

**Joint Review (MOPH-WHO)  
on Preparedness and Response  
to  
Pandemic Influenza (H1N1) with focus  
on vulnerable non-Thai populations**

**23 November – 6 December 2009**

# Contents

	<b>Page</b>
Contents	2
Abbreviations	3
<b>Executive summary</b>	<b>5</b>
<b>1. Introduction</b>	<b>8</b>
<b>2. Review methodology</b>	<b>8</b>
<b>3. Key findings</b>	<b>9</b>
3.1 Displaced persons in temporary shelters (camp)	9
3.2 Registered migrants	10
3.3 Unregistered migrants	12
<b>4. Recommendations</b>	<b>12</b>
4.1 Displaced persons in temporary shelters (camp)	12
4.2 Registered and unregistered migrants	13
4.3 Unregistered migrants	14
<b>5. Overarching issues in migrant health</b>	<b>14</b>
5.1 Issue: Political commitment	14
5.2 Issue: Policy consistency	15
5.3 Issue: Budget	15
5.4 Issue: National Preparedness Plan	15
5.5 Issue: Health seeking behaviour	16
<b>Annexes</b>	
I. Terms of Reference	17
II. Programme	18
III. People met	23
IV. List of relevant documents	27
V. Matrix for displaced persons living in temporary shelters (Thai-Myanmar border)	29
VI. Matrix for registered and unregistered migrant	34

## Abbreviations

AI	Avian Influenza
AMI	Aide Medicale Internationale
BCC	Behaviour Change Communication
BCP	Business Continuity Plan
BHSSD	Bureau of Health Service System Development
BOE	Bureau of Epidemiology
CCSDPT	Committee for Coordination of Services to Displaced Persons in Thailand
CDC	Centres for Diseases Control and Prevention
CPG	Clinical Practice Guideline
DDC	Department of Diseases Control
DHSS	Department of Health Service Support
DHO	District Health Office
HIS	Health Information System
IC	Infection Control
IEC	Information Education and Communication
ILI	Influenza Like Illness
IRC	International Rescue Committee
IOM	International Organization for Migration
MHW	Migrant Health Worker
MHV	Migrant Health Volunteer
MI	Malteser International
MOI	Ministry of Interior
MOL	Ministry of Labour
MOPH	Ministry of Public Health
NGO	Non-Governmental Organization
ODPC	Office of Disease Prevention and Control
OPD	Out Patient Department
OPDC	Operation Centre for Displaced Persons
PHO	Provincial Health Office
PPE	Personal Protective Equipment
PPP	Pandemic Preparedness Plan
RI	Respiratory Tract Infection
RTG	Royal Thai Government
RT-PCR	Real-Time Reverse Transcription Chain Reaction
SMRU	Shoklo Malaria Research Unit
SOP	Standard Operating Procedure

TB	Tuberculosis
TBBC	Thailand Burmese Border Consortium
UN	United Nations
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children Funds
WHO	World Health Organization

## **Executive Summary**

The Royal Thai Government (RTG) is currently undertaking a review of the Thai strategic response to pandemic H1N1 in collaboration with the World Health Organization (WHO). The current review, focusing on vulnerable populations is the seventh in this series.

There is an estimated 2.4 million non-Thai people who work or live in Thailand of which more than 80% from countries in the Greater Mekong Subregion. There are four main categories of non-Thai people: 1) displaced persons in temporary shelters, 2) registered migrants, 3) unregistered migrants and 4) stateless people (mainly registered through “colored Identification cards”). Unregistered migrants probably constitute 1.2-1.5 million people of which approximately 80% are from Myanmar.

Unregistered migrants may constitute a reservoir of high-risk populations for pandemic influenza, if they are not reached by the surveillance system and are reluctant to seek public health services including health education.

The review applied three methods: 1) A review of relevant documentation, 2) Field trips to temporary shelters (camps) where displaced persons reside and to provinces where large numbers of migrants live and 3) interviews and meetings with major stakeholders in Bangkok.

### **Major findings:**

The health of the populations in the camps along the border to Myanmar is entirely taken care of by a number of Non-Governmental Organizations (NGO's) with external funding. Ministry of Public Health (MOPH), Provincial Health Offices (PHO's) and District Health Offices (DHO's) play a supportive role. There is a good relationship between the NGOs and the health authorities.

In general, camp populations receive adequate basic health care and surveillance for major communicable diseases including Influenza Like Illness (ILI) is functioning.

The major problems are 1) the cramped living condition which facilitate rapid spread of communicable diseases, 2) the lack of plans for H1N1 vaccination of health staff servicing the camps and 3) limited surge capacity especially of staff, 4) training on Clinical Practice Guidelines (CPGs) has not been conducted in all provinces for health staff that supervise medics in the camps and 5) production and dissemination of health education and information material is fragmented and uncoordinated across key stakeholders.

Health services provided to migrants by public health institutions do not differ from that provided to Thai people. In terms of pandemic preparedness and response there are few significant disparities. Plans and implementation capacities are considered sufficient to handle an epidemic well though the areas of diseases surveillance and communication and public relations are relatively weak.

The Migrant Health Worker (MHW)/Migrant health Volunteer (MHV) system is a cornerstone in the services but the coverage is much less than in Thai populations and the networks of MHW/MHV are too thin to provide active diseases surveillance and reach migrants with relevant health education material and messages. Furthermore, since most MHW's are externally funded this jeopardizes long-term sustainability.

There is no discrimination between registered and non-registered migrants in the health sector regardless of ability to pay and all receive the same treatment at health facilities regardless of status.

The health seeking behaviour of unregistered migrants is not extensively surveyed and the gaps in surveillance are not known. It is likely to be much less sensitive than for the rest of population groups in Thailand.

The production of health education and information material in relevant languages is insufficient and messages do not reach all target populations.

### **Major recommendations:**

#### **Displaced persons:**

- Standard Operating Procedures (SOPs) for pandemic preparedness in all hospitals and DHO's, which are consistent with each other must be developed.
- MOPH/BOE should include camps in the exemption scheme for payments of lab tests.
- A vaccination strategy for camp health staff should be developed and MOPH/PHO requested to provide H1N1 vaccines accordingly.
- Preventive and care measures should be reinforced in all camps and messages spread to through MHW/volunteers, teachers and camp committees.

#### **Migrants**

- MOPH, WHO and other concerned agencies should advocate for a policy change that allows PHO's/DHO's to use the government budget to employ MHWs.
- MOPH with the support from Intergovernmental Organizations (IGO's) and NGO's should expand the MHW/MHV system to a level similar to Thai communities.
- PHO's/DHO's should strengthen surveillance networks (MHW/MHV) that reach unregistered migrant through employers, NGO and IGO that work with migrants.
- PHO's/DHO's should facilitate measures that will increase health care seeking from public health institutions through employers, NGO's and IGO's
- A mechanism for coordination of production and distribution of Information Education and Communication (IEC) material between MOPH, PHO's and NGO's should be established.
- PHO's should identify focal points in each province to facilitate systematic production and distribution of IEC material and coordinate with MOPH/Bureau of Health Service System Development (BHSSD) central level.
- MOPH/BHSSD should establish a mechanism for coordinated materials production (including that produced by Thai Health Promotion Foundation) and distribution in migrant languages.
- In collaboration with PHO/DHO, NGO's should consider producing more IEC material in relevant languages. Support should be explored from United Nations Children Funds (UNICEF) or other available funding sources.
- Health care providers in collaboration with employers, NGO's and IGO's that works for migrants should ensure that health education material is produced which target unregistered migrants.

### **Overarching recommendations:**

There are a number of important challenges to improving the health of migrants in Thailand. Among these are 1) the political commitment towards the consistency of the registration system, 2) the budgetary constraints, 3) the perception of the National Preparedness Plan and the 4) limited knowledge about the health seeking behaviour of unregistered migrants. In order to address these, the following recommendations are put forward.

- MOPH should discuss and facilitate with the Parliament and Senate Health committees' visits to camps and migrant communities in border provinces.

- WHO, United Nations High Commissioner for Refugee (UNHCR) and International Organization for Migration (IOM) should accelerate their agenda for dialogue with the RTG to promote migrant-friendly policies.
- The registration system for migrants should not be changed from year to year. Long-term consistency of the system should be promoted by RTG. This could include changing the one-year registration period to a longer duration.
- RTG should adapt the existing migrant health insurance scheme so that it is tailored to the needs of migrants and their employers.
- MOPH and WHO should advocate for a change in the legal provisions governing allocation of funds from the National Health Security Office (NHSO) to allow for budgets being provided for non-Thais.
- MOPH with the support from WHO and IOM should develop and pilot one or several of the financing options presented in the “Financing Health Care for Migrants” study such as a social/community health insurance scheme that will cover health services for unregistered migrants.
- All dependants of migrants should be included in the current health insurance scheme.
- The next revision of the National Preparedness Plan should state that the plan will cover ALL people in Thailand (regardless of Nationality)
- A meta-review of existing documentation on health seeking behaviour among unregistered migrants should be conducted. The review should identify major knowledge gaps and propose ways to bridge these knowledge gaps.

# 1. Introduction

The Royal Thai Government is currently undertaking a review of the Thai strategic response to pandemic H1N1 2009 in collaboration with the World Health Organization. This work has been divided into the following technical areas:

1. Surveillance and epidemiology
2. Laboratory capacity
3. Risk assessment and control/prevention measures, including infection control
4. Clinical management
5. Logistics, commodities and operations
6. Public communications
7. Special policies and measures for vulnerable, non-Thai populations residing in Thailand

The current review is the seventh in this series. The Terms of Reference is included in Annex I.

There is an estimated 2.4 million non-Thai people who work or live in Thailand of which more than 80% originate from countries in the Greater Mekong Subregion. There are four main categories of non-Thai people: 1) displaced persons in temporary shelters (camps), 2) registered migrants, 3) unregistered migrants and 4) stateless people (mainly registered through “colored IDs”). There are various estimates on the number of unregistered migrants. They probably constitute 1.2 – 1.5 million people of which app.80% are from Myanmar. Around one million migrants from Myanmar live in the border provinces of Thailand of which 140,000 live in temporary shelters (camps). People living in the camps for displaced persons have good access to basic health care provided mainly by NGO’s.

Outside the camps, migrants who register and obtain work permits are eligible for health insurance. Through this, they enjoy the same health services as Thai people. The health status and health seeking behaviour of unregistered migrants has been subject to various surveys but no comprehensive review of available information exists. Over recent years there have been variable efforts to have migrants register so that they can obtain work permits and be included in the Migrant Health Insurance Scheme. In 2009 this drive has been strong and so far approximately 1.2 million migrants have registered and the process is still on going. Recently this scheme has been extended to their children under 15 years of age, but other dependants are not covered.

It is possible that unregistered migrants constitute a reservoir of high-risk populations for pandemic influenza, if they are not reached by the surveillance system and are reluctant to seek public health services including health education. The focus of this review has been on this category.

## 2. Review methodology

The review applied three methods to explore pandemic preparedness and responses in displaced persons and migrants in Thailand.

1. A review of relevant documentation including six previous reviews of influenza preparedness and response components. The list of documents reviewed is shown in Annex IV.
2. Field trips to temporary shelters (camps) where displaced persons reside and to provinces where large numbers of migrants live. The following provinces were visited: Tak, Mae Hong Son, Bangkok, Samut Sakhon and Trat. The detailed programme is included in Annex 2. During the field trip interviews were held with stakeholders and

meetings were organized by provincial and district health authorities with health staff and with other relevant agencies.

3. Interviews and meetings with major stakeholders in Bangkok: MOPH, Ministry of Interior (MOI), Ministry of Labour (MOL), UNHCR, IOM.

A final debriefing was held at MOPH with a range of stakeholders to present key findings and recommendations and obtain inputs to the final report.

### **3. Key findings**

This review focus on those issues related to pandemic influenza preparedness and response that are specific to the displaced and migrant populations. In order to structure the findings they have been assessed across the six technical categories that have been the subject of earlier reviews. Additionally, pandemic preparedness planning as well as command and coordination mechanisms have been included. For each area, strength, challenges and recommendations have been formulated. These are presented in Annex V and VI, where registered and non-registered migrants are grouped together in Annex VI, but where differences between the two populations were found these have been mentioned.

In this chapter the most important findings are presented with emphasis on challenges.

#### **3.1 Displaced persons in temporary shelters (camps)**

##### **Overall:**

The health of the populations in the shelters along the border to Myanmar is entirely taken care of by a number of NGO's with external funding. MOPH, PHO's and DHO's play a supportive role but do not normally access the camps, which is controlled by MOI.

There is a good relationship between the NGO's and the health authorities. Examples are technical support on disease surveillance & outbreaks response, training and the provision of Tamiflu from MOPH to NGO's serving camp populations. There is also good coordination between the NGO's, which have developed their PPPs using a common format. They also provide consolidated health data to Committee for Coordination of Services to Displaced Persons in Thailand (CCSDPT) Health Information System (HIS) Coordinator who usually provides them and relevant partners with feedback on a weekly and monthly basis.

In general, camp populations receive adequate basic health care and passive surveillance for 13 major communicable diseases including ILI is functioning well supported by medics and surveillance nurses/doctors in each camp. However as ILI was added into the surveillance system in September 2009 there is no previous data to help formulate the thresholds in camps. In terms of health education there is a range of activities taking place. The referral system is functioning with support from district hospitals and provincial hospitals. In terms of health status the picture appear similar to that of Thai people in the areas.

The major challenges are 1) the cramped condition in camps which facilitate rapid spread of communicable disease, 2) the lack of plans for H1N1 vaccination of health staff servicing the camps, 3) limited surge capacity especially of staff and 4) training on CPGs has not been conducted in all provinces for health staff that supervise medics in the camps.

## **Specifically:**

- a) ***Pandemic Preparedness Plan (PPP) and command and coordination.***
  - Not all public hospitals have written SOPs for pandemic preparedness.
- b) ***Surveillance and epidemiology***
  - Threshold levels triggering outbreak alerts on ILI have not been established.
  - No active surveillance system has been initiated.
  - Timely information sharing between local health authorities and NGOs can be a problem. If outbreaks occur near camps, camp staff is not always informed.
- c) ***Clinical management***
  - Some public hospitals (that act as referral hospitals for camps) have limited capacity to care for severe respiratory illness.
  - Training on CPGs has not been conducted in all provinces for health staff that supervise medics in the camps.
- d) ***Laboratory capacity***
  - It takes several days before lab results are received from the government regional laboratory centres.
  - Each test is quite expensive, limiting the numbers of tests done.
- e) ***Infection control and preventive measures***
  - Monitoring of use of masks among health staff and patients in camps is not conducted comprehensively.
  - Guidelines in use of Personal Protective Equipment (PPE) are not always available or are inconsistent.
- f) ***Public communication***
  - IEC materiel in languages of camp populations is only available in limited quantities and languages.
  - Camp staff with a potential as health communicators, e.g. teachers are not involved.
  - Production and dissemination of health education and information material is fragmented and uncoordinated across key stakeholders (MOPH, PHO's, NGOs, international agencies).
- g) ***Logistics, commodities and operations***
  - Replenishment mechanisms for Tamiflu may not be adequate in case of major epidemics.

## **3.2 Registered migrants**

### **Overall:**

Health services provided in public health institutions in Thailand do not differ between Thai people and non-Thai people. In terms of pandemic preparedness and response there are few significant disparities. PPPs at provincial level comprise all people living and all relevant agencies in the area concerned. Capacities in various areas are considered sufficient to handle an epidemic reasonably effectively, except in the areas of disease surveillance and communication and public relations. This strength is especially found in provinces where NGO's support the work.

The MHW/MHVs are cornerstones in the services but the coverage is much less than in Thai populations. There are a number of general factors - mostly of policy nature - that hinder the health sector in effectively reaching out to migrants. These are described in Chapter 5.

The major weaknesses are the thin networks of MHW/MHV that help promote the active diseases surveillances and the limited reach with relevant health education material and messages.

**Specifically:**

**a) *PPP and command and coordination***

- At provincial level there are some key staffs who are not familiar with the national/provincial strategy and who do not know their responsibilities in case of an outbreak.
- Not all hospitals have written Standard Operating Procedure (SOP)/Business Continuity Plan (BCP) and they have only conducted tabletop drills.

**b) *Surveillance and epidemiology***

- The key to effective surveillance lies in the migrant health worker/volunteer networks but the reporting system is not properly standardised: e.g. data to be reported or reporting mechanism.
- Most MHW's are externally funded which in the long-term make it an unsustainable system.
- The MHW/MHV ratio per number of households is often much below Thai standards.
- There is an informal cross-border surveillance system (twin villages) in place and functional in several border districts in a province.

**c) *Clinical management***

- The capacity for treatment of severe respiratory illness will be inadequate in case of large outbreaks.

**d) *Laboratory capacity***

- The cost of lab tests is quite high limiting their use.

**e) *Infection control and preventive measures***

- The layout of some district and provincial hospitals makes it difficult to separate Respiratory Tract Infection (RTI) Out Patient Departments (OPDs) from other OPD patients.
- In the community many live under crowded and unhygienic conditions making social distancing difficult.

**f) *Public communication***

- Production of IEC material is fragmented and uncoordinated. Existing IEC material is not utilized efficiently.
- The distribution of IEC material, esp. in migrant languages appear ineffective from central level to periphery.
- Employers are not well informed about the epidemic and preventive measures in some provinces.

**g) *Logistics, commodities and operations***

- There are no specific challenges identified in this area.

### 3.3 Unregistered migrants

#### Overall:

There is no discrimination between registered and non-registered migrants by the health sector regardless of ability to pay and they receive the same treatment at health facilities regardless of status. Obstacles to health seeking are mainly associated with the poverty of unregistered migrants that may make it difficult for them to pay for transportation and/or be absent from work. There are several studies of their health seeking behaviour, but no comprehensive analysis of knowledge gaps in this area exist. Such an analysis would help identify specific obstacles to health care provision and health seeking behavior for unregistered migrants. Likely obstacles could be a lower sensitivity of surveillance for epidemic diseases and limited reach with health education and information.

The decentralised health system in Thailand means that the provinces may apply different strategies towards these populations. However, in provinces visited differences are small and the only major area identified was that of payments for referral to tertiary institutions outside the provinces.

There are three areas where this group differ significantly from registered migrants. They are:

#### *a) Surveillance and epidemiology*

- The health seeking behaviour is not extensively surveyed and the gaps in surveillance are not known. It is likely to be much less sensitive than for the rest of population groups residing in Thailand.
- The number of unregistered migrant is likely to be large and the many unknowns: number, distribution, movement patterns, dependants make it difficult to design effective surveillance in this group.

#### *b) Clinical management*

- It is assumed that they often resort to treatment from drug dealers and refrain from visiting the formal health system.

#### *c) Public communication*

- The production of health education and information material in relevant languages is insufficient and messages may not reach target populations. No material exists in certain languages, e.g. Khmer.

## 4. Recommendations

### 4.1 Displaced persons in temporary shelters

- SOPs for pandemic preparedness in all hospitals and DHO's, which are consistent with each other must be developed. The technical support could be mobilised from PHO and IOM.
- MOPH/ Bureau of Epidemiology (BOE) should include camps in the exemption scheme for payments of lab tests.
- The feasibility of expanding the Shoklo Malaria Research Unit (SRMU) lab services to include other camps should be explored by PHO's and relevant NGOs. This could be initiated by medical NGO's directly with SMRU.

- CPGs that have been translated to Karen should be shared with all camps where medics (and people) speak this language. This could be facilitated by CCSDPT.
- Province/district health offices should have a clear mechanism for updating NGO's when new guidelines are issued.
- Preventive and care measures should be reinforced in all camps and messages spread to communities through MHW/volunteers, teachers and camp committees.
- Medical NGOs should identify people in risk groups in all camps. CCSDPT HIS coordinator should be able to track the numbers for all camps and help liaise with MOPH at central level in case support is needed
- Guidelines for use of PPE should be developed and imparted on all health staff in camps. WHO can be contacted if a prototype is needed.
- Medical NGOs should ensure that the use of PPE be included in drills or infection control training among health staff, patients and general population.
- A forum for IC nurses working in camps, public hospitals and PHO's to regularly discuss IC measures should be established.
- In collaboration with PHO/DHO, NGOs should consider to produce more IEC material in relevant languages. Support should be explored from UNICEF or other available funding sources.
- A mechanism for coordination of production and distribution of IEC material between MOPH, PHO's and NGO's should be established.
- CCSDPT through Medical NGOs should make estimates for PPE requirements that include other groups besides health personnel. If external support is needed, CCSDPT must explicitly seek support from MOPH/ WHO or Centers for Disease Control and Prevention (CDC).
- A vaccination strategy for camp health staff should be developed and MOPH/PHO requested to provide H1N1 vaccines according to the strategy.

## **4.2 Registered and unregistered migrants**

- The collaboration among all ministries involved with migrants should be strengthened and regular drills that include migrants conducted at provincial and district levels.
- All PHO's/DHO's and hospitals should conduct drills of their BCP/SOPs as to ensure that all key staff knows their roles and responsibilities. Support can be mobilised from NGO's and IGO's (e.g. International Rescue Committee (IRC) and IOM).
- MOPH, WHO and other concerned agencies should advocate a policy change that allows PHO/DHO to use the government budget to employ MHW.
- MOPH - with the support from NGO and IGO, if needed - should expand the MHW/MHV system to a level similar to Thai communities.

- PHOs/DHOs, hospital and health centres should consider strengthening community participation, including MHVs in the surveillance system. Technical support can be sought from BOE and WHO
- All health services providers should reinforce the use of PPE with health staff and communities.
- PHO's should identify focal points in each province to facilitate systematic production and distribution of IEC material and coordinate with MOPH/BHSSD at central level.
- MOPH/BHSSD should establish a mechanism for coordinated materials production (including that produced by Thai Health Promotion Foundation) and distribution in migrant languages.
- PHO's/DHO's and hospitals should increase involvement of employers in distribution of IEC material and imparting health messages to their workers. Provincial employment offices can help reaching to employers.
- PHO's/Hospitals should consider strengthening Behaviour Change Communication (BCC) among migrants. Support can be sought from NGOs and IGO's working with migrants e.g. IOM, IRC and Raks Thai foundation.
- MOPH/BHSSD should intensively advocate including all dependants of migrant workers in the migrant health insurance scheme.

### **4.3 Unregistered migrants**

- PHO's/DHO's, hospitals and health centres should strengthen surveillance networks (MHW/MHV) that reach unregistered migrant through employers, NGO and IGO that work with migrants.
- PHOs/DHOs, hospitals and health centres should facilitate measures that will increase health care seeking from public health institutions through employers, NGO and IGO that work with migrants.
- Health care providers in collaboration with employers, NGOs and IGOs that works for migrants should ensure that health education material is produced which target unregistered migrants.

## **5. Overarching issues in migrant health**

### **5.1 Issue: Political commitment**

The political commitment to solve critical issues in migrant health has varied over time, though migrants contribute significantly to Thailand's socio-economic development.

There is a discrepancy between the approaches to education for migrants versus that of health. The education sector provides more services and reach further out to accommodate migrant children.

### **Recommendations:**

- MOPH should discuss and facilitate with the Parliament and Senate Health committees' visits to camps and migrants in border provinces. (similar to the education committee visits).
- WHO, UNHCR and IOM should accelerate the agenda within the United Nations (UN) system on changes in government policies and the dialogue with the RTG to promote required migrant-friendly policies.

## **5.2 Issue: Policy consistency**

The approach to registration – and thus to health insurance – has differed significantly in recent year with the result that the number of registered migrants fluctuate considerably from year to year. In 2009 the drive has been strong and the number of registrations has increased sharply. A more consistent policy would benefit migrants and provide more sustainable financing to provinces that harbour the largest number of migrants (e.g. Tak, Mae Hong Song and Ranong).

### **Recommendation:**

- The registration system for migrants should not be changed from year to year. Long-term consistency of the system should be promoted by RTG. This could include changing the one-year registration period to a longer duration.

## **5.3 Issue: Budget**

Financing health services for unregistered migrants constitute a major problem for provinces (e.g. Tak) with large numbers of these groups, whereas provinces (e.g. Samut Sakhon) where most migrants are registered do not face similar budgetary constraints. It is therefore desirable to develop and introduce a new financing mechanism. A study by the Health Insurance System Research Office presents several options for an innovative financing (Annex IV, 26).

### **Recommendations:**

- MOPH should adapt the existing migrant health insurance scheme so that it is tailored (e.g. seasonal work) to the needs of migrants and their employers.
- MOPH and WHO should advocate changing the legal provisions that governs the allocation of funds from the National Health Security Office to allow for budgets being provided for non-Thais.
- MOPH with the support from WHO and IOM to develop and pilot one or several of the financing options presented in the “Financing Health Care for Migrants” study such as a social/community health insurance scheme that will cover health services for unregistered migrants.
- All dependants of migrants should be included in the current health insurance scheme.

## **5.4 Issue: National Preparedness Plan**

There is a perception among a number of stakeholders, that the National Preparedness Plan does not include non-Thai migrants and displaced persons. However, no target group is specified in

the plan. From a disease control perspective it is obvious that all people in Thailand should be included.

**Recommendation:**

- The next revision of the National Preparedness plan should state that the plan will cover ALL people in Thailand (regardless of nationality).

## **5.5 Issue: Health seeking behaviour**

There are a number of studies that attempt to map the health seeking behaviour of migrants. They offer a patchy set of information on this aspect. Some of these are listed in Annex IV. They do not provide a comprehensive picture of behaviour that would facilitate the design of a surveillance system and health education strategies targeting this “difficult to reach” population.

**Recommendation:**

- A meta-review of existing documentation on health seeking behaviour among unregistered migrants should be conducted. The review should identify major knowledge gaps and propose ways to bridge these knowledge gaps.

## **Annex I: Terms of Reference**

This review is part of an overall policy and strategy review by a Ministry of Public Health-World Health Organization joint team in Thailand on mitigating the impact of the H1N1 pandemic.

Product of this review are a presentation to be shared at the debriefing session with senior decision making level of MOPH and WHO Thailand on 4 December 2009, as well as a report to be submitted to WHO Thailand and MOPH covering the strengths, gaps, and upcoming challenges related to policies, strategies, plans, and lessons learned of the Royal Thai government/MOPH in responding to the pandemic flu (H1N1) in relation to vulnerable, non Thai populations (migrants/displaced persons) residing in Thailand.

Duration of review: 23 November-6 December 2009

Tasks:

- Review key documents (e.g. plans, policies, strategies and implementation) related to preparedness and response to pandemic influenza in Thailand.
- Meet with key stakeholders including central and provincial level health authorities of MOPH, MOI, MOL as well as other International organizations (e.g. UNHCR, IOM) and non governmental organizations e.g. IRC, Malteser, Mae Toa clinic to better analyze and understand the gaps and needs.
- Document the achievements and strengths as well as the gaps and any potential upcoming challenges. Make specific policy/strategy recommendations to MOPH and WHO to address the gaps and upcoming challenges.
- Share experiences and lessons learned from other countries, if available

### **Thailand MOPH-WHO Review Team**

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## Annex II: Programme

### PROVISIONAL PROGRAMME (23 November – 6 December 2009)

#### Day 1: Nonthaburi and Bangkok (23 November)

09.00 -09.30	Courtesy call to the Permanent Secretary, Ministry of Public Health
09.30-10.30	Collective meet with DHSS team on policy and strategy on health care services and communication in public health emergencies for migrants <ul style="list-style-type: none"> <li>▪ Dr Nara Nakwattananukool- Director General</li> <li>▪ Dr Visit Tangnapakorn- Deputy Director General</li> <li>▪ Dr Chanvit Tharathep- BHSD Director</li> </ul>
11.00-12.00	Collective meet with DDC on policy and strategy on surveillance and response to the pandemic flu H1N1—displaced persons and migrants <ul style="list-style-type: none"> <li>▪ Dr Manit Teeratantikanon: Director General</li> <li>▪ Dr Somsak Akkrasilp : Deputy Director General</li> <li>▪ Dr Supamitr Schunsuttiwat -Senior Public Health Expert</li> <li>▪ Dr Darika Kingnate-Bureau of Emerging Infectious Diseases</li> </ul>
12.00-13.00	Lunch
13.30- 16.00	Group meeting on Policy and strategy on surveillance and response to the pandemic flu H1N1—displaced persons and migrants with <ul style="list-style-type: none"> <li>▪ Operation Centre for Displaced Persons (ODPC)/MOI (Mr Singh Sukawat, Chief of the Coordination Cluster)</li> <li>▪ Department of Disaster Prevention and Mitigation, Ministry of Interior (Mr Thamnoon Srivontna)</li> </ul>
	Over night in BKK

#### Day 2: Tak (24 November)

07.45-09.10	Travel from Bangkok to Sukothai (Bangkok airway)
09.20-10.30	Travel from Sukothai airport to PHO Tak
10.30-11.30	Meet with PCMO (Dr Pujjuban Henhongsa) and PHO Tak team <ul style="list-style-type: none"> <li>▪ Policy and strategy on preparedness and response to pandemic flu in displaced persons camps and migrant workers in Tak</li> </ul>
11.30-13.30	Lunch and Travel to Mae Sod
13.30-14.30	Meet with Director (Dr Kanoknaj Pisutthikul) and Mae Sot hospital team, District Health office <ul style="list-style-type: none"> <li>▪ Health care service for migrants and displaced persons-specific to pandemic flu</li> </ul>
14.30-15.30	Meet with SMRU –Dr Françoise Nosten and Dr Paul Turner Health care service (including lab component) for migrants and displaced persons-focus on pandemic flu in Mae la camp and migrants living outside camp

15.30-16.30	Meet with AMI Field Coordinator- Ms Anna Paul, Dr Thet Win, and AI team <ul style="list-style-type: none"> <li>Program policy and strategy on preparedness and response to pandemic flu in displaced persons camps (Mae La, Umpiem, Nupoh)</li> </ul>
	Overnight Mae Sod

### Day 3: Tak (25 November)

8.30-9.10	Visit Mae Toa Clinic Health care service for migrants –focus on pandemic flu
9.10-10.10	Travel to Mae la camp
10.10- 12.30	Report to MOI camp base at check point Visit health facilities OPD, IPD –AMI Visit School (boarding school)
12.30-13.00	Lunch
13.30-14.30	Meet with local MOI (base in camp)
15.00-16.00	Meet with Tha Song Yang district health office, Tha Song Yang hospital
16.00-18.30	Travel from Tha Song Yang district (Tak) to Mae Sa Rieng district (Mae Hong Son)
	Overnight Mae Sa Rieng (Mae Hong Son province)

### Day 4: Mae Hong Son (26 November)

9.00-9.45	Meet with Malteser Program Coordinator (Dr Maria Dung-Pham)
9.45-12.00	Travel from Mae Sa Rieng to Mae Hong Son
12.00-13.00	Lunch break
13.00-14.00	Meet with PCMO (Dr Suwat Kittidolkul ) and PHO-Mae Hong Son Team <ul style="list-style-type: none"> <li>Policy and strategy on preparedness and response to pandemic flu in displaced persons camps and migrant workers in Mae Hong Son</li> </ul>
14.00- 15.00	Meet with Director, Srisangwan hospital (Dr Adung Sriratanabul) and team <ul style="list-style-type: none"> <li>Health care service for migrants and displaced persons-specific to pandemic flu</li> </ul>
15.00-16.30	IRC Field and Medical coordinator(s) (Dr Nyun Naing Thein and Mr Somsak Thanaborikul)) <ul style="list-style-type: none"> <li>Policy and strategy on preparedness and response to pandemic flu in displaced persons camps and migrant workers in Mae Hong Son</li> </ul>
16.30-17.00	Courtesy visit to UNHCR Field coordinator-Mae Hong Son
	Overnight Mae Hong Son

**Day 5: Mae Hong Son (27 November)**

8.30-12.00	Visit to Ban Mai Nai Soi camp (with IRC ) Local MOI office (base in camp) OPD/IPD Discuss with doctor, medic, nurse, community health workers
12.00-13.00	Lunch break
13.00-16.30	Homework and prepare to leave to Mae Hong Son Airport
17.15-17.50 19.15-20.25	Travel to Chiang Mai then Bangkok by Thai airways
	Back to Bangkok

**Day 6, 7 (28-29 November)**

Paper review+ home work in BKK

**Day 8: Bangkok (30 November)**

9.00-10.15	Courtesy visit to Regional Representative of UNHCR-Bangkok (Mr Raymond Hall) Meet UNHCR team (Ms Amy Conlee) to discuss on <ul style="list-style-type: none"> <li>▪ Policy and strategy on preparedness and response to pandemic flu in displaced persons camps</li> </ul>
10.15-12.00	Courtesy visit to Chief of Mission- IOM Bangkok (Ms Monique Filsnoel) Meet with IOM team (Ms Nigoon Jitthai) to discuss on <ul style="list-style-type: none"> <li>▪ Policy and strategy on preparedness and response to pandemic flu targeting migrant populations</li> </ul>
12.00-13.00	Lunch
13.00-16.00	Visit Rajavithi hospital (Bangkok) <ul style="list-style-type: none"> <li>▪ Health care service for migrants</li> </ul>
	Over night in BKK

**Day 9: Samutsakorn (1 December)**

8.00-9.00	Travel to Samutsakorn
9.00-12.00	Meet with PCMO –Samutsakorn (Dr Chairat Wechapanich) and other related organizations <ul style="list-style-type: none"> <li>▪ Labour /employment office/MOL</li> <li>▪ Chamber of commerce</li> <li>▪ Employer(s)</li> <li>▪ Migrant representative (MHWs)</li> </ul>
12.00-13.00	Lunch
13.00-14.30	Visit Samutsakorn hospital

	<ul style="list-style-type: none"> <li>▪ Health care service for migrants</li> </ul>
15.00-16.00	Visit Srivichai 5 hospital (private hospital) <ul style="list-style-type: none"> <li>▪ Health care service for migrants</li> </ul>
16.00-17.00	Travel to Bangkok
	Over night in BKK

**Day 10: Trat (2 December)**

9.00-10.00	Travel from BKK to Trat (Bangkok airways)
10.30-11.15	Meet with PCMO -Trat <ul style="list-style-type: none"> <li>▪ Policy and strategy on preparedness and response to pandemic flu targeting migrant populations</li> </ul>
11.15-12.15	Visit selected hospital <ul style="list-style-type: none"> <li>▪ Health care service for migrants</li> </ul>
12.15-13.00	Lunch
13.00-14.00	Employment unit, MOL <ul style="list-style-type: none"> <li>▪ Policy and strategy on preparedness and response to pandemic flu targeting migrant workers</li> </ul>
14.00-16.30	Visit chamber of commerce, selected employer and migrant communities <ul style="list-style-type: none"> <li>▪ Civil society and community preparedness and response to pandemic flu</li> </ul>
	Overnight Trat

**Day 11: back to Bangkok (3 December)**

10.30-11.30	Depart from Trat to BKK (Bangkok airways)
11.30-13.00	Arrive MOPH/WHO
13.00-14.00	Lunch
15.00-17.00	Prepare presentation of findings and recommendations
	Overnight BKK

**Day 12 (4 December)**

10.00 -12.00	Presentation of findings and recommendations to MOPH senior decision making level
12.00-13.00	Lunch
13.00-17.00	Homework and prepare final report

**Day 13-14 (5-6 December)**

Prepare final report and submit to WHO Thailand/MOPH for final review and further distribution to relevant offices/organizations

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# **Annex III: People met**

## **I. Royal Government of Thailand, Ministry of Public Health**

### **1. Department of Health Service Support**

Dr Nara Nakwattananukool, Director General  
Dr Visit Tangnapakorn, Deputy Director General  
Dr Chanvit Tharathep, Bureau of Health Service System Development Director

### **2. Department of Diseases Control**

Dr Manit Teeratantikanon, Director General  
Dr Somsak Akkrasilp, Deputy Director General  
Dr Supamitr Schunsuttiwat, Senior Public Health Expert  
Dr Darika Kingnate, Bureau of Emerging Infectious Diseases Director

### **3. Office of Disease Prevention and Control Region 4 - Chonburi**

Dr Pongsathorn Chartpitak  
Technical Officer

### **4. Tak Provincial Health Office**

Dr Patjuban Hemhongsa, Provincial Chief Medical Officer  
Mr Suporn Kavinum, Technical Officer  
Ms Samorn Pech-umporn, Technical Officer  
Technical Officers

### **5. Mae Sot District Hospital/Tak province**

Dr Kanonoknaj Pisutthikul, Director  
Hospital staffs

### **6. Mae Sot District Health Office**

Mr Loechai Inthrasut, Chief of District Health Office

### **7. Tha Song Yan District Hospital/Tak Province**

Dr Tawatchai Yingtaweesak, Director  
Hospital staffs

### **8. Tha Song Yang Distric Health Office/Tak Province**

Mr Prasert Sonjarensup, Chief of District Health Office  
Technical Officer

### **9. Mae Hong Son Provincial Health Office**

Dr Suwat Kittidilokkul, Provincial Chief Medical Officer  
Dr Sumet Ongwandee, Deputy Provincial Chief Medical Officer  
Mr Pratom Nuankam, Technical Officer

## **10. Srisangwan (Provincial) Hospital/Mae Hong Son Province**

Dr Adung Sriratanabul, Director  
Dr Worachet Teacharak, Deputy Director

## **11. Samutsakorn Provincial Health Office**

Dr Chairat Wechapanic, Provincial chief Medical Officer  
Dr Kittti Parimattapol, Deputy Provincial chief Medical Officer  
Ms Teerada Suteerawut, Technical Officer

## **12. Samutsakorn Provincial Hospital/Samutsakorn Province**

Dr Sakon Punrataprapin, Director  
Ms Na-Hathia Julkarat, Registered Nurse  
Ms Kanittha Panraksa, Registered Nurse

## **13. Srivichai 5 (private) Hospital /Samutsakorn province**

Dr Saisunee Vanadurongwan, Chief Executive Director  
Dr Mongkol Wanichpakdeedacha, Deputy Director  
Hospital staffs

## **14. Trat Provincial Health Office**

Dr Krit Palsu, Provincial Chief Medical Officer  
Dr Chokejai Sakornpanich, Deputy Provincial Chief Medical Officer  
Dr Chaiporn Suchartsunthorn, Director of Laem Ngob hospital  
Mr Somnuek Ketkovit, Technical Officer

## **15. Trat Provincial Hospital/Trat province**

Dr Charun Bonyarithikarn, Director  
Hospital staffs

## **16. Rajavithi Hospital**

Dr Prakarn Thomyangkook, Assistant Director of Training Programme  
Medical and Nursing staffs

## **II. Royal Government of Thailand, Ministry of Interior**

### **1. Office Operation Centre for Displaced Persons**

Mr Sing Sukawat, Chief of the Coordination Cluster

### **2. Department of Disaster Prevention and Mitigation**

Mr Thamanoon Srivontna, Senior Officer

### **III. Royal Government of Thailand, Ministry of Labour**

#### **Labour Office/Samutsakorn Province**

Mr Kreetta Sobchok, Chief of labour Office, Samutsakorn

Mr Somchai Auampeng, Chief of Labour Social Welfare and Protection Office, Samutsakorn

### **IV. Intergovernmental Organization**

#### **1. United Nations High Commissioner for Refugees**

Mr Raymond Hall, Regional Representative

Ms Amy Conlee, Associate Programme Officer

Mae Hong Son Field Office staffs

#### **2. International Organization for Migration**

Ms Monique Filsnoel, Chief of Mission

Ms Nigoon Jitthai, Migrant Health Programme Manager

Mr Vittaya Sumitmoh, Tak Field Coordinator

#### **3. World Health Organization**

Dr Maureen Birmingham, WHO Representative to Thailand

Dr Charles Delacollette, MMP Coordinator, Border Health Programme Focal Point

Mr Chawalit Tantinimitkul, National Professional Officer

### **V. Non- Governmental Organization**

#### **1. Aide Medicale Internationale**

Ms Anna Paul, Field Coordinator, Mae la Camp

Dr Thet Win, HIS Officer

Dr Min Nwe Tun, TB Officer (former AI coordinator)

Medic Chief- Mae la camp

#### **2. International Rescue Committee**

Dr Nyunt Naing Thein, Senior Health Coordinator

Dr Tila Khan Ahmadzai, Health Coordinator

Dr Hnin Phyu, Clinical Manager

Mr Sonsak Thanaborikul, Mae Hong Son Field Coordination

Dr Moe Myint Oo, AI Coordinator

Other team members

#### **3. Malteser International**

Dr Maria Dung- Pham, Programme/Medical Coordinator

Ms Ladda Phunrunroj, HIS and Surveillance Nurse

#### **4. CCSDPT**

Dr Ram Sedhain, HIS Coordinator

## **5. Mae Toa Clinic**

Dr Nicole Wong Doo

## **VI. Research Institute**

### **Shoklo Malaria Research Unit**

Dr Françoise Nosten, Director

Dr Paul Turner, Chief of Laboratory

## **VII. Others**

Sumutsakorn Chamber of Commerce

Sumutsakorn Employer Association

Trat Chamber of Commerce

Trat Industrial Council

Representative from migrant communities, Trat

## **Annex IV: List of relevant documents**

1. MOPH letter dated 27 July 2009 requesting WHO to establish joint team (MOPH-WHO) on Pandemic Flu (H1N1)
2. WHO letter dated 11 August 2009 accepted the request of MOPH and propose to MOPH the TOR of the join team
3. MOPH letter dated 14 Sep 2009 informing WHO the MOPH focal points in each strategic area
4. The second National Strategic Plan for Prevention and Control of Avian Influenza and Preparedness for Influenza Pandemic (2008-2010)
5. Pandemic Influenza Preparedness and Mitigation in Refugee and Displaced Populations, WHO guidelines for humanitarian emergencies second edition, Geneva, 2008
6. MOPH Clinical Practice Guideline (up dated on 27 July 2009-translated version)
7. MOPH Clinical Practice Guideline for Care of Pregnant women falling ill or suspected falling ill with Influenza (translated version)
8. MOPH Clinical Practice Guideline for Cases with Pneumonia associated with Pandemic H1N1 2009 infection (7 Aug 09-translated version)
9. WHO initial guidance on clinical practice (21 May 09)
10. Note to the File from Informal Discussion among UNs and other key agencies on Pandemic Contingency Planning for Vulnerable Populations on 23 January 2009
11. WHO-Thailand Rapid Review on Camp Response Strategies on Pandemic Flu (15 Sep 2009)
12. CCSDPT letter dated 5 Aug 2009 requesting DDC/MOPH to provide Tamiflu for camp populations
13. MOPH letter dated 28 September 2009 informing the provinces to provide Tamiflu to camps (Thai)
14. SMRU Power Point Presentation-Respiratory virus surveillance
15. IRC- Pandemic Preparedness Plan for Ban Mai Nai Soi camp
16. MI- Pandemic Preparedness Plan for Mae La Oon camp
17. AMI-Pandemic Preparedness Plan for Mae la camp
18. TBBC- Program Preparedness for Pandemic Influenza (September 09)
19. WHO-QUICK REVIEW OF NATIONAL ACTIONS FOR PANDEMIC RESPONSE (QURNAP)-Tool
20. Review of Public and Risk Communication by Joint tem (MOPH-WHO)-Power Point Presentation
21. Review of Surveillance and Epidemiology by Joint team (MOPH-WHO)-Power Point Presentation
22. Review of logistic, Commodities and Operations by Joint team (MOPH-WHO)-Power Point Presentation and Matrix (Strengths and Weaknesses)
23. Review of Laboratory Services by Joint team (MOPH-WHO)- Power Point Presentation
24. Review of Clinical Management by Joint team (MOPH-WHO)- Report
25. Review of Control Measures by Joint team (MOPH-WHO) - Power Point Presentation
26. Financing Health Care for Migrants: A Case Study from Thailand, Health Insurance System Research Office
27. A Rights-based Policy Framework for Migrant Workers and Stateless People in Thailand, Migrant Working Group-May 2009
28. Avian and Human Influenza Pandemic Preparedness Plan in 4 Pilot Districts of Chiang Rai Province, A collaboration between Ministry of Public Health and International Organization for Migration
29. Summary Report on Influenza Pandemic Preparedness and Response Workshop, held in 2009, Tak province, in collaboration with Tak Provincial Health Office, Office of Diseases Prevention and Control Region 9 and International Organization for Migration (Original in Thai)
30. IRC Assessment Report 2007, SHIELDS Health and Education Interventions: Chiang Mai, Chiang Rai, Tak and Mae HJong Son province Thailand

31. DRAFT Report-IRC (SHIELD) Baseline Assessment for the Health program 2008:  
Chiang Mai, Chiang Rai, Tak and Mae HJong Son province Thailand
32. DRAFT Report-IRC (SHIELD) Baseline Assessment for the Health program 2009:  
Chiang Mai, Chiang Rai, Tak and Mae HJong Son province Thailand
33. Pandemic Influenza among Migrants in Thailand 2009, IOM Power Point Presentation

## Annex V: Matrix for displaced living in temporary shelters (Thai-Myanmar border)

Issues	Strengths	Challenges	Recommendations
<p><b>1. Preparedness and Response (including command and coordination)</b></p>	<p>All medical NGOs and non medical NGO (TBBC) have a preparedness and response plan based on AI and expanded to cover pandemic influenza (H1N1)</p> <p>NGOs' preparedness plans have been shared and discussed with local health authorities (PHO and DHO)</p> <p>Business continuity plans are drafted by some of NGOs</p> <p>Local MOI is involved in command and coordination with other sectors/agencies working in camps</p> <p>Some public hospital/DHO (those visited)/have SOPs for emergencies in general and pandemic influenza.</p> <p>There is good collaboration between health authorities and NGOs.</p> <p>Drill (table top, functional) exercises or meetings at provincial level has been carried out with GOs and NGOs</p>	<p>Not all public hospitals (that serve as referral hospitals for camps) visited have written SOPs for emergencies in general and for pandemic influenza</p>	<p>SOPs for emergencies in general and Pandemic H1N1 should be developed in all hospital/DHO, based on the existing plans and should be consistent with each other</p>

	Camp committees are prepared for flu outbreaks and provide strong links to the communities facilitating control measures, (such as closing schools)		
<b>2. Surveillance and Epidemiology</b>	<p>ILI surveillance system (passive) introduced in all camps in September 2009</p> <p>Data/Information from health NGOs is shared with MOPH at all levels on a weekly basis</p> <p>BOE compile data from all 9 camps and provide feedback to NGOs and local health authorities., Some health authorities provide NGOs with information on disease outbreaks outside camps</p> <p>With two camps (Mae la, Ban Mai Nai Soi) reported confirmed cases of H1N1 in September and November, Epidemiological data is collected and analyzed and guide the actions e.g. closing schools in Ban Mai Nai Soi camp</p> <p>Sentinel influenza virus surveillance has existed in Mae la camp (SMRU) since 2007</p>	<p>Since ILI surveillance is newly established in camps, formulation of threshold triggering an outbreak is not clearly defined at this stage</p> <p>Not all local health authorities share data/information on disease outbreak occurring close to camps with concerned NGOs</p> <p>No active supplementary surveillance system (using community network) was mentioned in the visited camps</p>	<p>Meetings among medical NGOs and BOE/MOPH should be conducted to discuss ILI surveillance including guidelines to formulate the threshold levels triggering an outbreak measures</p> <p>Mechanism to share/exchange information between NGOs and local health authority on diseases outbreaks should be strengthen</p> <p>Consider to use community network, like home visitors, migrant health volunteers to do active surveillance during flu season and outbreaks</p>
<b>3. Laboratory capacity (RT-PCR testing)</b>	<p>NGOs have established a mechanism to utilize the service from MOPH reference laboratories (Chiang Mai, Pitsanulok etc) through camps nearby hospitals.</p> <p>SMRU lab can manage around 100 samples per week for RT-PCR. It has capacity/is willing to</p>	<p>MOPH laboratory centres are not located in the provinces where camps exist, so it can take at least 3 days to get the lab result.</p> <p>Health NGO's in camps pay 2500 THB per test. Camps may only test a few</p>	<p>MOPH/BOE should include camps in the payment system for lab tests in early epidemics.</p> <p>Consider expanding collaboration with SMRU to other camps.</p>

	accommodate more specimens from other camps/places if needed.	patients since it is expensive.	
<b>4. Clinical management</b>	<p>Up dated MOPH CPG translated into English and circulated to NGOs through WHO focal point</p> <p>Tamiflu provided to NGOs by MOPH (at least 5 courses per camp), and a mechanism for replenishment is established</p> <p>Some provinces provided training on clinical management to NGOs- based on the MOPH guidelines.</p> <p>Some NGOs used English version/some translated the guideline into Karen language and trained their medics.</p> <p>A referral system between camp hospital and public hospital is established based on the Human H5N1 and Pandemic Flu SOPs.</p>	<p>Not all provinces visited conducted training on CPG to camp doctors /health personnel who supervise medics in camps on treatment</p> <p>Some provincial and district hospital visited has limited capacity to care for patients with severe respiratory illness (limited number of ventilators and negative pressure room)</p>	<p>NGOs to consider to share translated CPG in Karen version to camps where medics can read Karen language</p> <p>It is recommended to set up a clear mechanism in all the provinces (hosting camps) to share and discuss the updated guideline with all NGOs working in camps</p> <p>Preventive measures must be strongly emphasized in camps</p> <p>Key messages on preventive measures, proper home-base care, and danger signs must be spread to communities through home visitors, migrant health volunteers</p> <p>People in risk groups must be identified and targeted with preventive measures</p>
<b>5. Infection control/ Prevention and</b>	In all camps visited respiratory illness clinics are separate from main OPD, and a separate	It is difficult/ hard to monitor proper use of PPE e.g. N95/ surgical masks in	Drills should include the use of PPE and other IC measures and involve non-health

<p><b>Control measures</b></p>	<p>ward/space is provided for RI patients</p> <p>All NGOs visited have planned for surge capacity of 10 – 30 beds for in-patients</p> <p>All NGOs visited are aware of the WHO guideline on the use of PPE</p> <p>Some PHOs and hospitals provide recommendations on IC and the use of PPE to NGOs</p> <p>N 95 mask and surgical masks are available at camp level in sufficient quantities for staff.</p>	<p>health personal as well as patients.</p> <p>Details of guidelines related to IC and proper use of PPE vary from organization to organization and authority to authority, so NGO staff is at times confused</p> <p>There is very little material to guide the use of PPE in health facilities.</p> <p>Social distancing in camps is difficult to apply (crowded settings)</p>	<p>staff e.g. janitor, drivers</p> <p>Regular meeting for camp staff with IC nurses at local level should be put in place.</p> <p>Produce/obtain the guideline on the use of PPE and make sure that staff understands it.</p> <p>Promote key messages on preventive measures e.g. using face mask when appropriate, hand washing, and promote healthy behaviours.</p>
<p><b>6. Public/Risk communications</b></p>	<p>Some communication mechanisms are established between camp based health personnel and communities e.g. meetings, loudspeaker messages, home visitors and teachers.</p> <p>Some IEC material on H1N1 is available in Burmese and Karen.</p>	<p>Most camp populations speak Karen and Karenni, so more IEC material in these two languages is needed</p> <p>In some camps teachers are not involved in health education or distribution of IEC material.</p> <p>Production and distribution of health education material is fragmented and uncoordinated and existing material not properly utilized.</p>	<p>Produce/obtain more appropriate IEC materials in Karen and Karenni language</p> <p>Train and utilize more teachers to deliver key health messages.</p> <p>A mechanism for coordinated IEC material production (with inventory of what exist) and distribution. should be established</p>
<p><b>7. Logistics, commodities and operations</b></p>	<p>MOPH provides Tamiflu to camps since September 2009 (at least 5 course/camp)</p>	<p>In case of major flu outbreaks the need for rapid replenishment may exceed staff capacity and the health authority</p>	<p>MOPH should consider increasing the stockpile of Tamiflu for camps in case of impending epidemics</p>

	<p>At least 5 courses of Tamiflu is available with NGOs for each camp (regardless of the camp size)</p> <p>PPE is considered sufficient for now by all NGOs visited for their health staff – not for patients</p> <p>Other medicines and medical supplies are stockpiled in camps for up to 4-5 months</p> <p>MOI speed up approval of commodity transport into camps in case of outbreaks.</p>	<p>replenishment mechanism.</p> <p>If there will be more people infected in the 2nd wave, this will also affect camps and stocking and distribution of more stock is needed</p>	<p>NGOs should estimate additional quantities of PPE required in particular surgical mask for other groups besides the health personnel and work to make this stockpile available as soon as possible</p>
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### Over arching areas

### Gaps

- As urge capacity is camps is quite limited, so preventing health personal from getting sick is also important---that service in camps can be maintained and less dependent from the local Thai health facility nearby.
- There are no vaccination plans for health staff servicing the camps.

### Recommendations

- When H1N1 vaccine is made available in Thailand, health personal in camps who providing direct service to patients should be consider as a priority group to be vaccinated.

## Annex VI: Matrix for registered and unregistered migrants

Issues	Strengths	Challenges	Recommendations
<p><b>8. Preparedness and Response (including command and coordination)</b></p>	<p>Line of command seems to be clear at all level by having the following</p> <ul style="list-style-type: none"> <li>▪ National Committee to fight against H1N1 is established –Chair by Deputy Prime Minister, national strategy/measures to fight against H1N1 is updating with new knowledge and information obtained</li> <li>▪ H1N1 Directing Committee established at Provincial level, lead by the Governor, PCMO as secretary</li> </ul> <p>At provincial level, some provinces visited have been closely working with IGO/NGO (IOM/IRC) in developing PPP and BCP</p> <p>SOPs/Business continuity plan are developed in some visited hospital.</p> <p>To some extent, all provinces visited conducted drills (sometimes tabletop) to test PPP and/or SOPs. Migrants and NGOs are involved in some provinces.</p> <p>At provincial level, involvement of other line</p>	<p>At provincial level, not all key staff at the visited provinces are aware of the national strategy and new guidelines issued</p> <p>Though coordination and collaboration among all ministries involved at all levels is established through national, provincial committees on H1N1, not all key staffs involved are aware of their responsibilities</p> <p>Not all hospital visited has written BCP/SOPs in hands and drill the plan (the response to the recent outbreak of some interviewed staff is based on spontaneous action, not referring to the plan)</p>	<p>Strengthen collaboration among all ministries involve through regular meeting/various types of exercise, in particular at provincial and district level <b>AND</b> try to find the mechanism to ensure that all key staff involved aware about the latest instruction/policy/measures, guided by central level</p> <p>Support all hospitals to develop and drill their BCP/SOPs (Support can be mobilized from NGO, IGO e.g. IOM, IRC).</p>

	ministries to fight against H1N1 in migrant populations is evident		
<b>9. Surveillance and Epidemiology</b>	<p>Migrant populations ( both registered and non registered) are included into the passive MOPH existing systems ( ILI passive surveillance system, 506 system) identical to that used for Thai populations</p> <p>Some factories put in place a screening measure to measure body temperature of workers before entering the workplace and apply “ No work when Sick” policy</p> <p>In the visited provinces (not including Bangkok) migrant health volunteers/workers plays a crucial role in helping health authorities to conduct active ILI surveillance/outbreak investigation in their workplace/communities</p>	<p>Health seeking behaviours of migrants (especially unregistered) (common with self treatment, utilize private clinic) impede their service utilization reducing the sensitivity of surveillance.</p> <p>Though most health facilities visited, try to establish active surveillance in communities through the migrant community health volunteer/worker, the system is not systematic/standardized e.g. set of data to be reported, reporting mechanism</p> <p>Most of migrant health volunteers/workers are supported from external funding ,(by NGOs or IGO), making it less sustainable</p> <p>Though the number of registered migrants in 2009 has increased significantly, there is still large number of unregistered migrants. This still pose a challenge in outbreak control and investigation due to lack of data base to keep track where they are</p>	<p>Strengthen community network/participation in surveillance by establishing a systematic disease community base surveillance system and provide proper training to migrant health volunteer/worker. Technical support should come from BOE/WHO</p> <p>Advocate a clear (explicit) policy that allow health authorities to use the government budget (at least from revenue derives from CMHI) to hire migrant health workers and keep the migrant health volunteer system running</p> <p>Expand the MHW system to a level similar to the Thai community health worker system</p>

<p><b>10. Laboratory capacity</b></p>	<p>Rely on the MOPH existing systems</p> <p>There is no different in terms of health care including diagnostics between Thai and Non Thai ( registered and unregistered)</p>	<p>Cost for laboratory testing is quite high this may impede the outbreak detection</p> <p>Some hospital visited expressed that capacity of national lab is insufficient. When there was a peak during the first wave they were asked to limit the number of specimens sending to National laboratory centre (Department of Medical Science)</p>	<p>A similar exemption system (BOE) as that established for Thai people should put in place</p>
<p><b>11. Clinical management</b></p>	<p>All follow the MOPH guideline and there is no difference in standard of care between Thais and Migrant Populations ( both registered and non registered)</p>	<p>Refer to previous review of this area</p> <p>Some provincial and district hospital visited has limited capacity to care for patients with severe respiratory illness ( limited number of ventilators and negative pressure room)</p> <p>In the provinces visited (both border and central parts), there were very few cases reported with H1N1 among migrant populations, compared to Thai people.</p>	<p>Refer to previous review of this area</p> <p>AND</p> <p>Encourage a University to investigate why there are very few H1N1 cases reported among migrants compared to Thai's.</p>
<p><b>12. Infection control/ Prevention and Control measures</b></p>	<p>All hospital visited separate the areas for RI patients from other</p>	<p><u>Hospital</u></p> <p>It is difficult to modify/separate the</p>	<p><u>Hospital</u></p> <p>Where new constructions are planned</p>

	<p>Most hospitals visited have some capacity to deal with respiratory illness- though limitations exist in a small size district hospital</p> <p>Strong networks of migrant health volunteers/workers (with support of NGOs working in the areas (Raks Thai, IRC) assist health personnel in conveying key messages on preventive measures</p>	<p>areas to avoid contamination among RI patients and others due to the infrastructure</p> <p><u>Community</u></p> <p>Living conditions are very crowded, often unhygienic poor ventilation, too many people in one small room; Applying social distancing would be difficult.</p>	<p>the need for RI separation in OPDs must be considered.</p> <p><u>Community</u></p> <p>There must be strong emphasis on proper use PPE among patients and health staff and in communities. NGOs working in the areas can help reaching communities and/or convey messages</p>
<b>13. Public/Risk communications</b>	<p>MOPH (DHSS) with the support from UNICEF has produced IEC material in 3 migrant languages (Burmese, Laos, Khmer)</p> <p>There is a potential to use <b><u>network of migrants/employers/NGOs</u></b> to communicate with migrants' community on the information that needs to be spread out to the public</p> <p>Strong networks between NGOs IGO and working exist in some areas – which help disseminate information/key message</p> <p>A potential to mobilize resource from MOL/ reinforce if it is involved in workplace (acc to the instruction letter issued by DDPM/MOI dated 3 July 2009</p> <p>Several modes of communications have been used to communicate to migrants e.g. local</p>	<p>Distribution of produced IEC materials is inadequate—none of the hospitals visited received IEC material from central level</p> <p>Production and distribution of health education material is fragmented and uncoordinated and existing material not properly utilized.</p> <p>In some provinces visited, employers are not informed of the H1N1 situation.</p>	<p>Identify focal point in each province/DHSS to help facilitate systematic distribution of IEC materials</p> <p>A mechanism for coordinated IEC material production (with inventory of what exist) and distribution should be established</p> <p>Produce/translate (from Thai health foundation) more appropriate IEC materials in migrant languages</p> <p>The participation of employers in distributing and communicating with migrants with relevant information to employers/chamber of commerce should be put in place on a regular</p>

	<p>radio program, dissemination of health message by volunteers and NGOs staff.</p> <p>Lots of good IEC materials produced in Thai by others e.g. Thai health foundation</p> <p>Employers/chambers of commerce are prepared to help providing information</p>		<p>basis/timely manner.</p> <p>If resource allows, BCC should be implemented in both Thais and migrant community</p>
<b>7. Logistics, commodities and operations</b>	Follow the MOPH existing systems – refer to the review of this area	Follow the MOPH existing systems – refer to the review of this area	Follow the MOPH existing systems – refer to the review of this area

### **Overarching areas**

#### **Gaps**

- Access to health service- financial barriers plus other socioeconomic factors may still hinder a number of migrants in seeking health services.
- Budget constraints is still an issue to support expanding the capacity (or prepare for surge capacity that include migrant populations) of the public health authorities.

#### **Recommendations**

- Expand the MHW to the level in Thai communities.
- Allow use of budget to pay MHWs.
- Include all dependants in Migrant Health Insurance Scheme.