (Tor.Ror 38/1) for 1,184,920 migrants - Issuance of work permits for 838,943 migrants

Table 2.3: Summary of policy for administration and management of migrant workers from Myanmar, Cambodia and Laos (Con't)

Year	Related policy
2005	- Renewal of the registration for one more year (for those who have been registered/with Tor.Ror 38/1) - Open registration for illegal migrant workers who newly entered the country to work under the Immigration Act Section 54, allowing stay for one year - Employers had to place a deposit fee for each worker (10,000 baht for those with Tor.Ror 38/1 and 50,000 Baht for those without Tor.Ror 38/1)
2006	- Renewal of the registration for one more year, and abolishment of deposit fee
2007	- Renewal of the registration for one more year - The Cabinet accepted the policy on "nationality verification" of migrant workers, importing Burmese migrant workers to work legally, and open registration for migrant workers in the five southern border provinces - Stopped allowing workers' dependants to stay in Thailand, except for children of migrant workers registered in 2004 and renewing their work permits until 2007 - The authorized types of employment for migrant were confined only two including manual workers and domestic workers.

Table 2.3: Summary of policy for administration and management of migrant workers from Myanmar, Cambodia and Laos (Con't)

Year	Related policy
2008	- Renewal for two more year but not longer than 28 February 2010 (need to pass "national verification" process by then). Work permits have to be renewed each year - Registration opened for migrants who already had Tor.Ror 38/1 (registered in 2004) but did not renew their registration to re-register and request work permits
2010	- Extension of requirement to pass "national verification" for another 20-year till 28 February 2012
2011	- Registration opened for illegal migrant workers and dependants (aged not more than 15 years) from 15 June to 14 July 2011

Source: Modified and updated from Promboon Panitchpakdi., et.al. (2011); Bhassorn Limanonda and Narisara Peungposop (2011); and the MMC Newsletter (special edition, 2011)

As summarized in the table above, regularization of existing irregular migrant workers in the countries has been clearly prioritized to be done through the NV process since 2008. Totaled 1.3 million registered migrants were announced in the plan to be verified the nationality by February 2010. Owing to complications and requirement that migrant workers have to return home to complete the NV process, the process was taken place with delays and later than plan, especially among the workers from Myanmar which make up around 80 percent of all migrant workers in the country. NV of Myanmar migrants started at the end of 2009, which was 3 years after the start of the process for Cambodian and Laotian migrants. By late of 2009, there were only around 10,000 Myanmar migrants who had completed the NV (MMC, 2011).

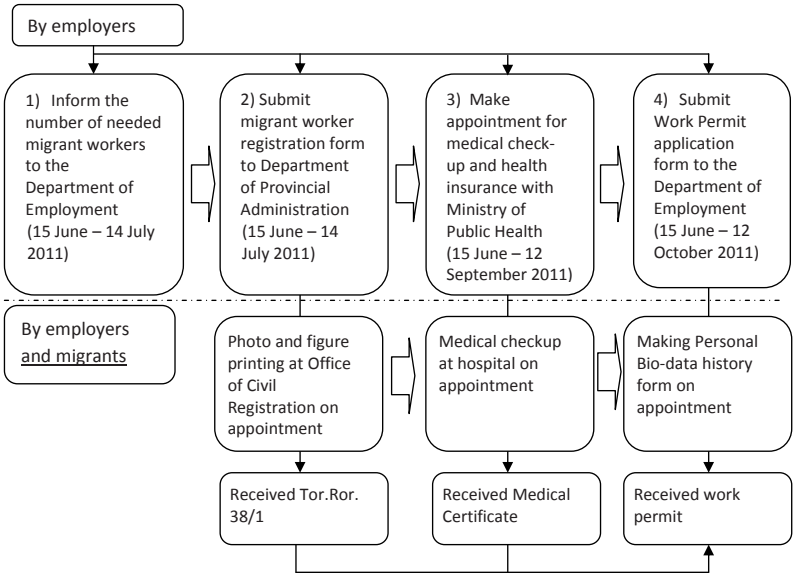
The delays in regularization process from highly complex nature of the NV process and importation of workers have resulted in another 2-year extension of the NV completion deadline to February 2012 by the Cabinet Resolution in January 2010. It was required that all migrants who had registered must enter the process by submitting biographical information to home country by the old deadline (February 2010). Over 930,000 migrants met this deadline but, due to misunderstanding with false information to receive permission to stay in the country until February 2012, over 300,000 failed to do so and, as a consequence, turned to be irregular migrant workers (MMC, 2011).

Due to an increasing number of irregular workers with frequent calls from employers and manufacturers for a new registration to relieve ongoing shortage of low-skilled labors in the country, approved under the Cabinet Resolution in April 2011, a new registration for irregular workers from the three countries to stay and work legally for another

1 year in Thailand was carried out between June 15th to July 14th, 2011. The process of irregular migrant workers' registration in 2011 is illustrated in Figure 2.1. This was against the earlier resistance in June 2010 of the Thai government that no new migrant registration would be allowed. The registration in 2011 was also extended to accompanying children not over 15 years old.

So far, some problems with the registration and work permit process have been complained by the employers and migrant workers are as follows (Brahm Press. 2011; p. 28-30). Firstly, the registration periods were usually opened once a year for only four to six weeks which are not long enough. Secondly, the process was time consuming and requiring going to at least two different locations; i.e. the provincial employment office, the hospital for medical checkups. Thirdly, it was usually announced only a month in advance providing too short preparation time for the employers and migrants. Fourthly, there was little communication, lacks of announcement and explanations to the migrants in their language making them have to be reliant mostly on the employers and sometime exploitative agents. The registration was too strictly linked to the employers as the migrants were not allowed to register on their own. The migrants were required to either remain with their original employer or transfer the work permit to a new employer to maintain the registration status. Payment or fee charged to complete the process was also blamed to prohibitively expensive for migrants and their employers. This includes a fee of 1,900 Baht paid at a local hospital (600 Baht for a medical checkup and 1,300 Baht for Compulsory Migrant Health Insurance: CMHI), and a fee for a work permit paid to the Ministry of Labor (900-1,800 Baht).

Figure 2.1: Registration process of irregular migrant workers by the employers and migrant workers, 2011



According to the regularization framework of the Thai government, some challenges and constraints of the NV process which is used as a key method in regularizing irregular migrant workers existing in the country are also identified as follows: (a) an inability to develop efficient system with other countries concerned; (b) the highly complex nature of the process and absence of one-stop services; (c) insufficient information among employers and migrants about what the process entails; (d) high costs and possibly overcharged by unregulated and exploitative brokers; (e) delays caused by requirement to return home for NV by the migrants from Myanmar, which are the major group of migrant workers; (f) inability of migrants to easily change employer

even having completed NV; (g) also failure of employers to register NV migrants for the Social Security Scheme (SSS), leaving this group of regularized migrants without health insurance (this will also be entailed further in the later section); and (h) exclusion of migrant children as part of the process (MMC, 2011).

Defined by legal working status, migrant workers from the three countries are broadly classified into 3 groups. The first group is the regularized workers with a work permit who entered the country illegally but are allowed to work legally under the cabinet resolution. The second group is the regular workers with a work permit legally entered the country under the MOU either through NV process or direct importation from the home country. The third group is irregular migrant workers who illegally entered the country, have not registered with MOI and a valid work permit from the MOL. Differences of rights and limitations faced by migrant workers in each group in the aspects of labor protection, health protection and social security, and other issues are briefly summarized and compared in Table 2.4.

In August 2011, according to Table 2.4, regular migrant workers of the 3 nationalities with work permit account for 1,565,600 workers. This number consists of 1,036,212 workers of the first group as mentioned above; 529,388 workers of the second group or those who completed the NV (465,941 workers) and imported from the home country under the MOU (63,447 workers). The number of the last group or irregular migrant workers is then estimated at around 1 million.

Table 2.4: Rights and limitation for migrant workers by category of registration

Issues/ category of registration	Illegally entered the country, but have registered with the MOI and the MOL	Legally entered the country through MOU process (imported and nationality verification)	Illegally entered the country and have not registered with the MOI and the MOL (irregular migrant workers)
Labor protection, and work-related issues	- Basic rights protection including entitlement to minimum wages and benefits equal to the Thais, and formal protection under Thai Laws - Work permit renewable annually, in some cases up to two years and must remain registered as a condition to renew (except during supplementary registrations) - Only able to work in occupation designated at time of registration and as indicated on work permit	- Basic rights protection including entitlement to minimum wages and benefits equal to the Thais, and formal protection under Thai Laws - Formal work contracts - Unable to change employer or type of work - Two-year contract, renewable once; after 4 years in total, must return home and not to work in Thailand for 3 years before reapplying	- Basic rights protection including entitlement to minimum wages and benefits equal to the Thais, and formal protection under Thai Laws

Table 2.4: Rights and limitation for migrant workers by category of registration (Con't)

Issues/ category of registration	Illegally entered the country, but have registered with the MOI and the MOL	Legally entered the country through MOU process (imported and nationality verification)	Illegally entered the country and have not registered with the MOI and the MOL (irregular migrant workers)
	- Able to change employers under certain circumstances or with permission of current employer within a seven day period - Not allowed to form unions but able to join Thai unions		

Table 2.4: Rights and limitation for migrant workers by category of registration (Con't)

Issues/ category of registration	Illegally entered the country, but have registered with the MOI and the MOL	Legally entered the country through MOU process (imported and nationality verification)	Illegally entered the country and have not registered with the MOI and the MOL (irregular migrant workers)
Health protection and other social security	- Compulsory Migrant Health Insurance Coverage same as Universal Coverage for Thais with exceptions - Not able to contribute to or benefit from the national social security system (Social Security Scheme: SSS)	- Eligible for contribution to and benefits from the SSS, which include health insurance (after 3-5 months from hire) and limited worker compensation - Contribution made to repatriation fund (under the SSS) by employer through deduction from wages; repatriation costs covered if returned to home address at end of contract, or the migrant can return home at his/her own expenses and request reimbursement upon leaving at official border crossing point; supposedly processed within 30 days (Note: no verification of this policy being implemented)	- No health insurance provided - No access to the SSS

Table 2.4: Rights and limitation for migrant workers by category of registration (Con't)

Issues/ category of registration	Illegally entered the country, but have registered with the MOI and the MOL	Legally entered the country through MOU process (imported and nationality verification)	Illegally entered the country and have not registered with the MOI and the MOL (irregular migrant workers)
Mobility and other issues	- Limitations on mobility to sub-district of work location; must obtain permission by governor to leave area or else forfeit work permit status	- Able to travel outside of locality and across provinces - Allowed to visit home country without loss of visa status	- Risky to be arrested, detained and deported - Formally able to access legal mechanisms but deportation can interferes

Source: Brahm Press, (2011), The PHAMIT Story, p. 38

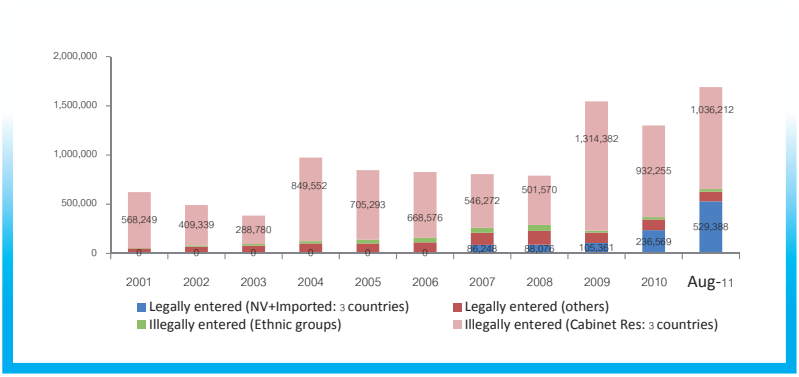
Table 2.5 : Numbers of foreign workers (on the basis of "work permit" or "worker registration"), August 2011

Region	Grand total	Legal entry						Illegal entry		
		Total	Section 9				Section 12	Total	Section 13	
			Life long	Temporary (general)	MOU		Investment promotion (BOI)		Minorities	3 nationalities under cabinet resolution (Myanmar, Cambodia and Laos)
					Nationality Verification	Imported				
Whole kingdom	1,690,036	626,927	983	72,054	465,941	63,447	24,502	1,063,109	26,897	1,036,212
Bangkok	439,616	243,005	10	40,892	174,628	13,307	14,168	196,611	3,041	193,570
Vicinity	351,685	120,983	N.A.	6,208	102,173	10,810	1,792	230,702	1,626	229,076
Central	334,226	122,607	182	9,047	83,849	22,307	7,222	211,619	2,923	208,696
North	183,621	27,476	25	4,480	22,204	78		156,145	18,855	137,290
Northeast	38,277	15,482	171	2,087	9,144	3,734	346	22,795	195	22,600
South	342,611	97,374	595	9,340	73,943	13,211	285	245,237	257	244,980

* Alien Worker Act
Source: Office of Foreign Worker Administration (Work Permit)

Up to the present, policies towards the administration and management of migrant workers and their dependants from Myanmar, Cambodia and Laos in Thailand are often criticized to remain on a short-term basis, unpredictably changing almost year-by-year, and still lack of appropriate strategies and efficient implementation. This is reflected by the numbers of registered migrant workers with work permits from the 3 countries in Figure 2.2 which appears fluctuating from year to year, especially during the past 5 years, while the number of those who have completed the NV is increasing gradually.

Figure 2.2 : Foreign workers with work permit in Thailand 2001-2011



Source: Office of Foreign Worker Administration (Work Permit)

This, as will be elaborated afterward in the report, is identified as one of the significant challenges and key constraints to be overcome in order to improve health and protections for migrants, their access to needed care and services, and also the effort of the HSS for migrants in Thailand.

2.3 Migrant health in brief

In this section, health profiles of migrants in brief in terms of sickness, morbidity rate and health care seeking behavior are explored from available sources or existing surveys.

So far, Department of Disease Control, Ministry of Public Health by Bureau of Epidemiology (BOE) has conducted at least two routine disease surveillance systems in foreigners living in Thailand including migrant groups. One is the "Diseases Surveillance in Foreigners" which has been conducted since 1996 with targets on all groups of foreigners including migrants. A report on disease surveillance in foreign patients is submitted periodically from health facilities nationwide to the BOE using the same report form (Report Form 506) as used in disease surveillance in Thai patients. The other one is the "Temporary Shelters Disease Surveillance" which started in 2002. The system functions as the surveillance and an outbreak alert system of infectious diseases in the 9 temporary shelters of displaced persons along the Thai-Myanmar border. It is operated under a collaboration of BOE, NGOs working in the shelters and the World Health Organization (WHO).

Apart from the disease surveillance systems, information on health profiles and care seeking behavior of migrants in Thailand is quite limited and fragmented, in terms of representativeness and continuity. So far, with supports from Raks Thai Foundation and the Global Fund to Fight AIDS, TB and Malaria (GFATM), Institute for Population and Social Research (IPSR), Mahidol University, has conducted at least four quantitative surveys and data collections among the migrants in a wide scale on these issues. Three of the four are as part of the

evaluation of the Prevention of HIV/AIDS among Migrants Workers in Thailand (PHAMIT) consisting of the Baseline Survey and Impact Survey of PHAMIT-1 in 2004 and 2008, respectively, and the Baseline Survey of PHAMIT-2 in 2010. The surveys covered and represented total target migrant population of the project in 22 provinces of PHAMIT-1 and 10 pilot provinces (from 37 provinces) of PHAMIT-2. The sample size of migrants interviewed was at 3,374 migrants in 2004, 3,387 migrants in 2008, and 3,405 migrants in 2010. In these surveys, even if the focus was placed on the prevention of HIV/AIDS and sexual behaviors; information with respect to health seeking behavior and access to health services, family planning and reproductive health of migrants were also collected.

Another survey was "A National Survey on Knowledge, Attitude and Practice (KAP) on Tuberculosis (TB) among Thai Population and Non-Thai Population" conducted in 2011. The total 560 samples of non-Thai population including migrant workers and ethnic minorities were sampled from the 11 targeted provinces under the project on "Strengthening quality TB control among vulnerable populations and empowering communities in Thailand" supported by GFATM Round 8. Some evidence on migrant health from the surveillance system in foreigners of the BOE and previous surveys on migrants as mentioned above are selected to present in this section.

a) Foreign patients in Thailand

The diseases surveillance in foreigners of the BOE has classified foreign patients in Thailand into 3 groups: 1) migrant workers; 2) foreign tourists; and 3) foreigners in temporary shelters and those from other neighboring countries who came to get medical treatments in Thailand. The numbers

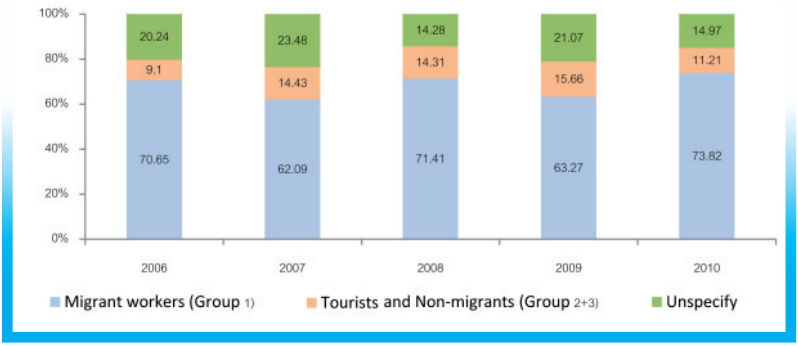
of foreign patients at Thai health facilities are reported to increase from 19,599 in 2001 to 44,552 in 2010 (Table 2.6), of which more than 70 percent are migrant workers from Myanmar, Cambodia and Laos (Figure 2.3). The number of foreign patients who were migrant workers reported in this surveillance is, nevertheless, estimated to be much lower than the actual number owing to a huge number of irregular migrant workers without work permits and health insurance who could not access care at health facilities when needed.

Table 2.6: Number of foreign patient cases in Thailand by nationality (2001-2010)

Year	Total	Nationality				
		Myanmar	Laos	Cambodia	Malaysia	Others
2001	19,599	14,344	1,529	788	35	2,903
2002	24,250	18,768	1,568	640	66	3,208
2003	21,205	15,271	1,050	601	21	4,262
2004	22,321	14,003	1,847	1,070	15	5,386
2005	27,031	17,910	1,649	1,457	44	5,971
2006	31,205	22,550	1,529	1,676	52	5,398
2007	30,041	21,892	1,060	1,584	61	5,444
2008	33,397	23,180	1,305	1,512	54	7,346
2009	43,517	25,612	2,259	2,494	63	13,089
2010	44,552	26,801	1,415	3,313	78	12,945

Source: Report of Diseases Surveillance in Foreigners; December, 2010 (BOE, 2011)

Figure 2.3: Percentage of foreign patient cases by groups (2001-2010)



Source: Annual Epidemiological Surveillance Report 2010 (BOE, 2011)

The 10 provinces with the first highest reported numbers of foreign patients in 2010 were 1) Tak (11,116 patients), 2) Chiangmai (5,400 patients), 3) Chiangrai (1,941 patients), 4) Kanchanaburi (1,717 patients), 5) Phuket (1,688 patients), 6) Phang-nga (1,652 patients), 7) Rayong (1,466 patients), 8) Trad (1,449 patients), 9) Mae Hong Son (1,415 patients), and 10) Suratthani (1,311 patients).

Compared to Thai patients, prevalently found sickness or causes of illness among foreign patients are presented in Table 2.7 The first 3 most prevalent sicknesses among foreign patients are Acute Diarrhea (36.33 percent), Pyrexia (16.69 percent), and Malaria (16.64 percent), respectively. As can be seen, patterns of sickness and prevalent diseases among foreign patients are not so different from Thai patients. Somehow, emerging disease such as “Malaria” and “Tuberculosis” are still found with more prevalence rate among foreign patients compared to Thai patients. By comparing the prevalence between Thai and foreign patients, it was found that the prevalence of malaria among the foreign

patients was approximately 26 times of the Thais living in the same locale; STI infection was over 8 times; leprosy was about 4 times; and TB was about 2 times (Krittaya, 2007 cited in Bhassorn and Narisara, 2011).

Table 2.7: Prevalently found sickness among the foreigners compared with the Thais, 2010

Foreigners			Thais		
Disease	**Sick**	**Dead**	**Disease**	**Sick**	**Dead**
Acute diarrhea	16,303	4	Acute diarrhea	1,285,280	74
Pyrexia	7,556	0	Pyrexia	366,514	20
Malaria	7,137	9	Malaria	17,404	24
D.H.F (total)	2,300	8	D.H.F (total)	111,800	131
Pneumonia	1,994	9	Pneumonia	159,350	1,052
H. conjunctivitis	1,466	0	H. conjunctivitis	109,271	0
Tuberculosis (total)	1,164	1	Tuberculosis (total)	37,181	114
S.T.L.(total)	1,163	0	S.T.L.(total)	23,665	0
Food poisoning	1,083	1	Food poisoning	100,281	11
Influenza	1,060	1	Influenza	111,690	125
Chickenpox	542	0	Chickenpox	46,306	5
Dysentery (total)	389	0	Dysentery (total)	13,993	0
Cholera	328	4	Hand, foot and mouth	12,160	3
Scrub typhus	296	0	Scrub typhus	6,160	8
Herpes zoster	252	0	Herpes zoster	24,182	0
Mumps	213	0	Mumps	15,020	0
Snake bite	160	0	Snake bite	7,684	1
Hepatitis (total)	158	0	Hepatitis (total)	9,616	10
Enteric fever	137	0	Enteric fever	5,796	1
Measles (total)	88	0	Leptospirosis	4,562	41

Source: Report of Diseases Surveillance in Foreigners; December, 2010 (BOE, 2011)

b) Morbidity rate and health care seeking behavior

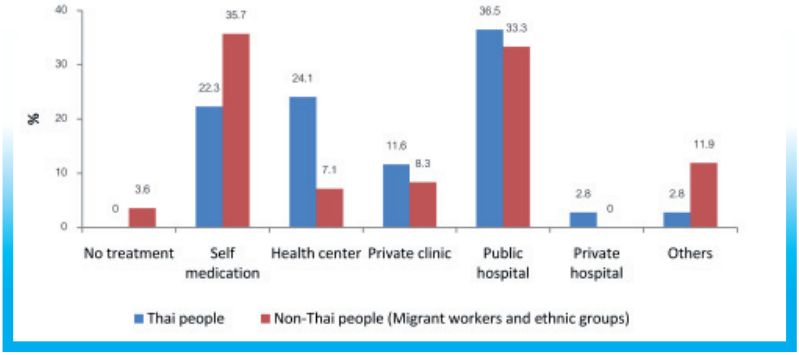
From previous surveys and data collections on migrants as mentioned earlier, selected figures reflecting recent evidence on morbidity, health care seeking behavior, and entitlement to, as well as utilization of benefits from, health welfare or insurance scheme of the migrant are presented.

Table 2.8: Average times of outpatient and inpatient sickness of persons aged 15 up by nationalities, 2011

Sickness	Thai people	Non-Thai people (migrant workers and ethnic groups)
Outpatient sickness (times/person/year)	4.929	4.174
Inpatient sickness (times/person/year)	0.079	0.050
Sickness needed rest at home (times/person/year)	0.186	0.286

Source: Computed from "A National Survey on Knowledge, Attitude and Practice (KAP) on Tuberculosis (TB) among Thai Population and Non-Thai Population", (Wathinee, et al. 2011)

Figure 2.4: Health seeking behavior for the last OP sickness of persons aged 15 up by nationalities, 2011



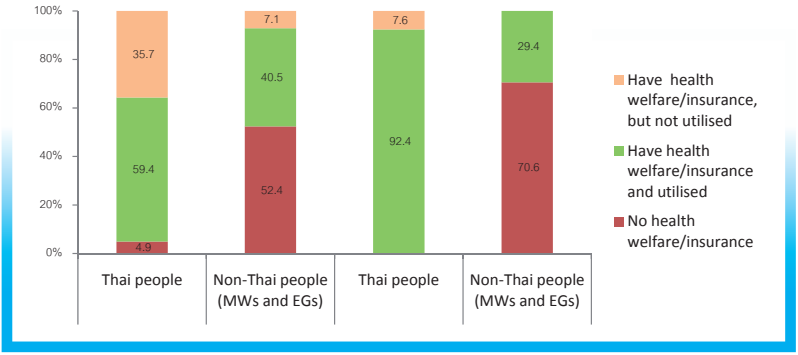
Source: Computed from "A National Survey on Knowledge, Attitude and Practice (KAP) on Tuberculosis (TB) among Thai Population and Non-Thai Population", (Wathinee, et al. 2011)

From the survey in 2011 (Table 2.8), compared to the Thais, average times of both outpatient sickness and inpatient sickness (that needed to be admitted into a hospital) in a year was found lower among migrant groups. Anyway, when asked about times of sickness needing rest at home in average, it was found higher among migrants than the Thais. To some extents, this implies less access to care or treatment that needs hospitalization in a facility of migrants than the Thais, resulting in more times of sickness needing rest at home but fewer times of inpatient sickness of the migrants.

Considering care seeking behavior of migrants when falling sick the last OP sickness (Figure 2.4), 3.6 percent reported do nothing and around 36 percent reported self-medication by buying medicine from a drug store. Around one-third and 7.1 percent utilized care at a public hospital and health center, respectively. As compared to migrant

patients, less proportions of Thai patients reported self-medication but larger proportion reported utilize care at a public hospital, health center and also private clinic.

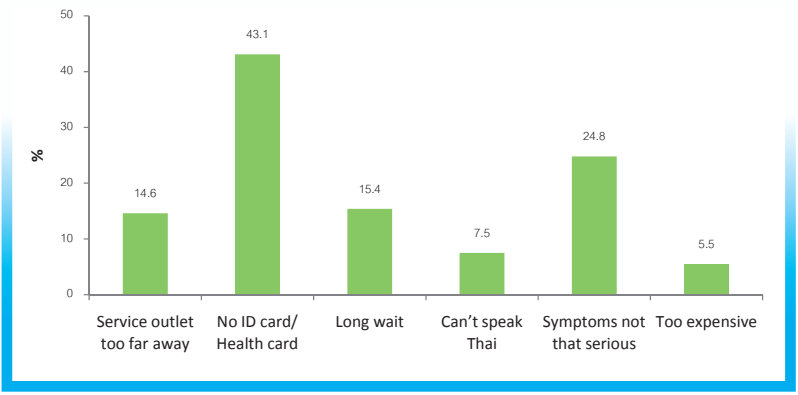
Figure 2.5: Utilization of benefits from health welfare program or insurance scheme for the last OP and IP sickness of persons aged 15 up by nationalities, 2011



Source: Computed from "A National Survey on Knowledge, Attitude and Practice (KAP) on Tuberculosis (TB) among Thai Population and Non-Thai Population", (Wathinee, et al. 2011)

Explanations for less admission rate of inpatient and also less utilization of institutional care for outpatient sickness among migrants as compared to the Thai lie within the evidence shown in Figure 2.5. From the same survey, more than 50 percent and 70 percent of migrant outpatients and inpatients, respectively, reported have no entitlement to any health welfare or insurance scheme. This is quite contrasting to Thai patients that nearly all reported to have entitlement to at least one health welfare or insurance scheme, even some decided not to utilize benefit from the welfare or the scheme they are entitled to.

Figure 2.6 Reasons for not going to receive care at a public health facility when falling sick of migrant workers



Source: Computed from "Prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT): The Baseline Survey 2010", (Apichart et.al., 2011)

From the PHAMIT-2 Baseline Survey 2010, migrant workers were asked about the reasons or constraints that would prevent them from going to receive care or health service at a public health facility when falling sick. It was found that (Figure 2.6), having no legal identification card or the health card was a key constraint, followed by reasons of time-consuming, far distance to a facility, language and fees charged.

These selected figures are reflecting some evidence on difficulties and constraints faced by migrants in accessing needed health care and services which was caused by either financial factors or non-financial factors.

c) Reproductive health and family planning

This is one of concerned issues on the migrant health in Thailand. Major problems are identified to be a high number of children born to migrant workers and ethnic groups. The estimated number of children born to Myanmar migrant workers each year was at 2,000 in average (Bhassorn and Narisara. 2011; p.40). The actual number of birth, nevertheless, was suspected much under-reported. Estimated by Prasartkul et al., the number of births to migrant workers was somewhere in the range between 42,000 and 98,000 births in 2010. The TFR among migrant workers was more than two times higher than the Thais at 3.6. So was those of the ethnic groups which in average at 2.3 in 2010 (NESDB and UNFPA. 2011; p.20-21). Health problems related to a high number of newborn to migrants are infectious diseases in children including TB, diphtheria, tetanus, whooping cough, encephalitis, mumps and measles (Bhassorn and Narisara. 2011; p.40). These diseases are, in fact, able to be prevented by vaccination. Anyway, challenges are still about how to expand coverage of vaccinations among migrant children in the context of high mobility and limited access to health services of their parents.

More information on sexual behaviors, reproductive health and family planning among migrant groups is available in the report of Baseline Survey and Impact Survey of PHAMIT-1 in 2004 and 2008, respectively, and the Baseline Survey of PHAMIT-2 in 2010 by the Institute for Population and Social Research, Mahidol University. (Apichart and Wathinee. 2009; Apichart et al., 2011).

2.4 Master plans and health strategies on migrant health in Thailand

The Ministry of Public Health (MOPH) by Bureau of Policy and Strategy of the Permanent Secretary Office has developed and officially launched the first Border Health Development Master Plan 2007-2011 in 2007. The plan was aimed to improve the quality of life and health of border populations, including migrants. The second Master Plan for the period of 2008-2012 has already been drafted and on the process of its finalization. Key contents of the plans and defined actors are summarized in Table 2.9.

Table 2.9: Border Health Development Master Plan: Year 2007-2011 VS Year 2012-2016

Border Health Development Master Plan	Year 2007-2011	Year 2012-2016 (Draft, September 2011)
Visions	By the year 2011, a basic health service system is established in the border communities with universal access for all and accompanied by an effective disease surveillance system.	Healthy for all border population
Missions	1. Strengthen collaboration among stakeholders and develop a quality health service system 2. Promote access to primary health services with participation from all stakeholders	1. Develop a quality health service system 2. Promote access to primary health services 3. Strengthen collaboration and participation from all stakeholders and all sectors

Border Health Development Master Plan	Year 2007-2011	Year 2012-2016 (Draft, September 2011)
	3. Act as a framework for all relevant agencies, governmental and non-governmental organizations, in promoting healthy border populations, regardless of nationality or religion.	
Health strategies	1. Promote access to health care services and improvement of health facilities 2. Promote healthy communities through local community participation 3. Improve migrants' public health through improved access to health services 4. Promote and support community participation to establish the primary health care system in border communities 5. Integrate the work plan and develop appropriate mechanisms to promote coordination and collaboration among key stakeholders 6. Promote inter- country cooperation with neighboring countries	1. Health care system development 2. Access to primary health care 3. Collaboration and participation among all stakeholders 4. Effective management

Border Health Development Master Plan	Year 2007-2011	Year 2012-2016 (Draft, September 2011)
Key actors (with roles defined)	Governmental organizations - Ministry of Public Health - Ministry of Labor - Ministry of Interior - Ministry of Defense - Ministry of Foreign Affairs - Immigration Bureau - Royal Thai Police - Office of National Security Council International organizations and private organizations - World Health Organization - International Organization for Migration - United Nations High Commissioner for Refugees - Kenan Institute Asia - World Vision Foundation - International Rescue Committee - SAMEO TROPMED Network - Raks Thai Foundation - Thailand U.S. CDC Collaboration (TUC) - Global Fund	Governmental organizations - Ministry of Public Health - Ministry of Labor - Ministry of Interior - Ministry of Defense - Ministry of Foreign Affairs - Ministry of Natural Resource and Environment - National Health Security Office - Thai Health Foundation - Immigration Bureau - Royal Thai Police - Office of National Security Council - Department of Livestock Development, Ministry of Agriculture and Cooperatives - Department of Disaster Prevention and Mitigation International organizations and private organizations - Raks Thai Foundation - World Vision Foundation of Thailand - United Nations High Commissioner for Refugees - Kenan Institute Asia - Thailand U.S. CDC Collaboration (TUC) - International Organization for Migration

Border Health Development Master Plan	Year 2007-2011	Year 2012-2016 (Draft, September 2011)
		- World Health Organization - Aide Medicale Internationale - American Refugee Committee International - European Commission-DG for Humanitarian Aid and Civil Protection - International Rescue Committee - Research Triangle Institute - SAMEO TROPMED Network - Shoklo Malaria Research Unit The Global Fund

Apart from the Border Health Development Master Plan, the National Master Plan for HIV/AIDS Prevention, Care and Support for Migrants and Mobile Population (MMP), 2007-2011 was developed and launched officially in 2007 by the Department of Disease Control with aims to reduce new HIV infected people among MMP and increase quality of life of the HIV infected MMP. Key contents of this plan are summarized in Table 2.10.

Table 2.10: Master Plan for HIV/AIDS Prevention, Care and Support for Migrants and Mobile Population (MMP), 2007-2011

Target population	1) External migrants: migrants from Myanmar, Lao PDR and Cambodia who cross international borders and live in Thailand either in cross border or inner provinces, including both documented and undocumented to be allowed to stay in Thailand 2) Displaced people residing in camps in Thailand 3) Thai migrant workers: Thai people who cross international borders to work in foreign countries 4) Ethnic minorities
Concept for interventions	a) Vulnerability and risk b) Safe mobility approach through understanding the mobility process, which leads to contiguous programming at source, transit and destination c) HIV/AIDS and Development: Early Warning and Rapid Response System (EWRRS) d) Gender mainstreaming, language and cultural diversity as key consideration to enhance the access to services and effective interventions e) Support the meaningful involvement of migrants and mobile populations f) Integrated sexual health into HIV/AIDS prevention, care and support intervention
Goals	Reduced new HIV infected people among MMP and increased quality of life of the HIV infected MMP
Purposes	1) Increased access to effective HIV/AIDS prevention, care and support for MMP 2) Reduced HIV vulnerability and risk for MMP

Outputs	O1: Enabled and feasible policy/law for HIV/AIDS prevention and care among MMP O2: Improved capacity of individuals and institutions working on HIV/AIDS among MMP O3: Developed database system to provide information for planning, monitoring and evaluation O4: HIV prevention infrastructure development O5: Functional collaboration at local cross-border, bilateral and regional level
Main Activities	
Output 1	1.1 To revise national laws, decrees and sub-decrees as well as national security which obstruct the implementation of HIV prevention, care and support for migrants and mobile population 1.2 To build positive attitude of societies toward migrants and mobile populations thoroughly and continually e.g. to build up better understanding of MMPs as MMPs are vital workforce of economic growth and to recognize the religions, cultures, community development of MMPs in order to create constructive environment in the community 1.3 To build capacity of MMPs through migrant rights based approach and to develop mechanism to access information from MMPs and network among governmental organizations, employers and migrant associations

Output 2	2.1 To develop national network of capacity building of institutions working on HIV/AIDS in MMPs 2.2 To conduct training need assessment, develop curriculum, training for trainers and develop capacity building plan on HIV/AIDS and MMPs 2.3 To deliver training program to implementation staff 2.4 To set up and develop center for medias in different languages at national and target provincial levels 2.5 To develop more channels to access services, i.e. drug stores, private clinics, private hospitals as well as to provide outreach services, e.g. peer-to-peer education and mobile VCT to MMPs
Output 3	3.1 To review existing database system and add variables useful for HIV/AIDS prevention and care among MMPs 3.2 To empower the staff working on MMP data and information at national and target provincial levels to develop their database system 3.3 To develop information system to the implementation plan at sub-district, district and provincial levels 3.4 To develop monitoring and evaluation system that can be linked at national, specific provincial level and be able to be used for the implementation plan, advocacy and networking among stakeholders 3.5 To develop the exchanging and referring data and information between organizations in the country as well as with source countries for migrants and transit and destination countries for Thai migrant workers 3.6 To develop information system management to the evaluation

Output 4	4.1 To set up the Early Warning Rapid Response System in order to report potential scenarios of what will happen to HIV vulnerability under conditions of development, to which responses should be built to prevent HIV transmission beforehand 4.2 To create collaboration from private sectors for HIV prevention among MMP in infrastructure development projects
Output 5	5.1 To identify and develop technical methodology needed for the operationalization of the signed MOUs 5.2 To set up technical assistance mechanism to operationalize the MOUs 5.3 To support the collaborative mechanism between countries at regional, national and cross-border levels

Source: Modified from Healthy Migrants, Healthy Thailand: A Migrant Health Program Model, (IOM and MOPH, 2009: p. 105-110)

Lastly, there is also the Migrant Health Strategy which has been developed by a working committee in collaboration with relevant government and non-government agencies and was drafted in 2006-2007 by the Department of Health Service Support, Ministry of Public Health. The strategy was targeted on migrant populations which refer to migrant workers, their families and dependents, who are Myanmese, Laotian, Cambodian and other nationalities. This includes those who have been registered with the Ministry of Interior (with a 13-digit identification number) and those who have not been registered (no 13-digit identification number), as well as ethnic minorities living in Thailand. However, displaced persons from civil conflict who are residing in the temporary shelters are not included as target population in this strategy. Key contents of the strategy which was drafted are summarized in Table 2.11.

Table 2.11 : Migrant Health Strategy (draft, 2006)

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

Strategies	S1. Migrant health service system S2. Health insurance scheme S3. Participation of migrants and communities in self and family health care S4. Development of information system S5. Management system
Migrant Health Strategy: Goal, Key Performance Indicators, and Methodologies	
Strategy 1 Migrant health service system	*Goal:* Public and private health facilities provide quality, comprehensive and accessible health services in accordance with conditions and limitations of the population *Key Performance Indicators:* 1. Percentage of health facilities that provide health services to migrants without communication barriers 2. Percentage of health facilities that provide health promotion and disease prevention to migrants both in the community and at health facilities 3. Proportion of migrants receiving health promotion and disease prevention services *Methodologies:* 1. Develop a friendly service system and reduce communication barriers by using appropriate mechanisms 2. Develop a health promotion system, active disease prevention and control including occupational health and safety 3. Promote living conditions of migrants according to the principles of environmental health

	4. Develop in-country and cross-border migrant referral networks for appropriate treatment by establishing a referral coordination center 5. Strengthen the capacity and attitude of public health personnel as well as the public health workforce in accordance to demands for the workload 6. Develop and promote migrant health workers to support migrant health services
Strategy 2 Health insurance scheme	*Goal:* Migrants who are registered according to the cabinet resolution or holding a Tor. Ror 38/1 have universal health coverage *Key Performance Indicators:* 1. Percentage of registered labor migrants who have health insurance 2. Percentage of dependents of registered labor migrants who have health insurance 3. Availability of other health care systems for other groups of migrant population *Methodologies:* 1. Strengthen the coordination, monitoring and auditing systems of the migrant health insurance scheme for migrants and dependents who are registered according to the cabinet resolution or holding a Tor.Ror 38/1 2. Promote understanding of health insurance entitlements, particularly among employers and migrant populations 3. Develop alternative health care systems for other groups of migrants in accordance to local contexts

	4. Integrate a system for collective monitoring and coordination systems among relevant organizations and employers in order to increase the coverage of health insurance among migrants
Strategy 3 Participation of migrants and communities in self and family health care	*Goal:* 1. Migrants, together with their host communities, can take care of their own health as well as the health of the community 2. Communities that host migrants consistently implement joint health care activities *Key Performance Indicators:* 1. Percentage of communities that have representatives in the form of health volunteers, workers, leaders (such as migrant health volunteers, migrant health workers and migrant health leaders), or Migrant Community Health Posts 2. Number of participatory health promotion activities conducted by the community 3. Number of vaccine-preventable disease outbreaks among migrants and the incidence of major communicable diseases or severe diseases in the community such as diarrhea, tuberculosis, avian influenza in humans, sexually transmitted infections, AIDS, etc. *Methodologies:* 1. Promote and support migrant community health workers and volunteers/migrant health leaders through appropriate position employment policies 2. Strengthen the capacity of migrant community health workers and volunteers, and migrant health leaders in self, family and community health care

	3. Promote learning networks and support the work of migrant community health workers and volunteers, and migrant health leaders including coordination with Thai village health volunteer networks 4. Promote a supportive participation, system, and the positive attitude of networks including government, private sectors, the Thai population, entrepreneurs and local administrative organization on providing primary health care to migrant communities 5. Establish the Migrant Community Health Post as deemed appropriate within the local context
Strategy 4 Development of information system	*Goal:* Accurate and up-to-date migrant health information is available, accessible and connected to other databases that can be used in planning, monitoring and evaluating health activities at all levels *Key Performance Indicators:* 1. Number of migrant health information centers at provincial and central level 2. Number of persons/organizations that utilize the information at the migrant health information center *Methodologies:* 1. Develop an information system to link with relevant databases of other sectors 2. Allocate a budget to support the information system 3. Establish a migrant health information system at provincial and central levels

	4. Promote the dissemination and use of migrant health information in planning, monitoring and evaluation 5. Establish a structure for migrant health information management in the form of a committee that comprises relevant agencies including both government and private sectors
Strategy 5 Management system	*Goal:* Efficient and effective management system is established in order to support the implementation of the Migrant Health Strategy *Key Performance Indicators:* 1. Number of policies at all levels that support migrant health activities 2. Number of migrant health work plans that are developed with participation from all sectors 3. Number of public health agencies at local and central levels that have migrant health management structures established and responsible persons appointed 4. Amount of the budget contributed from various organizations to support migrant health activities *Methodologies:* 1. Promote an integrated policy and work plan for migrant health activities 2. Establish a migrant health management committee that comprises relevant government and private sectors 3. Manage the migrant health insurance budget to support effective migrant health activities

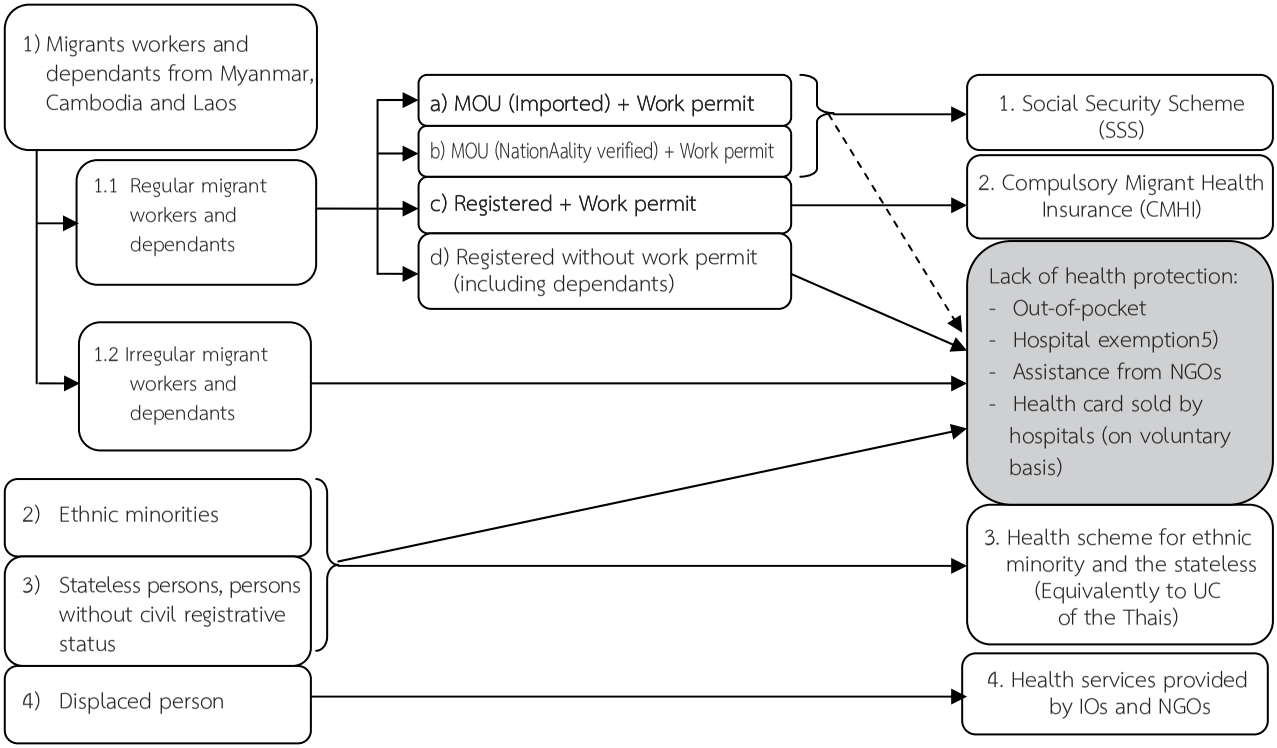
	4. Establish supporting mechanisms including sufficient budget and/or resource allocation from all sectors to serve migrant health management 5. Support migrant health monitoring and supervision according to the government inspector system or other similar system

Source: Modified from Healthy Migrants, Healthy Thailand: A Migrant Health Program Model, (IOM and MOPH, 2009: p. 111-114)

Identified by IOM and MOPH (2009), Border Health Development Master Plan, Master Plan for HIV/AIDS Prevention, Care and Support for Migrants and Mobile Population (MMP) and the drafted Migrant Health Strategy possessed some shared values; which are (i) improving health service access among target populations, (ii) enhancing meaningful participation of target communities, (iii) establishing and strengthening coordination and collaboration among relevant stakeholders, (iv) developing and improving relevant health information systems, (v) establishing and strengthening effective administrative and management systems, and (vi) supporting positive policy development and implementation.

Noticeably, master plans and health strategies relevant to the improvement of migrant health and health system for migrants in Thailand have provided importance and emphases on nearly all the six building blocks of health systems according to the WHO's framework; especially service delivery system, health information system, human resources, financing and health scheme for migrant, management and governance. However, to date, evidence and information available to monitor implementations and evaluation of performances as well as outcome, as identified and expected by the plans and strategies, are still limited and insufficient.

Figure 2.7 : Health insurance or benefit schemes by categories of migrants



2.5 Financing and coverage of health insurance

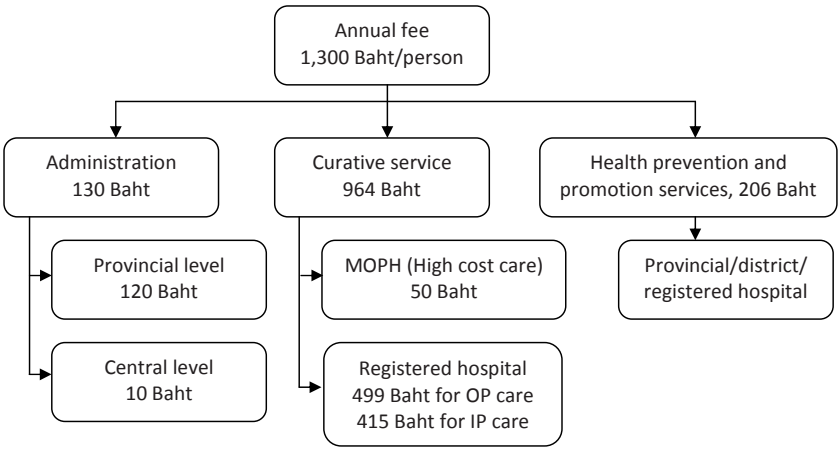
To date, existing health schemes and protections to migrants by groups of migrants are illustrated in Figure 2.7 Summarily, these health schemes and protections include the Social Security Scheme (SSS), the Compulsory Migrant Health Insurance (CMHI), the health scheme for ethnic minority and the stateless which is equivalent to UC of the Thais, health welfare provided by international organizations and NGOs for displaced persons in temporary shelters, and health cards sold by hospitals or service providers in some migrants intensive areas.

According to the figure, it should be noted that;

1) According to Social Security Act B.E. 2533, equivalent to the Thais, 7 benefits are entitled to the migrants under the SSS including benefits for medical services, death, disability, maternity, children allowances, old-age, and unemployment.
2) Only registered migrants can apply for the CMHI at a cost of 1,300 Baht per year (management and allocation of this fee is presented in Figure 2.8), with additional 600 Baht fee for medical checkup. However, once migrants completed the NV process, they are no longer eligible to apply to the CMHI and must register for the SSS instead. In 2006, health insurance scheme was expanded to cover also migrant workers' dependants but on a voluntary-basis. Anyway, enrollment among the dependants was very low and mainly by those with health problems, i.e. with chronic diseases.

3) Under the Cabinet resolution on March 23, 2010, basic rights to access health benefits under this scheme was offered to 457,409 persons living in Thailand who have problems about legal status and rights.
4) A practice of health cards sold by hospitals has started since 2008
5) Cited in Bussayarat Kanchanadit (2011), health exemption or uncollected fee from poor migrant patients at 172 MOPH's hospitals in 15 provinces was as high as 500 million Baht, of which 447 million Baht for inpatients and 21 million Baht for outpatients. 5 hospitals with highest burdens included Mae Sod Hospital, Chiangrai Hospital, Mahanakorn Chiangmai Hospital, Nakhonphing Hospital and Ranong Hospital, respectively.
6) Even if migrant workers who have completed nationality verification or those who were imported legally from the home country are eligible for contribution to and benefits from the Social Security Scheme (SSS), one emerging problem which is currently a key challenge is failures of the employer to register these migrants to the SSS, leaving a large number of these workers without health insurance and protection. In Samutsakorn, out of the total 86,404 workers who have completed the NV or imported under the MOU (mid of 2011), only 22,000 has been registered with the SSS leaving the rest 64,404 without any health protection as they are not eligible to enroll the CMHI neither.

Figure 2.8 : Management and allocations of CMHI fee



Source: IOM and WHO (2009). Financing Health Care for Migrants: A Case Study from Thailand, p.36

Considering the entitlement to health welfare or insurance scheme, migrants are still uninsured and lack health protection. These include the following groups.

a) Regular migrants workers (and dependents) who
   - completed NV or imported under the MOU but failed to register with the SSS
   - registered with the MOI but not applied for a work permit and not enrolled to the CMHI

b) Irregular migrant workers (and dependants), or those who have not registered with the MOI and the MOL

c) Ethnics minorities, stateless/rootless persons, persons without civil registrative status who are not covered by the health scheme under the cabinet resolution on March 23, 2010

d) Displaced persons who escaped from or lived outside the shelters

Benefits, limitations, financing and approximate coverage of major health schemes (and health welfare) currently entitled to migrant workers; the Social Security Scheme (SSS), the Compulsory Migrant Health Insurance (CMHI); are compared and presented in Table 2.12.

Table 2.12: Comparison of existing health schemes for migrant workers

	The Social Security Scheme (SSS)	The Compulsory Migrant Health Insurance (CMHI)	Uninsured migrant workers (including irregular workers and dependants)**
Benefits	• Equivalent to Thai workers in formal private sector • Extensive set of conditions covered • Includes coverage for HIV related opportunistic infections • Payment of treatment for occupational injuries	• Equivalent to Thai Universal Coverage (UC) with some exceptions • Covers treatment of HIV related opportunistic infections	• General health services provided at discretion of health facility and staff • Emergency service and basic medical treatments
Limitations	• Can only receive benefit at designated hospitals • Must remain employed with original employer • Limit on type of medicines available (same as scheme for Thai), and an unclear policy on ART for migrants	• Can only receive benefit at designated hospital • List of excluded conditions that are prohibitively expensive, including elective surgery • No extended treatment beyond 180 days • No ART	• Quality of service at discretion of health personnel and ability of migrant to pay out of pocket • Constraints on type of service when payment from the health facility's welfare budget or hospital exemption

	The Social Security Scheme (SSS)	The Compulsory Migrant Health Insurance (CMHI)	Uninsured migrant workers (including irregular workers and dependants)**
	• Not able to utilize insurance until three months after enrolling • Part of payment goes to retirement fund which migrant cannot receive		
Financing	• Contributions at 5 percent of monthly wage by the migrant, 5 percent by the employer (question of whether the employer actually contributes or deducts full 10 percent from the migrant)	• Flat annual fee of 1,300 Baht at time of registration • Required to take annual medical checkup at cost of additional 600 Baht	• Payment upon delivery of service, negotiable to some extent • health facility's welfare budget or hospital exemption
Coverage	Approx. 90,000 migrants (as of 2009)*	Approx. 1.04 million migrants registered with work permits in August 2011	Approximately, 1 – 1.5 million migrants

Note * In August 2011, the number of migrant workers who have completed the NV or imported into the country under the MOU stands at 529,388. These workers are eligible to register for the SSS, but a large number is expected to fail to do so and left uninsured by any health insurance or protection. If situation in Samutsakorn is used as a threshold that this group accounts for as high as 75 percent of all the eligible, it is estimated that nearly 400,000 regular workers under NV and importation process are still left uninsured

****** Under the policy of health care for all, uninsured migrants and their dependents can generally access emergency and basic medical treatment under the hospital charitable funds and, also in many cases, the NGOs or charity provisions.

Source: Modified with updated information from Brahm Press, (2011), The PHAMIT Story, p. 44

2.6 Health information of migrants

As mentioned in a previous section, information on migrant health in Thailand, either from routine information systems or existing surveys, is still limited, insufficient and fragmented in terms of representativeness and continuity. A review by the Border Health Program (BHP) of the WHO has reviewed over routine data sources and reporting on migrants in 2008, which is summarized in Table 2.13.

Table 2.13: Summary of existing data collection related to migrant health in 2006

Principle implementers	MOPH/DHSS	WHO-MOPH-IOM	MOPH/DDC/BOE (506 Form)	MOPH/DDC/BOE (Non Camp Survey) Piloted in Ranong and Samutsakorn	MOPH/DDC/BOE (Camp-MR1)
Other implementing partners	MOI MOL	-	-	-	NGOs working in camps AMI ARC IRC MI
Target population	Migrants	Migrants	Thai and Migrants	Migrants	Migrants
Geographical target	3 pilot provinces in three borders-under the selection process	2 pilot provinces: Samutsakorn Ranong	Nationwide	Nationwide	Nationwide
Type of information collected	1. Demographic data 2. Pattern of migration 3. Health record 4. Medical record 5. Financial information 6. Specific information • HIV/AIDS • Environmental health	1.Diseases surveillance: focus on main communicable and vaccine preventable diseases 2. Other health figures based on family folder and service utilization at target health facilitiese.g. • Demographic data • Diseases • Vaccine coverage • Family planning • ANC, PNC coverage	81 diseases under surveillance in 7 main categories: • Food and Water-Borne Infectious Diseases • Vector Borne Diseases • Vaccine Preventable Diseases • Zoonoses • CNS Infectious Diseases • Respiratory Infectious Diseases • AIDs and other infectious diseases	• Demographic data • Diseases-based on history of illness • Vaccine coverage • Family planning • ANC, PNC coverage • EH e.g. clean drinking water coverage, waste management, latrine coverage	18 diseases under surveillance in: • Food and Water-Borne Infectious Diseases • Vector Borne Diseases • Vaccine Preventable Diseases • Zoonoses • CNS Infectious Diseases • Respiratory Infectious Diseases

		• EH e.g. clean drinking water coverage, waste management, latrine coverage			
Source of information	Hospitals	Health centers /communities based through CHWs/CHVs network	Health facilities	Household based survey	Community based survey
Frequency of data collection and flow of data	Monthly from hospital to PHO, then to DHSS (similar to Thai HIS) and then to 17 different locations	Monthly from MHWs to PHO	Weekly from health facilities to PHO and then to BOE	Planned to be conducted annually or bi-annually	Monthly to PHO and then BOE

Source: WHO (2008). Supporting health systems development for migrant populations: A WHO strategy for support to migrant health development in Thailand, p. 37; and World Health Organization (Thailand). N.A. Assessment on Migrant Health Information System (MHIS) in Ranong and Samutsakorn Provinces, p. 22.

In the 2004, the WHO's BHP started an initiative to develop a standardized data collection tool and information system for migrants with collaboration from the Ministry of Public Health (MOPH), NGOs, International Organization for Migration (IOM), and other UN agencies. The "Development of Migrant Health Information System" program under this effort has been implemented since 2004 and was assessed its performances in Ranong and Samutsakorn in 2006 (WHO, N.A.). Summary of this assessment on existing migrant health information system under the MOPH structure by the five information subsystems including; i) Demographic Data, ii) Communicable Diseases Surveillance System, and iii) Special vertical program, i.e. Malaria, TB, EPI and HIV/AIDS and administrative management system is presented in Table 2.14.

Table 2.14 : Summary of migrant health information recording and reporting systems under the MOPH structure assessed by the WHO

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
1. Demographic Data	1. Bureau of Health Service System Development	Migrants Unit/PHO	Estimated data	1. No-standardized data among provinces 2. Incompleteness of obtained data 3. Important characteristics e.g. age, sex were not addressed	1. Conduct survey in pilot provinces (scale up NGO's effort on the up-coming exercise for census survey) 2. Using updated MOI data base as a baseline and work with NGOs, IGO to estimate the population size
	2. Bureau of Health Service system Development	Migrants Unit/PHO folders	Individual/Family (Ranong)	1. Covered only reachable migrants within target population of pilot projects-supported by PHAMIT, IOM and WHO	1. Continue to update information and expand the coverage periodically
2. Communicable Diseases					
2.1 HIV/AIDS	1. Bureau of Epidemiology	Technical Application Unit/PHO	Sero-Sentinel surveillance/ anonymous individual record -Migrant workers -Migrant seafarers -Migrant pregnant women attended ANC at government hospitals	Results generated from surveys conducted among migrant seafarers and migrant pregnant women are not able to explain the HIV prevalence in these target groups, since sample size required are calculated for general seafarers: Thai and migrants were included.	1. Design surveys for migrant seafarers and migrant pregnant women separately 2. Consider to conduct survey in private hospital –main contracting health service provider for migrants (Srivichai Hospital)

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
	2. Bureau of Epidemiology	Epidemiology Unit/PHO	Passive disease surveillance/ individual record	1. Definition of migrants applied 2. Limitation of the system when applied in the low service utilization population	1. Consider to revise definition of migrants. 2. Using other types of information e.g. risk behaviour survey to help determine the HIV situation and trends among migrants
	3. Bureau of Policy and Strategy	Health Information Unit/PHO	Routine system/individual record	System is under development	None
2.2 TB	1. Bureau of Epidemiology	Epidemiology Unit/PHO	Passive disease surveillance/ individual record	1. Definition of migrants applied. 2. limitation of the system when applied in the low service utilization population 3. Data is not allowed to compare with the routine or vertical program system due to - Different reporting time frame - Definition applied e.g. mainly probable case - Primary source of data e.g. report from private hospitals included	1. Consider to revise definition of migrants. 2. Develop a complimentary system for example; a community based active surveillance system 3. Adjust the reporting time frame
	2. TB Cluster/ Bureau of AIDS, TB and STIs	Technical Application Unit (SSK)/Migrants group (RN)/PHO	Summary report	Limitation of the system when applied in the low service utilization population figure relied on TB detection approach (passive/active)	Consider to apply active approach for TB detection through establishing of community based surveillance

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
	3. Bureau of Policy and Strategy	Health Information Unit/PHO	Routine system/ individual record	System is under development	None
	4. Bureau of Health Service System Development	Technical Application Unit/Migrants group/PHO	Summary report	1. Deportation policy yielded the right figure 2. Data covered/represented only migrant workers who undergone for health check 3. Recoding error due to - rush work - manual error	1. Discuss with MOI and MOL to adjust the regulation to minimize impact on public health 2. Promote registration and enrolling in health insurance scheme among migrants 3. Develop computerized recording and reporting system linking with all levels within MOPH
2.3 Malaria	1. Bureau of Epidemiology	Epidemiology Unit/PHO	Passive disease surveillance/ individual record	1. Definition of migrants applied 2. Under reporting- due to time constraint at primary data collection level e.g. vector born unit-outreach program 3. Limitation of the system when applied in the low service utilization population 4. Data is not allowed to compare with the routine or vertical program system due to - Different reporting time frame applied - Primary source of data e.g. report from private hospitals included	1. Consider to revise definition of migrants 2. Provide appropriate and sufficient number of staff at the primary level 3. Develop a complimentary system -a community based active surveillance system 4. Adjust the reporting time frame (or the other way around)

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
	2. Bureau of Vector-Borne Diseases	Health Information Unit/PHO	Summary report	None	At present, malaria figures produced from this system is the most reliable source to explain malaria situation in migrants
	3. Bureau of Policy and Strategy	Health Information Unit/PHO	Routine system/individual record	1. At central level, priority given to improve the Thai system- resulted in less technical support provided to the field 2. Obstacle on IT technical support to modify the Thai exiting reporting system for migrants 3. Person identification	1. Provide IT support to health centers to modify the IT programme (HCIS) that can be sort out migrant data properly 2. Provide IT support to establish a unique identifier into the existing system (HCIS)
	4. Bureau of Health Service System Development	Technical Application Unit/Migrants group /PHO	Summary report	1. Data covered/represented only migrant workers who undergone for health check 2. Recoding error due to - rush work - manual error	1. Promote registration and enrolling in health insurance scheme among migrants 2. Develop computerized recording and reporting system linking with all levels within MOPH
2.4 Filariasis	1. Bureau of Epidemiology	Epidemiology Unit/PHO	Passive disease surveillance/ individual record	The same as described in malaria section	The same as described in malaria section

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
	2. Bureau of Health Service System Development	Technical Application Unit/ Migrant group /PHO	Summary report	1. Data covered/represented only migrant workers who undergone for health check 2. Recoding error due to - rush work - manual error	1. Promote registration an enrolling in health insurance scheme among migrants 2. Develop computerized recording and reporting system linking with all levels within MOPH
	3. Bureau of Vector-Borne Diseases	Technical Application Unit/PHO	Summary report	Study did not probe into details	None
2.5 Other important diseases -M.Meningitis -Diarrhea	1. Bureau of Epidemiology	Epidemiology Unit/PHO	Passive disease surveillance/ individual record	The same as described in malaria section	The same as described in malaria section
3. EPI (Children under 5 years)	1. Bureau of Health Service System Development	Migrant Unit/PHO	Summary report	1. Only polio vaccine figures conducted on NID and sub NID reported to central level 2. Other records on number of vaccine shot given kept at PHO level –mainly unable to generate the EPI coverage due to lack of denominator	1. Conduct cross sectional survey in target provinces with technical inputs from BOE and DOH 2. Promote the use of maternal and child record pink book

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
	2. Bureau of Policy and Strategy	Migrants Unit/PHO	Routine system/ individual record	1. At central level, priority given to improve the Thai system- resulted in less technical support provided to the filed 2. Obstacle on IT technical support to modify the Thai exiting reporting system for migrants 3. Person identification	1. Provide IT support to health centers to modify the IT programme (HCIS) that can store and process migrant data properly 2. Provide IT support to establish a unique identifier into the existing system (HCIS)
4. RH - family planning - mother and child health	1. Bureau of Health Service System Development	Migrants Unit/PHO	Summary report	Unable to monitor the status of target population, due to their mobility	1. Pilot in the target province- using one data base, with unique identifier to support referral system among target health faculties 2. Develop minimal data set with inputs from PHOs, DOH and other relevant agencies
	2. Bureau of Policy and Strategy	Migrants Unit/PHO	Routine system/ individual record	The same as described in EPI section	The same as described in EPI section
5. EH	1. Bureau of Health Service System Development	Migrants Unit/PHO	Summary report	Among 51 provinces reported, only 23 provinces reported on this component (2005)	1. Define basic minimal data set of EH and standardized data collection procedure with inputs from PHOs, DOH and relevant agencies 2. Pilot in the two provinces

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
	2. Bureau of Policy and Strategy	Migrants Unit/PHO	Routine system/ individual record	The same as described in EPI section	The same as described in EPI section
6. Health Expenditure	1. Bureau of Health Service System Development	Migrants Unit/PHO	Summary report	Only 51/76 provinces reported figures (2005)	1. Identify causes and encourage (in particular) provinces hosting large number of migrants to participate in the reporting system through M&E 2. Useful data provided in the website of BHSSD, simplifying and grouping data by each component will help readers to follow
	2. Bureau of Policy and Strategy	Migrants Unit/PHO	Routine system/ individual record	The same as described in EPI section	The same as described in EPI section
7. Human Resource		Migrants Unit/PHO		1. Limited number of technical staffs at PHO level to concentrate on MHIS development on both public health and information technology 2. Limited capacity of MHWs to support data processing	1. Allocate appropriate staffs to concentrate on MHIS development 2. Bring in temporally IT experts from central level to support IT Program modification and train responsible staffs at provincial level 3. Recruit MHW who has potential for data management

MHIS	Data Source (Central level)	Data Source (peripheral level)	Type of Data/ System	Major Limitations	Recommendations
					4. Strengthen MHWs' capacity through formal and on job training on data collection and analysis
8. Other resources		Migrants Unit/PHO		Insufficient equipment for data processing at health center level e.g. computer, internet	Allocate budget or seek extra fund to equip target health center with proper equipments

Source: WHO (N.A.). Assessment on Migrant Health Information System (MHIS) in Ranong and Samutsakhon Provinces.

III
Recent programs on migrant health

Part 3

Recent programs on migrant health

In the past decade, issues of migrant health with efforts to enhance access to needed health care and protection to migrant groups as well as population in the country living along the border have been more emphasized and provided importance. Some previous and also ongoing programs under this effort by the MOPH with collaboration and supports from international organization, NGOs and other stakeholders which are relevant to health system strengthening for migrants are in brief reviewed in this section. This includes; The Border Health Program (BHP) during 2001-2007 by the World Health Organization (WHO) with supports from the UK Department for International Development (DFID), previous and ongoing program with supports from the Global Fund, and Migrant Health Program under the collaboration among the Ministry of Public Health (MOPH), the International Organization for Migration (IOM), and the (WHO).

3.1 The Border Health Program (BHP)

The Border Health Program was initiated in 2001 by the World Health Organization (WHO) Thailand with supports from the DFID. The program in the beginning was a 2–year project which later on extended to the end of 2007. It was aimed to improve health situation with focus as well on humanitarian aspects of the population living along Thai-Myanmar border with targeted geographical areas in ten provinces. These areas consisted of communities of the Thais, the non-Thais including both regular and irregular migrant workers, their spouses and children, and displaced persons registered in the nine UNHCR-run temporary shelters. Particular target was placed on the health of vulnerable groups such as irregular or non-registered migrant workers and their dependants and migrants living outside the shelters.

Key health issues and challenges along the border of Thailand and Myanmar by the program were given to: i) large vulnerable population who did not have adequate access to health services; ii) challenges in addressing public health needs of, as well in collecting data on, these population due to security, political, cultural, financial and language barriers; and iii) mobility of the population and cross border movement which increased opportunity of the transmission of diseases among migrants and local populations (Elisabeth, 2008).

Main activities undertaken by the BHP focused on

i) Improvements of coordination: i.e. Annual Border Health Meeting from the 2002-2007 with a collaboration from the Department of Disease Control of the MOPH; Provincial Health Coordination Meetings between Provincial Health Offices and NGOs in border provinces; UN Border Health Meetings, cross-border meetings between Thailand and Myanmar public health officials at the local level, and also Technical Meetings on TB, malaria and HIV/AIDS.

ii) Health information system strengthening: i.e. promoting standardization of data collection by funding towards an MOPH project to develop an epidemiological data collection tool for migrants with target on the irregular ones which was field-tested in Ranong and Samutsakorn in 2006 and 2007; developing a database of studies and assessments that had been done in the border area, compiling existing research and other information related to migrants into an accessible format.

iii) Capacity building: i.e. improving primary health care services to migrants in the border areas with a pilot project in Ranong and Samutsakorn in collaboration with the IOM and the MOPH under the Migrant Health Program, hosting technical meetings, supporting outreach activities to vulnerable populations, distributing technical publications and information to health workers in the border areas such as standardized maternal/child multi-lingual medical records book.

3.2 Programs supported by the GFATM

Since 2004, many interventions and initiatives under programs on fighting AIDS, TB and Malaria in Thailand have been supported by the GFATM. To date, most of the supported programs are the three disease-specific interventions with identified targets on particular groups of the population, especially the high-risk population and the vulnerable groups including migrants. A summary of these programs in Global Fund Round 1 to Round 10 is presented in the following tabulation.

Table 3.1 Summary of previous and ongoing programs against HIV/AIDS, TB and Malaria in Thailand under the GFATM supports

Round	Disease (period)	Grant approval	Program title	Target groups	Key interventions
R 1	AIDS 2004-2008	Yes	Strengthening National Prevention and Care of HIV/AIDS	Youth and people living with HIV/AIDS (PHA)	a) HIV/AIDS prevention among youth b) Care for the PHA c) Provision of ART to migrant workers under NAPHA extension initiative (in late of the fourth year of the program)
	TB 2004-2008	Yes	Strengthening National Prevention and Care of Tuberculosis	Prisoners, border population (including migrants), urban population and PHA	a) Advocacy on Direct Observed Treatments (DOTs) in hospitals b) Promote TB patient screening and drug-resistance surveillance
	Malaria	No			
R1-RCC	AIDS 2008-2014	Yes	Aligning Care and Prevention of HIV/AIDS with Government Decentralization to Achieve Sustainable Coverage and Impact (ACHIEVED)	Provincial Coordinating Mechanism (PCM) PHA and migrants	a) Integration of HIV/AIDS interventions into the decentralization process and provincial plan b) Care, assistance and treatment provision including ART for migrants who are the PHA under NAPHA extension initiative (* limited number of the eligible with a long waiting list)

Round	Disease (period)	Grant approval	Program title	Target groups	Key interventions
R 2	AIDS 2004-2008	Yes	Enhancing of HIV Related Care and Treatment for HIV Infected Mothers and Their Partners and Children (ECAT)	HIV infected mothers and their family Network and groups of PHA in community	a) Related care and treatment for HIV infected mothers (after child delivery) and their family b) Strengthen community network and groups of PHA with mentoring system, assistance, counseling and mental supports by hospitals, and relevant stakeholders in community c) In the 3rd year, interventions also covered HIV infected mothers who were migrant workers
			Prevention of HIV/AIDS among Migrant Workers in Thailand Project (PHAMIT)	Migrant workers and families	Prevention of HIV/AIDS among migrant workers, with objectives to a) increase condom use and RH practices among migrant workers b) make health system favorable for migrant workers

Round	Disease (period)	Grant approval	Program title	Target groups	Key interventions
					c) support psychosocial environment and community strengthening for migrant workers d) promote a political environment that supports rights to health and treatment of migrant workers
	TB	No			
	Malaria 2005-2009	Yes	National Prevention and Control Program on Malaria in Thailand	Villages with problems in accessing health care in risky area of malaria infection	a) Malaria prevention by distributing mosquito net and creating malaria awareness to villagers b) Malaria post to enhance access to diagnosis and treatment within 24 hours
R 3	AIDS	Yes	Preventing HIV/AIDS and Increasing Care and Support for Injection Drug Users in Thailand	Injection drug users (IDUs)	HIV/AIDS prevention, Care and support for the IDUs (Raks Thai Foundation-RTF is the principle recipient-PR)
	TB	No			
	Malaria	No			
R 4, 5	No	No			

Round	Disease (period)	Grant approval	Program title	Target groups	Key interventions
R 6	AIDS	No			
	TB	Yes	Reduction of TB Morbidity in Vulnerable Populations	Workers in manufacturing factory and migrant workers	a) Laboratory capacity strengthening (by the Bureau of TB) b) Treatments for TB patients in manufacturing factory (by Thailand Business Coalition on AIDS : TBCA) c) Treatments for TB patients among migrant workers (by World Vision Foundation of Thailand : WVFT) d) Advocacy, communication and social mobilization (ACSM) in communities with coordination from public agencies to strengthen referral system of patients to hospitals
	Malaria	No			
R 7	AIDS	No			
	TB	No			

Round	Disease (period)	Grant approval	Program title	Target groups	Key interventions
	Malaria	Yes	Partnership Toward Malaria Reduction in Migrant and Conflict-affected Population in Thailand	Risk groups to malaria infection, including migrant workers	a) Continuing distributing mosquito net from R-2 b) Expanding target areas to migrant worker villages with assistance (for home visit and translation) from Migrant Health Volunteer: MHV and Community Health Worker: CHV
R 8	AIDS	Yes	Comprehensive HIV Prevention among the Most at Risk Populations (MARPS) by Promoting Integrated Outreach and Networking: (CHAMPION)	IDU, men having sex with men (MSM), female sex workers (FSW), prisoners and migrant workers	HIV/AIDS prevention among all groups of MARPS, including migrant workers which run the program in continuation of PHAMIT in R-2 by expanding target areas to 37 provinces under the PHAMIT-2 (ongoing)
	TB	Yes	Strengthening quality TB control among vulnerable populations and empowering communities in Thailand	Thai population and non-Thai population groups (except those in shelters)	a) Continuing from TB program in R-6 b) Laboratory capacity strengthening and TB prevention among Thai population (by the Bureau of TB)

Round	Disease (period)	Grant approval	Program title	Target groups	Key interventions
					c) TB prevention and care among non-Thai populations (by Raks Thai Foundation)
	Malaria	No			
R 9	No	No			
R 10	AIDS	Yes	Aligning Care and Comprehensive HIV-Prevention among Youth, MARPs, Children Infected and Affected by HIV/AIDS and Other Vulnerable Children by Promoting Integrated Outreach and Networking with Government Decentralization to Achieve Coverage and Impact: (ACHIEVED)	Children affected by HIV/AIDS	Recently started
	TB	Yes	Universal access to quality TB control & care and empowering communities in Thailand	Thai and non-Thai population	Continuing from TB program in R-8
	Malaria	No			

Source: Compiled by the research team (as of November 2011)

3.3 Migrant Health Program: Healthy Migrants, Healthy Thailand

The Migrant Health Program was an initiative under the collaboration among the Ministry of Public Health (MOPH), the International Organization for Migration (IOM) and the World Health Organization (WHO) which started in 2003. To develop innovative and sustainable model of basic health provision for migrants, both the regular and the irregular, and their families, the program was undertaken with close coordination from local health authorities and relevant facilities. Implemented areas were focused on those with migrant-rich communities and villages along the Thai-Myanmar border. Primarily, the program was first launched in 2003 in Tak (3 districts) and Chiangrai (3 districts), then expanded in 2004, 2005 to cover the following geographical areas; Chiangrai (4 districts), Tak (3 districts), Ranong (Muang district), Samutsakorn (Muang municipality), Phang-nga (4 districts).

The program's ultimate goal was contributed to the Healthy Thailand policies of the government. Overall objective was to provide assistance and supports to the government in improving health knowledge, awareness, practices and access to needed health care among migrants and their Thai host communities through the provision of a comprehensive, participatory, sustainable and cost-effective migrant health. Six strategies were identified and undertaken to achieve the objective: 1) Strengthening the capacity of relevant counterparts at all levels; 2) Increasing access to migrant-friendly health services;

3) Developing a sustainable MHP model that can be replicated elsewhere; 4) Strengthening collaboration among key stakeholders; 5) Facilitating the development and supporting the implementation of positive migrant health policies; and 6) Strengthening community preparedness and response to potential disaster and/or disease pandemics.

Particular purpose, key activities and key successes of the program under each strategy are summarized in Table 3.2 (Nigoon, 2009).

Table 3.2 : Purposes, activities and successes under the Migrant Health Program

Migrant Health Program's Strategy	Purpose	Key activities	Key successes
Strategy 1 Strengthening Human Capacity	To strengthen the capacity of relevant counterparts in the planning, design and provision of primary health care services to migrants and their communities. Counterparts include government and non-government agencies as well as health and non-health sectors who play a key role in improving community health and well-being. Migrants themselves are also key stakeholders of the MHP	- A series of formal training to the Migrant Health Team in each target district. The training consisted of representatives from local public health personnel - Migrant Community Health Worker (MCHWs) and Migrant Community Health Volunteers (MCHVs), and local Thai host communities, particularly community leaders and Thai Village Health Volunteers - Regular team meetings, mentoring and on-the-job training for MCHWs and MCHVs - Annual participatory project review and work plan development - Annual cross-fertilization workshops and field exchange visits	**Government and non-government counterparts** - Increased understanding among public health personnel about international migration and migration health, and are more familiar with responding to migrant populations - Ensured migrant-friendly services through a series of formal and informal capacity building activities - Participation of local and national partners as well as selected MCHWs in conferences and various formal/informal forums about legal and policy issues - Opportunities to government counterparts to encourage increased exposure to current migration and migrant health issues and services through field exchange visits, learning by doing, and cross fertilization workshops among MHP teams from different districts and provinces **Migrant communities** - Established networks of One-hundred and Eleven (111) trained, paid, full-time MCHWs who serve as interlockers between target migrants/communities and government health systems - Established networks of more than 1,300 MCHVs in each target - A standard training curriculum for MCHWs and MCHVs

Migrant Health Program's Strategy	Purpose	Key activities	Key successes
Strategy 2 Increasing Primary Health Care Access	To improve health related knowledge, awareness and behavior as well as to improve access to health information and services among migrants and host communities through community participation and strategies that target behavior change	- Community and facility-based health services to target communities - Community outreach by public health personnel with assistance from MCHWs and MCHVs through mobile clinics, home visits, and campaigns - Providing health information - Health prevention and promotion, health care, treatment and referral to target populations - Promoting access to migrant-friendly health services at public health facilities - Community health posts and health corners in migrant communities and workplaces	**Introduction to the concept of migrant-friendly health services** - Bilingual IEC materials in Thai and the local languages in each target site, to enhance health communication between clients and service providers; i.e. updated and reproduced in bilingual format of the MOPH's Maternal and Child Health Handbook - 10 community health posts in migrant-rich communities along the border provinces of Tak and Chiangrai, as well as in the coastal province of Phang-nga - 39 migrant health corners established at migrant workplaces in Ranong and Samutsakorn **Primary care and health IEC** - Reach of IEC to one-one and small group discussions, and large scale campaigns - Reach of primary care - Health services responding to specific local context, needs and national policy **Reproductive health including maternal and child health** - Increase in contraception - Increase in perinatal care - Increase in vaccination **Communicable disease control and prevention** **Environmental health and community sanitation**

Migrant Health Program's Strategy	Purpose	Key Activities	Key successes
Strategy 3 Migrant Health Program Model Development	To monitor, document and evaluate Program's achievements, lessons learned and recommendations for future programming	- A series of consultative among representatives from the MOPH, the local MHP teams and IOM to come to an agreement on MHP implementation structure, roles and responsibilities of relevant parties and management flow - Experience sharing among team members and other agencies working on similar issues - Monitoring and evaluation during the program model development - Identifying potential for replicating and/or expanding the model/approaches - Identifying the challenges and recommendations for future migrant health programming	**Key components of health program models to be replicated elsewhere** 1. Sustainable program structure 2. Human resources 3. Co-management modality 4. Comprehensive and cost-effective program services 5. Appropriate implementation sites 6. Multi-sectoral collaboration 7. High level of participation among various stakeholders 8. Potential for sustainability 9. Cost-effectiveness of the Program **Program implementation approaches and good practices** 1. Remote and isolated communities - Approach 1.1 Community health post - Approach 1.2 Mobile clinic 2. Urban community - Approach 2.1 Promoting access to public facilities - Approach 2.2 Community health post and mobile clinic 3. Workplace intervention - Approach 3.1 Migrant health corner - Approach 3.2 Mobile clinic 4. Cross-cutting approaches - Approach 4.1 Community outreach - Approach 4.2 Comprehensive programming - Approach 4.3 Multi-sectoral collaboration

Migrant Health Program's Strategy	Purpose	Key Activities	Key successes
Strategy 4 Strengthening Multi-Stakeholder Collaboration and Reduction of Stigma and Discrimination	To reduce stigma and discrimination and encourage a harmonious co-existence between migrants and their host communities through multi-stakeholder collaboration, community participation, and information, education and communication (IEC) strategies. Increased harmony in any multi-cultural society will assist with paving the way for a more holistic approach to community health programming, and therefore, less exclusion of any sub-populations	Several stakeholder meetings and training sessions conducted at the district, provincial and national levels - To enhance mutual understanding about international migration and health, basic human rights and migrant rights, and health security as a component of national and human security - To encourage involvement and ownership of the MHP	- Consultative meetings in each province with key stakeholders from all levels of various sectors prior to beginning a project - Reduced duplication of services when there is more than one agency working in a target area, enhancing a coordinated and collective response, and leveraging limited resources as mentioned earlier - Referral mechanisms among government and non-government services were enhanced - Partner and network agencies work very well together through both formal and informal coordination mechanisms - Peer-peer discussion and learning strengthening multi-sectoral collaboration and coordination
Strategy 5 Support and Implementation of Migrant Health Policy	To support existing public health policy, further development of the policy, and implementation of the policy in order to	- Several meetings/workshops/ conferences, in addition to monitoring field visits by MOPH and IOM representatives - Policy updates to local teams	- Periodic joint field monitoring visits by technical staff from IOM and the MOPH providing new policies and guidance as well as reiterating and refreshing the existing policies and guidance to teams at the field level - Advocacy and provided input on migrant health issues to

Migrant Health Program's Strategy	Purpose	Key Activities	Key successes
	attain equitable access to primary health care services among migrants and host communities. This in turn will contribute to the government Healthy Thailand governance agenda.	- Guidance and assistance to local teams to appropriately and effectively translate and implement existing policies - Providing an opportunity for field implementers to share information and concerns as well as advocate for policy change	central level MOPH by addressing service gaps and constraints due to insufficient policies - Annual Joint Technical Team Meeting, and the National Migrant Health Conference - Migrant Health Strategy drafted and based on the considerable experiences and lessons learned from the program
Strategy 6 Community Preparedness and Response to Disaster/ Pandemic	To ensure that migrants and host communities are prepared, protected and assisted before, during and after a disaster, whether natural or human-made, as well as during a disease outbreak and pandemic	- Facilitating and promoting community disaster and disease pandemic preparedness planning that includes both registered and unregistered mobile and migrant populations - In the aftermath of a disaster, providing basic essentials during a humanitarian emergency, in addition to health information and services including mental health and psychosocial support to affected migrants, their families and communities - Providing assistance to the government on other related issues as required	- Humanitarian response for Tsunami relief - Tsunami disaster victim identification - Disaster and pandemic preparedness

Source: Compiled and summarized from Nigoon (2009)

From the implementations and activities undertaken under the Migrant Health Program, experienced challenges and lessons learned which were identified into two levels of policy and implementation; i) policy and implementation at the national level; and ii) implementation at the field level (Nigoon. 2009).

In the national level; lack of a clear, long-term government policy related to the management of migrant workers from neighboring countries and beyond was claimed as key difficulties to an overall migrant management policy, and for the MOPH to effectively manage migrant health issues. Lacks of appropriate policy included:

1) Limited human and financial resources at all levels of the MOPH;
2) Lack of systematic development of the migrant health service system (i.e. lack or insufficiency of performance indicator for migrant health service, employment of MCHWs, migrant health information system, inter-departmental coordination within the MOPH, monitoring Program development, and inter-ministerial coordination); and
3) Contradictory health and national security concerns.

In the field level, key challenges included:

1) Migrant characteristics, in terms of low level health knowledge and concerns, difficulty in personal identification among some migrant groups, and high mobility among some migrant groups;
2) Physical environments in urban and rural settings;

3) Cooperation from some key stakeholders, i.e. business, housing owners, and other relevant agencies;
4) Local health authorities and care providers in terms of preparedness of relevant implementing partners, time constraint and competing priorities, management capacity including monitoring and evaluation, and also migrant health information system at the field level.

According to key challenges indentified above, list of crucial recommendations for the future migrant health programming is provided as summarized in Table 3.3.

Table 3.3 : Recommendations for future migrant health programming from the Migrant Health Program

Areas	Recommendations
1) Development of a long-term policy and mechanism for the management of international migrant workers	- Develop an appropriate, efficient and affordable migrant management policy with long-term vision for a balance of national, economic and health security for migrants and the Kingdom of Thailand in general - Recognize the significant contribution that migrants make to the Thai economy by developing a sound labor migration policy - Encourage and support all labor migrants and dependents to register with the government
2) Development of an official migrant health policy, migrant health service, and migrant health information system	- The development of an official migrant health framework/policy within the MOPH as a foundation mechanism to effectively respond to migrant health needs - Advocate and maintain a separation of issues relating to legal status and registration processes from the human and health rights of migrants to access the health service system - Develop and integrate a systematic migrant health service system into the standard structure of all MOPH departments at the central and peripheral levels to support front line public health personnel and to promote long-term systemic self-reliance - Establish a Migrant Health Unit at the central level within the MOPH to ensure more effective coordination within and outside the MOPH

Areas	Recommendations
	- Establish a Migrant Health Information System to bridge information gaps and inform future program development as well as to justify additional supports in order to effectively address issues
3) Demonstration of the transparency of the program at all levels	- Raise the profile of the positive contributions of labour migrants to Thai society and sensitize communities and society in general to provide non-judgmental and non-discriminatory health services - Advocate the provision of health services to migrants by demonstrating the transparency of the Program to the public health sector and other sectors that involve national security such as the National Security Council, the Governor, Local Administration Organization, Military and Police divisions at all levels
4) Scaling-up migrant health services by promoting good practices and effective strategies	- Expand the scope and scale of migrant health services to ensure increased access to essential health services to improve the health condition and health security of society as a whole - Capacity building and greater insight into the social determinants that influence migrant health, awareness and behavior among all public health stakeholders across communities and society - Official recognition and certification of MCHWs and Volunteers by the MOPH as skilled workers and integration into the existing Thai Village Health Volunteers network to ensure a collective response to community health issues

Areas	Recommendations
	- Innovative solutions that take into consideration the mobile characteristics and nature of migrant populations and an adjustment of health service protocols to respond to these characteristics - Promote and develop strategic communications with migrant communities to enable behavior change that educates and empowers migrants to take charge of their self and community health - Develop creative and innovative population-based approaches to expand the Program to engage hard to a reach population groups including seafarers - Streamline/restructure financing of migrant healthcare options to enable a more balanced, equitable and efficient financing mechanisms and cost recovery including the securing of private sector resources - Promote low or no cost health prevention and promotion by ensuring that a skillful health workforce, primarily MCHWs and volunteers, are maintained within the public health system to deliver basic health prevention strategies to their communities - Promote community participation and responsibility in self and community care to raise ownership of community health and wellbeing and to promote the concept of a good citizen who is aware of their responsibility to maintain health security of their host community - Utilize MCHW networks to address other social issues that impact on health such as awareness raising on preventive measures to reduce human trafficking

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

Source: Compiled and summarized from Nigoon (2009)

IV
Key constraints and gaps for HSS for migrants in Thailand

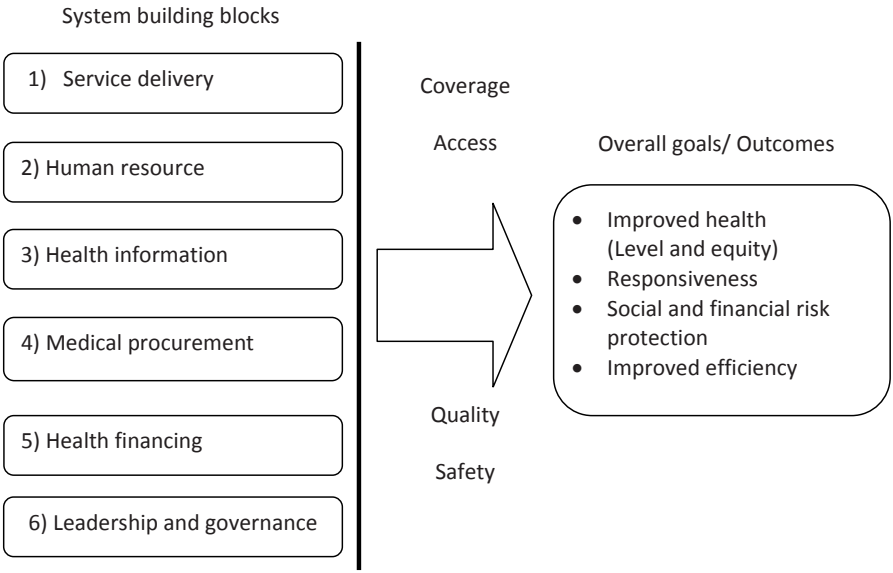
Part 4:

Key constraints and gaps for HSS for migrants in Thailand

From 1) comprehensive reviews of literature on migrant health and related health program in Thailand to date; 2) experience and opinion sharing during brainstorming meeting and conference recently held focusing on these issues[1]; and 3) discussions with academic and experts working on migration and health; key constraints and significant gaps to be overcome in order to move forward health system strengthening for migrants are indentified in this section.

[1] Including key outputs from; 1) The meeting on "The Challenges and Potential of Health System Strengthening for Non-Thais, Migrants and Dependents" organized by Raks Thai Foundation with collaboration from The Global Fund (Thailand) and the PHAMIT network during September 26-27, 2011; and 2) The 3rd National Migrant Health Conference Steering Committee, "Towards Universal Access to Health Care Services: Policy development, Implementation, and Challenges", 18-20 August 2010

Figure 4.1 : WHO's Health System Building Blocks



Source: Modified from World Health Organization (2007), Everybody's business: Strengthening Health System to Improve Health Outcome, p.3

Figure 4.1 illustrates the WHO's health system framework which identifies crucial components of the health system into 6 building blocks; including service delivery, human resource and workforce, health information, medical procurement (medicines and technology), health financing, and leadership and governances. To achieve overall goals of health system; improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources; intermediate goals are to achieve greater access to and coverage for effective health interventions (and protections). Identifying

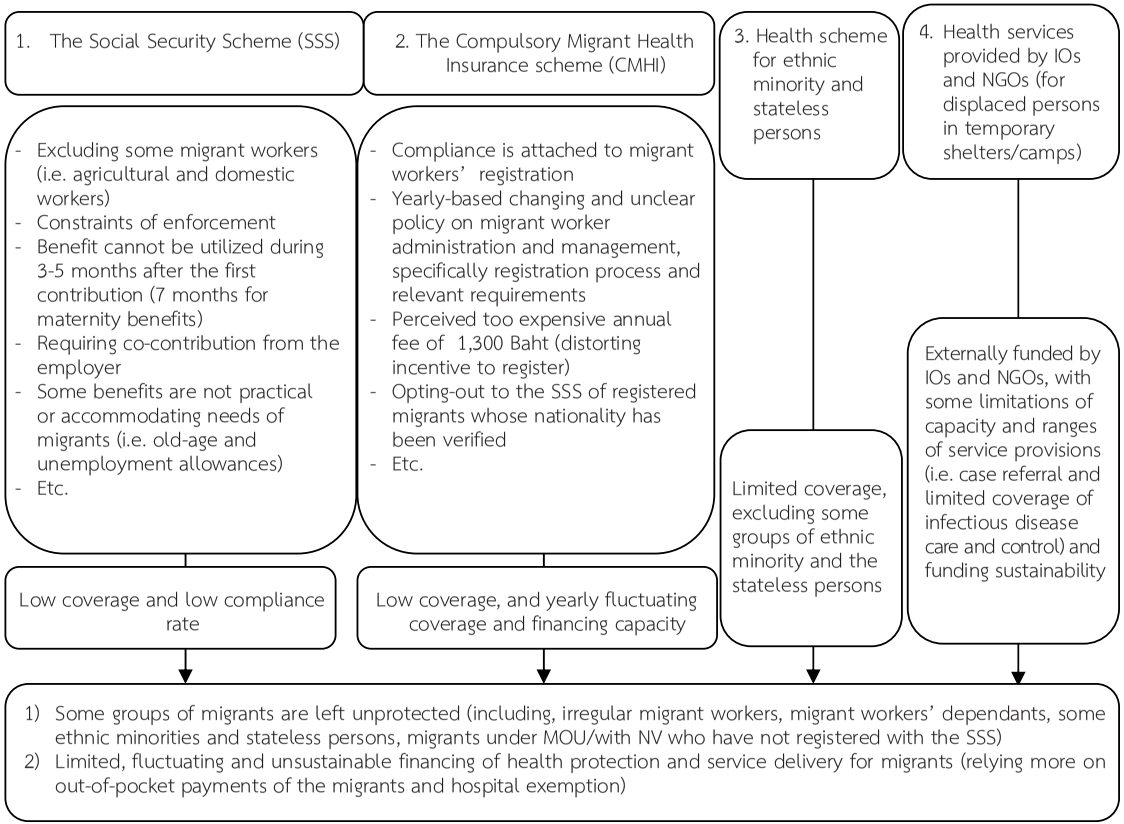
constraints and gaps for HSS for migrants in Thailand in this report is grounded on this framework for each building block and remaining unachieved intermediate goals.

Table 4.1 : List of obstacles/barriers of accessibility to health services of migrants

Financial factors	➽ Lacks of health insurance and protection, and entitlement to public welfare/assistance ➽ Accordingly, inability to pay for services and related expenses (i.e service fee, transportation costs)
Non-financial factors	➽ Illegal status (both residential and working statuses), resulting in fears of being arrested or abused refraining them from accessing needed health services ➽ Geographical factors (particularly, remoteness) and inability to access health facilities of some migrant groups (i.e. seafarers and highly mobilizing migrants) ➽ Inability to communicate (i.e. language barriers) and some health belief affecting health and care seeking behaviors ➽ Lacks of knowledge, information, awareness on rights and protection entitled to (for those with health insurance/SSS) ➽ Retained work permit and health card by the employer ➽ Time constraints (i.e. time spent for utilizing care and transportation, not allowing work-hours)

Improved access and coverage has been defined lie at the heart of health system strategy by the WHO (2007). Obstacles and barriers faced by migrants in accessing safety and quality health services can be identified into the financial and non-financial ones as summarized in Table 4.1. The latter, the non-financial barriers, appears crucial needing emphases in health system strengthening for the non-Thai population. These barriers interfere migrants in accessing needed care when falling sick, resulting in seeking behaviors that they would access to receive institutional care mostly when the conditions of sickness are severe (as evidently shown in earlier section).

Figure 4.2 : Limited coverage and unsustainable financing capacity of the existing health schemes and programs for migrants



In the aspect of "coverage", particularly coverage of health protection and insurance scheme among migrants, key constraints to be highlighted are on limited coverage and unsustainable financing capacity of the existing health schemes and programs for each migrant group[2]. These constraints and consequences are depicted in a simple diagram in Figure 4.2.

With respect to yet achieved intermediate goal of health systems in terms of "access" and "coverage" to migrant groups, the following tables provide lists of key factors and existing gaps suggested to be fulfilled under the HSS efforts in each particular building block to achieve its aims and desirable attributes.

[2] Limitations of coverage of health benefit provided under each scheme and program has been summarized in section 2.5.

Building block 1: Service delivery

Aims and desirable attributes	Gaps/Key constraints
Good **health services** are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources (WHO, 2007)	1) Incomplete coverage of health insurance scheme, and uneven benefit coverage entitled under each exiting scheme (for curative care, prevention and promotion, occupational health and work injury, outreach activities for health education and provision of health information) 2) Inaccessible services/inaccessibility of target migrant groups - Long distance to facilities, and restricted movement of (some) migrants, both those with legal and illegal status - Inflexible work-hours, time consuming care utilization, and (in some cases) not allowed by the employer - For those covered by health insurance: Fixed to access only at registered facilities, and exclusion of private hospitals. This is (in many cases) against nature of high mobility among migrant workers - Insufficient outreach activities and proactive service provisions, especially for health education, promotion and preventive work on specific infectious diseases among migrants; i.e. TB, Malaria, HIV/AIDS and STIs

Building block 1: Service delivery (Con't)

Aims and desirable attributes	Gaps/Key constraints
	3) <u>Constraints to efficiency, safety and quality of services delivered</u> - Negative attitudes of service providers - Communication barriers (especially, language and culture) - Limited capacity of facilities; i.e. financial and non-financial ones (i.e. burdens of hospital exemption, limited pooling of fund from health insurance, insufficient workforces) - Constraints of case referral - Fragmented and uncoordinated service provisions to unreached migrants, especially outreach activities for health education, health promotion and prevention - Discontinuity of service provision (i.e. for TB patients) caused by high mobility of migrants

Building block 2: Human resource

Aims and desirable attributes	Gaps/Key constraints
A well-performing **health workforce** is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances (WHO, 2007)	1) Inadequate human resources (quantity) i.e. number and mixes of staff/personnel 2) Unresponsiveness (quality and capacity) caused by, - Negative attitudes of service providers - Problems with awareness, understandings and doubts of service providers on rights that the migrants are entitled to (including human rights, legal rights and rights entitled by health insurance) - Communication barriers (especially, language and culture) 3) Needs of supporting health workforce for service provision to migrants; i.e. Migrant Health Workers (MHWs), Migrant Health Volunteers (MHVs), interpreters, etc. - Existing in some areas but with limited coverage, limited capacity, and discontinuously employed - MHWs are not yet recognized by law, quasi-legally (disguisedly) employed as “domestic workers” in health facilities or by NGOs

HSS

Building block 3: Health information

Aims and desirable attributes	Gaps/Key constraints
A well-functioning **health information system** is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants health systems performance and health status (WHO, 2007)	1) Lacks of sufficient information of migrant population, especially irregular migrant workers and dependants (demographic and health profiles; i.e. health status and determinants, morbidity, care seeking behaviors) 2) Data from routine health information system is scarce, usually attached to information system of the Thais, fragmented and unable to represent the whole picture of migrants (only some reachable groups), inaccurate with data errors caused by rush work and manual errors, inefficient and difficult to identify migrants and their status. Information system needs to be strengthened and expanded in scope of information and geography 3) Routine information system is centralized with insufficient coordination from other relevant stakeholders, especially local authorities (i.e. TAOs, community leaders) who can play crucial roles in the provision of updated surveys or census monitoring basic information of migrant population 4) Existing data about migrants is incomparable from different sources, consequently, not utilized effectively in generating useful information. There is no cross-cutting analysis from existing survey results. Lacks of advocacy on knowledge building, information sharing (i.e. from routine system, across health insurance funds), and research-based/ evidence-based activities

Building block 3: Health information (Con't)

Aims and desirable attributes	Gaps/Key constraints
	5) Lacks of monitoring and evaluation mechanism on the performance of health system for migrants 6) Insufficient IT and technical supports: At operating level, strengthening health information system of migrants is not given yet priority

Building block 4: Medical procurement

Aims and desirable attributes	Gaps/Key constraints
A well-functioning health system ensures equitable access to essential **medical products, vaccines and technologies** of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use. (WHO, 2007)	1) Constraints of health insurance coverage and benefit provided (i.e. AZT for HIV infected migrant mothers is not covered for those without insurance). For those with health insurance, some treatments are not covered within the benefit packages (i.e. ART, hemodialysis) 2) Obstacles/barriers in accessing health services of the migrants and of the "service delivery" building block 3) Some vaccines are not provided; i.e. Japanese B, Hepatitis B vaccines

Building block 5: Health financing

Aims and desirable attributes	Gaps/Key constraints
A good **health financing** system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them (WHO, 2007)	1) Constraints of limited, fluctuating and unsustainable financial resources and pooling of existing health insurance for migrants and external funding: - Low and fluctuating coverage of CMHI and SSS (mainly due to attachment to registration, work permit and nationality verification process, and ineffective enforcement) - Limited coverage of health scheme for ethnic minority and stateless persons, excluding some groups of ethnic minority and the stateless persons - Health services provided (for displaced persons in 9 camps externally funded by IOs and NGOs which in quest of sustainability) - Health education, outreach activities, and proactive preventive works on some infectious diseases (i.e. HIV/AIDS, TB, STIs) are mainly funded by external donors 2) Uneven coverage of health benefits under existing health insurance, and fragmented administrative body of existing funds (i.e. CMHI, SSS, health benefits for ethnic minorities and stateless persons) - Occupational health and work injury is not covered by CHMI - Disease prevention and health promotion is not covered by SSS - Some uncovered costs, such as costs of translation and interpreter

Building block 5: Health financing (Con't)

Aims and desirable attributes	Gaps/Key constraints
	3) Huge reliance on out-of-pocket payments and hospital exemptions, resulting in financial risks to the migrants (especially, irregular migrants and dependants) and burdens to health facilities from uncollectable fees 4) Yet pooling from additional potential financing sources, especially local administrative authorities, private sectors beneficial from migrant workers 5) Lack of monitoring and evaluating mechanism on financing performance and efficiency (for the whole system and for each health fund)

Building block 6: Leadership and governance

Aims and desirable attributes	Gaps/Key constraints
Leadership and governance involves ensuring strategic policy frameworks existed and are combined with effective oversight, coalition building, the provision of appropriate regulations and incentives, attention to system-design, and accountability (WHO, 2007)	1) Unclear recognitions of the migrants' rights (especially, in aspects of "health", of irregular migrant workers and dependants) among policy makers and relevant stakeholders due to controversy between the principles of national security (reflecting on legal contexts and immigrant laws), economic security of the nation, and human rights of migrants 2) Lacks of "appropriate migrant health policy" due to limitations of health information, and "national guidelines" for service provisions to migrants, resulting in variation of service practices and management 3) Insufficient multilateral/multi-sectoral/multi-level/ integrative collaboration among relevant stakeholders (including governmental organizations, NGOs, IOs, private or business sector, local administrative agencies, donors, academic institute, medias, communities and also migrants themselves) 4) Constraints of health insurance governance - Ineffective enforcement (especially, the low compliance rate of migrants under MOU (imported and NV) to the SSS) - Enrollment to health insurance (of the CMHI and the SSS) which is attached to registration, work permit and NV process

Building block 6: Leadership and governance (Con't)

Aims and desirable attributes	Gaps/ Key constraints
	- Inefficiency due to inappropriate financing mechanism (i.e service purchasers and providers are mostly identical for the CMHI and health benefits for ethnic minorities and stateless person) 5) Lacks of monitoring and evaluating mechanisms on the achievements and constraints of the "Master Plan for Border Health" and other relevant migrant health policies 6) Inefficient administrative and management system of health system for migrants due to limitations of health information

V
Recommendations for HSS for migrants

Part 5:
Recommendations for HSS for migrants

Synthesized from reviews, experiences and lesson learned from previous migrant health program (in Part 3), brainstorming meeting and conference on improving health system for migrants; inter-connections of key constraints and gaps defined in the last section (in Part 4) are illustrated in Figure 5.1. According to presented systematic linkages in the figure, it is suggested that HSS for migrants' priorities should be given to "leadership and governance", "health information" and "health financing" building blocks.

Particular recommendations for strengthening of each building block of the health system for migrants, and as well external determinants, are provided in Table 5.1.

Figure 5.1: Systematic linkages of key constraints in the 6 building blocks of health system for migrants in Thailand

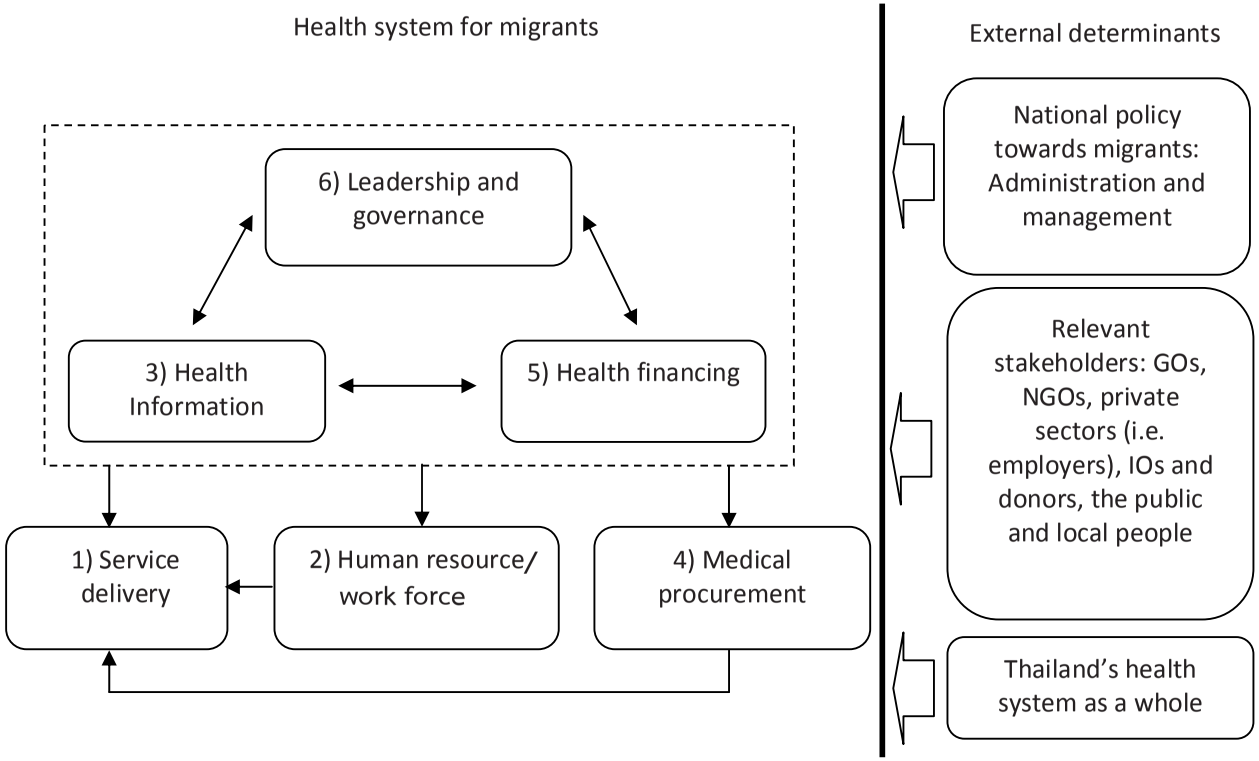


Table 5.1 : Recommendations for HSS for migrants

Building blocks	Recommendations
1) Service delivery	• Comprehensive interventions on maternal and child health (i.e. expansion of vaccination coverage among migrant children, prenatal and antenatal care, family planning) • Intensive provisions of health education, promotion and prevention, knowledge and awareness of entitled health rights to encourage accessibility and service utilization of the migrants, through regular outreach activities with collaboration from networks of local health providers • Promoting the concept of "migrant-friendly health services" • Appropriate service delivery system for different contexts and settings (i.e. rural and isolated, urban, workplace, and cross-cutting setting) of migrants. This can be done by scaling-up or replicating migrant health services from program implementation approaches and good practices developed by the Migrant Health Program (summarized in Part III)*

Building blocks	Recommendations
2) Human resource/ work force	• Advocacy for capacity-building and empowering MWHs and MHVs through the legalization of their employment status, provisions of standardized training and skill development; with a recognition of necessity for specific language interpreter in health facilities, and outreach activities to migrants (i.e. health education, promotion and prevention)*
3) Health information	• Development of integrative information system, with target on irregular/undocumented migrants (i.e. "Community-based active surveillance system" as a complimentary migrant health information system) • Strengthening the routine migrant health information system to produce complete and reliable information relevant to health determinants and health status of migrants, and health system performance for "evidence - based" policy advocacy, planning and guiding direction **
4) Medical procurement	• Coverage of AZT, ARV for HIV infected migrants • Universal provisions of medicines and vaccines necessary for caring and preventing specific infectious diseases (i.e. HIV infected migrant mothers, TB, Japanese B and Hepatitis B vaccines) which is unconditioned by the migrants' status • Collaboration from drug store and private clinics in migrant-rich communities

Building blocks	Recommendations
5) Health financing	• Additional financing sources to assist health facilities burdened with "hospital exemption" for poor migrants/uninsured migrants (i.e. government subsidy/budget, contributions or funding from local administrative authorities, and private or business sector) • Expansion of CMHI or development of additional insurance schemes on a compulsory-basis to cover irregular migrant workers and dependants (i.e. CMHI is suggested not to solely attach with migrant workers' registration and work permit process), and expansion of benefits for "occupational health" and "work injury compensation" • Revised SSS which accommodates better needs and contextual status of migrants, to induce more incentive and higher compliance rate among MOU (imported and NV) migrant workers
6) Leadership and governance	• Development of "National agenda" and "Official policy" on migrants and migrant health issues with collaboration from all relevant stakeholders (including GOs, NGOs, IOs, donors, academic institute, journalist and media, civil society and communities, private and business sector, and also migrants) • Development of "National guidelines" for service provisions to migrants • Management of health insurance and financing on "area-based approach" (rather than "issue-based approach"). Migrant groups in each area have different contexts.

Building blocks	Recommendations
	• Effective enforcement on health insurance enrolment of the migrants (on a "compulsory-basis") • Expansion or imitation of existing initiatives and activities those are successfully implemented in pilot areas (i.e. Ranong Model, Samutsakorn Model, NGOs' outreach activities) • Advocacy for research-based/evidence-based/ lesson-learned policy making, cross-cutting disseminations of existing information about migrants from routine data and survey results • Monitoring and evaluating mechanism in assessing each building block of health system for migrants • Empowerment and capacity-building to local administrative authorities and community leaders on public health for migrants, specifically for the strengthening of service delivery (i.e. health posts, provisions of basic care and outreach activities), workforces (i.e. MHWs and MHVs), and information (i.e. population survey, community-based active surveillance system, monitoring and evaluating health system performances) • Appropriate health system management (of all building blocks) which can accommodate the "high mobility" or migrants (especially, irregular or unregistered migrants)

Building blocks	Recommendations
External determinants	• Development of national policy for the administration and management mechanism of migrants on a "long-term" basis (i.e. migrant workers' registration and NV process, and others regulation relevant to rights and legal status of migrants) with coordination and collaborative consensus from all relevant policy agencies (including MOI, MOL, MOPH, Ministry of Defense, Royal Thai Police and Ministry of Foreign Affairs) • Accurate, complete and well-performing database system of migrants in the country • Creating positive attitudes of the public towards migrants by building up awareness and understanding of the migrants' contribution to the country

Note: * See some specific interventions suggested in Table 3.3 (Part 3, section 3.3)

** See some specific interventions suggested in Table 2.14 (Part 2, section 2.6)

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