

# Migrants' access to antiretroviral therapy in Thailand

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## Summary

**OBJECTIVE** To investigate migrants' access to antiretroviral therapy (ART) and assess the applicability of ART guidelines to migrants.

**METHODS** Six focus group discussions (FGD) were conducted in Thailand with 74 Burmese migrants: factory workers in Mae Sot and Bangkok, construction site workers in Chiang Mai and unemployed and undocumented HIV-positive migrants in Mae Sot. Thirteen key stakeholders and migrants were interviewed for triangulation.

**RESULTS** (1) Present criteria for in-/exclusion restrict migrants' access to ART. (2) Leading ART guidelines are not applicable for migrants in general. (3) Migrants are likely to experience more problems with adherence to ART than local patients, which increases the importance of ART guidelines.

**CONCLUSIONS** Without ART guidelines that take into consideration the specific circumstances that limit migrants' access to ART, health care providers will continue to render HIV-positive migrants ineligible. Interventions are needed to both make the ART guidelines applicable to migrants and to overcome obstacles restricting migrants' access to ART. This will greatly improve migrants' access to ART and help to save the lives of thousands of HIV-positive migrants.

**keywords** ART, migrants, access, ART guidelines, Thailand, antiretroviral

## Background

The introduction of antiretroviral (ARV) drugs in 1996 led to a radical change in the perspective of hundreds of thousands of people living with HIV (PLHIV) with access to sophisticated health care systems. As the cost of ARV decreased, antiretroviral therapy (ART) programmes proliferated, and now ART is becoming increasingly available in resource-limited settings also.

It is estimated that approximately 1 million people are currently receiving ART in developing countries, although about 6.5 million PLWHA are still in urgent need of ART (UNAIDS/WHO press release 2005; UNAIDS/WHO 2005). In response, UNAIDS and WHO argue for the simultaneous acceleration of prevention and treatment efforts, with the ultimate goal being universal access to prevention, treatment and care (UNAIDS/WHO, press release 2005). The joint WHO/UNAIDS initiative 'Treating 3 Million by 2005' (3 by 5) has played a crucial role in the advancement of ART programmes in the developing world (UNAIDS/WHO 2005).

'Access for All' was the theme of the XVth International HIV/AIDS Conference in Bangkok 2004, while 'Time to Deliver' was the theme of the XVIth International HIV/AIDS Conference in Toronto in 2006. How to provide access to ART for vulnerable populations such as migrants

was one of the many questions raised at both the conferences. Even so, little research has been conducted on this topic. The relationship between HIV/AIDS and migration is recognized, and the IOM argues that work should not only be done to reduce migrants' vulnerabilities to HIV, but also to increase their access to health care and ART (International Organization for Migration 2002).

Perceived adherence to treatment is often a precondition for being allowed to participate in ART programmes. The rapid replication and mutation rate of HIV means that very high levels of adherence,  $\geq 95\%$ , are required to achieve sufficient suppression of the viral load and to avoid the development of treatment-resistant viruses, treatment failure and opportunistic infections (International HIV/AIDS Alliance 2005; Aidsmap 2006; WHO 2003; Machtinger & Bangsberg 2006; WHO 2005). Non-adherence to ART is common, with the average rate of adherence being approximately 70% (Machtinger & Bangsberg 2006). Research suggests that drug resistance is most common when adherence rates are between 50% and 85% (WHO 2003). Drug-resistant viruses limit therapeutic options, and this may be an especially important issue in resource-limited settings where second-line ARV options are in short supply. Despite frequent difficulties with achieving proper adherence rates, various studies have concluded that it is possible to provide ART in resource-limited settings with

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good adherence rates (Nachega *et al.* 2004; Akileswaran *et al.* 2005; Laniece *et al.* 2003; Orrell *et al.* 2003).

High adherence rates are crucial for successful ART. WHO and other organizations have developed ART guidelines in the effort to accelerate and facilitate safe and effective ART while achieving sufficient adherence rates. These guidelines play an important part in the development of ART programmes (WHO 2003).

Patients who are perceived to be unable to adhere to ART guidelines will be deemed ineligible and denied access to ART. If ART guidelines are unsuitable for migrants because of lack of sensitivity for migrant issues, migrants will be unable to adhere to the guidelines and health care personnel will be unable to provide ART to migrants according to the guidelines.

This study investigated whether ART guidelines are suitable for use with migrant workers in general because they tend to be exclusive. Lack of suitability will have three important effects: (i) HIV-positive migrants may easily be regarded as unfit for ART and denied access to it; (ii)

migrants on ART may receive suboptimal treatment because recommendations made by ART guidelines do not apply to them; and (iii) ART guidelines which are unsuitable for migrants and anticipated problems with ART of migrants will cause policy-makers to exclude migrants from ART programmes. This will affect hundreds of thousands of HIV-positive migrants in need of ART.

Six leading ART guidelines have been reviewed to identify their main recommendations for providing ART (Tables 1 and 2) (WHO 2004; WHO 2003; WHO 2005; WHO 2004; International HIV/AIDS Alliance 2005; The Panel of Clinical Practices for Treatment of HIV Infection 2004). Based on these recommendations, five basic conditions were considered necessary in order to provide ART according to the guidelines (Table 3). These basic conditions are used as a tool to assess the applicability of the ART guidelines on migrants.

Few migrants are currently receiving ART in low- and middle-income countries. This study is the first to examine the usefulness of ART guidelines for migrants and to

**Table 1** Reviewed antiretroviral therapy (ART) guidelines

| Authors  | Document  | Available at:   |
|--|---|---|
| WHO  | <i>Chronic HIV-Care with ARV Therapy, IMAI</i>  | <a href="http://ftp.who.int/htm/IMAI/Modules/IMAI_chronic.pdf">http://ftp.who.int/htm/IMAI/Modules/IMAI_chronic.pdf</a>   |
| WHO  | <i>Scaling up Antiretroviral Therapy in Resource-Limited Settings: Treatment Guidelines for a Public Health Approach. 2003 Revision</i>     | <a href="http://www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf">http://www.who.int/hiv/pub/prev_care/en/arvrevision2003en.pdf</a>                                 |
| WHO  | <i>Adherence to Long-Term Therapies: Evidence for Action</i>  | <a href="http://www.who.int/chronic_conditions/en/adherence_report.pdf">http://www.who.int/chronic_conditions/en/adherence_report.pdf</a>                                 |
| WHO  | <i>General Principles of Good Chronic Care, IMAI</i>  | <a href="http://www.who.int/3by5/publications/documents/en/generalprinciples082004.pdf">http://www.who.int/3by5/publications/documents/en/generalprinciples082004.pdf</a> |
| International HIV/AIDS Alliance  | <i>Antiretroviral Treatment Fact Sheet 04: Adherence</i>  | <a href="http://synkronweb.aidsalliance.org/graphics/secretariat/publications/FS04.doc">http://synkronweb.aidsalliance.org/graphics/secretariat/publications/FS04.doc</a> |
| AIDS info: The panel of Clinical Practices for Treatment of HIV Infection convened by the Department of Health and Human Services (DHHS) | <i>Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents: Adherence to Potent Antiretroviral Therapy</i> | <a href="http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL_AdherenceSup.pdf">http://aidsinfo.nih.gov/ContentFiles/AdultandAdolescentGL_AdherenceSup.pdf</a>       |

**Table 2** Summary of antiretroviral therapy (ART) guidelines

1. Assess the patient's readiness, motivation, beliefs and expectations with regards to ART, and negotiate a treatment plan to which the patient commits.
2. Create a good and understanding patient–doctor relationship, with good cooperation and involvement of the patient in decisions concerning the treatment.
3. Give appropriate education about HIV, the benefits and demands of ART and the importance of good adherence.
4. Provide regular consultation to monitor the progression of the disease and treatment effects and to reinforce adherence; provide effective management of side-effects and co-morbidities (including psychological issues and psychiatric disorders).
5. Provide social support by involving family, friends and/or other community members, including peer educators.
6. Reduce the pill burden; tailor the regimen to fit the patient's daily routines; and introduce other methods to help the patient remember to take his or her medicines.

**Table 3** Conditions needed to provide antiretroviral therapy (ART) in accordance with the ART guidelines

1. Patients' daily life should not restrict him/her from taking the medicines correctly.
2. Patients should have reliable access to health care and be able to attend monthly follow-up appointments.
3. Patients and health care personnel should be able to communicate well with each other.
4. Health care providers should not discriminate against patients.
5. Sufficient social support, like family members and/or close friends who are willing to support and help the patients adhere to ART, should be present.

provide recommendations for interventions to improve and facilitate ART for migrants. Investigation of the applicability of ART guidelines on migrants is performed by interviewing key stakeholders and migrant workers about their experiences with the basic conditions for ART and their ideas on the possibilities of overcoming the constraints.

Thailand has experienced success in fighting the HIV/AIDS epidemic, and has reduced the number of new infections by 83% from 1991 to 2003 (UNAIDS 2004). It is estimated that > 50% of the more than 100 000 PLWHA in need of ART are currently receiving it in Thailand (UNAIDS/WHO 2005; UNDP 2004). An important reason for the high ART coverage in Thailand compared with other developing countries is the production of local, low-cost generic ARVs (GPO-vir: d4T, 3TC and nevirapine) (UNAIDS/WHO 2005).

Thailand is a major destination country for migrant workers. By 2004, there were approximately 1.27 million documented workers and 1–2 million additional undocumented migrants in Thailand (Thai Ministry of Public Health 2005). WHO estimated that close to 1 million undocumented migrants live in the border provinces along Burma alone (IOM 2005). The HIV/AIDS prevalence of migrants in Thailand is estimated to be 17%, compared with 1.5% among adult Thais (Renu Garg HIV/AIDS Unit Department 2005; WHO, UNAIDS, UNICEF 2004).

Some provinces provide ART only to migrants who can pay for all of the treatment themselves, while other provinces provide ART (or part of the ART) for free to a select group of migrants.

## Methods

### Setting

This study attempts to identify and explore important issues and challenges when providing ART to migrants. Using qualitative research methods, documented and undocumented Burmese migrants were interviewed about access to ART programmes. Information was primarily collected from Burmese factory workers in Mae Sot and Bangkok, and from Burmese construction workers in

Chiang Mai (this study refers to 'Burmese' as migrants from Burma, regardless of ethnic origin). Five focus group discussions (FGD) were conducted with migrant workers, and one FGD was conducted with HIV-positive, unemployed and undocumented migrants in Mae Sot.

The number of participants in the FGD varied from 6 to 18. There were a total of 74 participants in the FGD: 27 females and 47 males. The participants were of different ethnic origins: in Mae Sot and Bangkok interviewees were primarily Karen, Burmese and Mon; and in Chiang Mai the interviewees were mainly Chan. Thirteen interviews were held with key informants: NGO workers, health care workers and PLWHA. These interviews were used for triangulation purposes.

### Procedure

The study was conducted in the spring of 2005. Participants were recruited by snowball sampling or convenience sampling. On the advice of local NGO, limited personal information was gathered from the participants in order to create a trusting atmosphere where the participants felt safe to share their experiences.

The five conditions in Table 3 were used as themes in the FGD, and the FGD would start off with 'access to health care' as the general topic. This was done to identify problems and understand how limitations to accessing health care would challenge access to ART for migrants. The second part of the FGD would begin with issues concerning HIV/AIDS and ART, and would then move to a discussion of the perceived challenges of ART adherence.

A tape recorder was used during the sessions. The tapes were transcribed the same day or one day after the FGD. Transcripts were translated one or two days after that. Key informants on migrant issues were used as translators.

### Analysis

Results from the FGDs were analysed continuously during the study in order to identify issues that needed further exploration in additional FGDs. Outcomes were verified in discussions with key informants and with migrants working in local NGO. After all the FGDs were completed, the

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statements were organized according to the themes identified in the content. The statements were then thoroughly analysed, and the results were compared with the key informant interviews.

## Results

### Taking medicines at work

The ARV regimen most widely used in Thailand is GPO-vir, which must be taken every 12 h. Migrant workers tend to work very long shifts, and migrants on ART will probably take at least one dose at work. Most participants did not think this was a problem, but some disagreed: 'The workers can't stop to take medicines at work,' and '...it will be impossible to take medicines during the workday'.

Most participants believed HIV-positive workers would be fired if their status was revealed, and hiding their HIV status was very important for the HIV-positive participants interviewed. Taking medicines at work was not uncommon, and participants suggested that PLHIV could pretend that the ARVs were non-HIV-related medicines.

HIV-positive migrants already pretended medicines for opportunistic infections were ordinary painkillers or heart medications

Some participants believed that workers would get fired if the symptoms of HIV/AIDS made them unable to work. Being fired has serious consequences for HIV-positive migrants because many migrants lack a social network to take care of them and it is difficult for PLHIV to find a job.

An HIV-positive migrant from Mae Sot explained: 'We want to work, but we can't get any jobs. It is harder to find work if you are HIV-positive, because we can't work as hard as healthy people can. Many employers require new workers to take a blood test before offering them a job, and I'm afraid other people will find out that I'm HIV-positive this way. Besides the employer would not hire anyone who is HIV-positive'. PLHIV who remain healthy, have fewer problems continuing in their work.

Some non-infected participants argued that PLHIV should change jobs if they could not take the medicines at work. They believed that, contrary to what the HIV-positive participants were saying, there were less demanding jobs available. The HIV-positive participants, however, only managed to get poor paying day jobs that few others wanted.

### Access to health care

Several factors were identified as restricting participants' access to general health care. Reliable access to health care is extremely important because attending regular appoint-

**Table 4** Factors that restrict migrants' access to health care

|                                  |  |
|----------------------------------|--|
| Economic concerns                | Cost of transport<br>Cost of medical treatment<br>Avoiding loss of income                                |
| Work-related obstacles           | Power dynamics<br>Sick leave<br>Working hours, overtime and days off<br>Access to the official documents |
| Transportation and safety issues | Fear of harassment and arrest by the police<br>Forced to pay bribes                                      |

ments is an important part of ART, as set out by the ART guidelines. The identified challenges that impair migrants' access to health care have been organized into three categories: economic concerns, work-related obstacles and transportation and safety issues (Table 4). Participants from Mae Sot experienced the most challenges in accessing health care. It appears that this is related to their more pronounced financial problems, greater fear of the police and more demanding work conditions.

### Economic concerns

All factory workers were poor and received less than the minimum wage. For instance, migrant factory workers from Mae Sot were entitled to at least €2.86 per day (135 Baht per day), but the participants received salaries between €0.85 and €2.12 per day (40–100 Baht per day). Migrant factory workers from Bangkok were entitled to at least €3.82 per day (180 Baht per day), but the participants received salaries between €2.12 and €3.18 per day (100–150 Baht per day).

Several participants saved money to support their families in Burma, and economic concerns were of high priority. Participants from Mae Sot seemed to experience the most financial challenges. Migrants' financial position can have implications for ART in at least three ways: regular cost of transportation to the health care centre may be too much to afford; the cost of treatment may be too much; and missing work to attend medical appointments may result in loss of income and dismissal.

### Cost of transportation

The cost of transportation to health care centres ranged from €0.21 to €3.18 (10–150 Baht) and was primarily a problem for workers living far away from health care centres. Some participants from Mae Sot explained that they could not seek health care, because they could not

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afford the cost of transportation. The cost of transportation was discussed in general, and it is likely that the increased cost of frequent visits to health care centres associated with ART is a great challenge to migrants who make very little money.

**Cost of medical treatment**

The cost of medical treatment was an important factor when deciding where to seek health care, and some participants from Mae Sot did only seek free health care at the Mae Tao Clinic. The cost of medication and health care services pose a major obstacle in attempting to adhere to ART. As a male factory worker from Mae Sot said: 'If treatment is too expensive, we may not be able to take it, because it is lifelong. 1–3 months is ok. But we can't afford to pay for lifelong treatment'. Similarly, a male construction worker from Chiang Mai said: 'We won't be able to afford any food, if we have to pay for medicines'.

**Loss of income**

In order to avoid missing work and having their wages reduced, many participants explained that they obtain medicines at the pharmacy when they become ill. If the over-the-counter medicines did not help, they would then go to a health care centre. Most participants expressed that they did not like public hospitals because of the long waiting hours, the long travel time and the poor treatment they received. Private clinics were often preferred by participants who could afford the extra cost of treatment, because it took less time and was more convenient. They also believed they would get well faster, because they received certain treatments like injections.

**Work-related obstacles**

Employers tend to have a lot of power over their workers, and labour and human rights are often ignored. Typical migrant jobs are often hazardous and dangerous, and the employers often care little for the workers' well-being. Most participants had minimal knowledge of their rights, and few means to improve their living and working conditions. Most participants rented their accommodation from their employers, and some were in debt after paying for their work permit and health care insurance. Workers who challenged or disobeyed their employers risked being punished, fined or fired. Some employers required blood tests of their workers, and some participants from Mae Sot explained that their employer had tested all the workers' blood samples for HIV without their consent. As a consequence of this, five

persons who were found to be HIV-positive were immediately fired against their rights.

At some work sites, participants were rarely allowed sick leave but forced to work instead. In other sites, they were allowed sick leave, but workers who missed work too often risked being fired. Participants from Mae Sot experienced the most challenges in getting sick leave, especially if there was an upcoming deadline. Many did not dare to seek health care without permission, and those who tried were punished or fined by their employer. Health care personnel at Mae Sot Public Hospital explained that seriously sick (and often undocumented) migrant workers were often left behind at the hospital by their employer, sometimes too late to be treated. A group of participants from Chiang Mai believed it would be practically impossible to follow ART, because they would never be allowed sick leave to attend monthly appointments. Some participants could not choose where to go for treatment. As a female factory worker from Mae Sot explained: 'If someone at the factory gets sick, the employer refuses to send them to the hospital, but insists on sending them to the nearby clinic instead. The employer thinks that the hospital or other clinics are too far away. If the nearby clinic is not open, you will have to wait until it opens'. Participants working at factories with small health care centres inside the factories were often not allowed to seek health care elsewhere. Participants complained that the treatment was of poor quality, and did not trust the nurses working there.

All participants had long working hours, worked 7 days a week and had few days off. Their working hours varied with their occupations and employers. Factory workers from Mae Sot usually worked in three shifts: 8–12 am, 1–5 pm and 6–11 pm. Factory workers from Bangkok usually worked from 9 am–9 pm, with additional overtime. The participants from Chiang Mai usually worked from 8 am–6 pm or 9 am–5 pm, with additional overtime. The participants were allowed few breaks, and workers that were caught taking a break risked being fined. Most participants frequently had to work overtime, especially if there was an upcoming deadline. A nurse from Mae Sot explained that many migrant patients were admitted because of exhaustion after working continuously for many days to meet upcoming deadlines.

Health care centres were only open during participants' working hours, except some private clinics in Chiang Mai, which were open until 8 pm. Most participants were thus forced to seek health care during their working hours. The participants from Mae Sot, in particular, complained about the lack of time to seek health care services. A doctor providing ART at a public hospital in Chiang Mai explained that appointments for ART were only made on Tuesday to Thursday between 8.30 am and 4 pm. Patients who could not follow this schedule would not receive ART.

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Three migrants received ART compared with about 200 Thais at this hospital, despite an excess of ARV. The doctor argued that 'We do not deny migrants ART, but many migrants do not fulfil the inclusion criteria'. Inclusion criteria included: physical parameters, interest in ART, previous adherence to treatment of opportunistic infections and anticipated adherence to ART.

Documented migrants with a work permit and registration card can pay €27.40 (1300 Baht) for health care insurance. Thai Law states that migrant workers are entitled to have possession of their registration, work permit and health care insurance documents, although it is still the case that these documents are usually held by the employers. Participants from Mae Sot and Bangkok were only given copies of these documents. Participants interviewed from Chiang Mai were allowed to keep their health insurance and were given copies of the other documents. Not holding the original documents made migrants more vulnerable to harassment by the police and restricted their freedom of movement, and therefore their access to health care. Many participants from Mae Sot and Bangkok found that health insurance issues were among the greatest obstacles when seeking health care. As a male factory worker from Mae Sot explained: 'The copy of the health insurance card is not enough to get treatment at the hospital. If there is an emergency, you can go to the hospital first, but there you will have to wait until someone brings the health insurance card'.

### Transportation

Many participants argued that motorized transportation was necessary when seeking health care because of long distances to the health care centres and fear of harassment by the police while en route. As articulated by a female factory worker from Mae Sot: 'People could walk to the health care centre even though it is far, but they can't because they are afraid the police will arrest them and put them in jail, even though they are sick'. Migrants were often forced to pay bribes to the police and were arrested if they could not pay. The participants from Mae Sot experience the most harassment, although almost all of the participants in the study said they were afraid of the police. Harassment and arrest by the police have important implications for ART for migrants, because PLWHA on ART may not have access to their medicines if they are arrested. Arrest would also cause them to miss follow-up appointments, which, if missed too frequently, would result in their being dismissed from ART programmes. Despite these concerns and a general lack of safety, a group of undocumented and unemployed HIV-positive migrants in Mae Sot managed to visit the Mae Tao Clinic at least once a week.

### Communication

Good communication between health care providers and patients is crucial for successful ART. Most participants from Chiang Mai perceived communication at the health care centre only to be a minor problem, because they spoke a bit of Thai. The participants from Mae Sot and Bangkok, however, considered language barriers to be one of the greatest challenges when seeking health care. Frustration, misunderstandings and distrust were common consequences of inadequate communication at health care institutions. Professional translators were only present in Mae Sot Public Hospital, but participants complained that there were not enough and that their language abilities were poor. This being the case, most participants brought someone to translate for them when they sought health care.

Drivers from the factory often brought participants from Mae Sot to the health care centre, and these drivers would usually serve as translators. This could ultimately be a great problem in accessing ART, because many participants believed HIV-positive workers would be fired. Using other non-professional translators, such as friends and colleagues, could be equally problematic, because many PLWHA fear stigmatization and discrimination.

Good communication with health care professionals is important during all phases of ART: during the assessment of patients, when delivering information, and when explaining and supporting adherence to the ART regimen. Inadequate communication can cause migrants to be excluded from ART programmes because properly assessing patients is not possible. It can also lead to lower quality of treatment and poor treatment outcomes.

### Discrimination

Most participants in Mae Sot had experienced discrimination when seeking diagnosis and treatment from health care professionals. Considering public hospitals, participants talked about doctors being rude, being denied access to treatment, poor quality of the treatment and being tricked into paying more for treatment and services. Participants believed they were discriminated against as they were migrants and because they use the 'migrant health care insurance' (similar to the 30 Bath health care insurance). A male construction site worker from Chiang Mai said: 'One time I went to the [public] hospital; the doctor said: "Oh, you are Burmese, you are not Thai." You see, if the patient is Thai, they will get good treatment, but because I'm a migrant worker, I got poor treatment'. Hospitals denied discriminating against migrants. Contrary to this, a doctor from Chiang Mai explained that migrant patients were frequently discriminated against and that

doctors' attitudes towards migrants were often poor. Most doctors would however not admit this.

### Social support

Involvement of family members and close friends is important when adhering to ART. Some Thai hospitals required patients seeking ART to have at least one close friend or family member who knew about the patient's HIV status and was willing to support the patient. Participants disagreed as to whether a lack of social support would be a problem for migrants on ART. A male factory worker from Bangkok said: 'I don't think attending monthly appointments at the hospital will be a problem, but social support can be difficult. You see, we don't live with our families'. HIV-positive migrants were very reluctant to disclose their HIV status, even to their closest relatives. Many migrants travel alone and lack close friends that they trust in the host country, which can make the struggles of coping with HIV/AIDS and its treatment even more overwhelming. Fortunately, there are HIV/AIDS groups for migrant workers that provide support and education in Mae Sot, and the HIV-positive participants were very pleased with the support they received there.

### Discussion

This study draws three main conclusions: criteria for in/exclusion to ART restrict migrants' access to ART; current ART guidelines are not suitable for most migrants because basic conditions for providing ART are not fulfilled; and migrants are likely to experience more challenges in adhering to ART than local patients. This increases the importance of reviewing current ART guidelines in the effort to achieve sufficient adherence rates and optimal treatment outcomes.

We need to resolve problems related to basic conditions for providing ART to formulate ART guidelines that will improve migrant workers' access and adherence to ART (Table 5). This is important to make sure that principles of equity are maintained in the ART upscale.

The participants from Mae Sot experienced the greatest problems in accessing health care as a result of limited sick leave, long working hours, the cost of treatment, limited access to the health care insurance, a lack of safety en route to health facilities and communication problems at health centres. These problems were also experienced by most of the participants from Bangkok, but to a lesser degree. The participants from Chiang Mai experienced many of the same problems as the participants from Mae Sot and Bangkok, but to a lesser extent than the participants from both of these cities. In Chiang Mai, being permitted sick

leave was usually a problem only if it was too often; communication was primarily an issue for the newcomers; safety did not pose a great challenge in trying to seek health care compared with Mae Sot; and most participants held their own health insurance cards.

Variables compound and interact to complicate the process of migrants accessing ART. Limited sick leave and long hours of work, combined with public health facilities that are only open during migrants' working hours, force migrants in need of ART to choose between work and ART. Missing work to attend follow-up appointments can easily cost migrant workers their jobs. Finding a new job is difficult for HIV-positive migrants, and many lack a social network to help them if they are unable to care for themselves. It is thus important for ART to be delivered in such a way that it does not force patients to choose between ART and work, because both are essential for survival.

The challenges identified in this study are all more or less related to migrants' marginalized status in the host country. However, they can further be divided into three categories according to whether they are specific for migrants, directly related to the migrant status and whether they might be shared by local patients as well:

1. Challenges specific to migrants
  - a. Limited access to health care insurances (and work permits)
  - b. Language and communication barriers
  - c. Fear of harassment and arrest by the police
2. Challenges not specific for migrants but directly related to their migrant status
  - a. Discrimination
  - b. Limited sick leave
  - c. Limited social support
3. Challenges not specific for migrants and not directly related to their migrant status
  - a. Cost of treatment
  - b. Cost of transportation.

Not all migrants will experience greater difficulties adhering to ART than local patients. Several participants did not believe it would be difficult to follow ART, and a few HIV-positive migrants were already successfully receiving ART in Chiang Mai. Many migrants may be perfectly able to receive ART without extra interventions, and health care personnel may have few problems in providing ART to them. However, initiatives are still sorely needed if all migrants' access to ART is to improve.

Limited knowledge about migrants' status in the host country and the relationship between migration and health can cause health care providers to perceive migrants as an unpredictable and difficult group to treat, causing them to exclude migrants from ART. A lack of knowledge may also

**Table 5** Challenges and recommendations for antiretroviral therapy (ART) for migrants

| Factors/challenges  | Possible interventions  |
|---|---|
| Access to health care insurance and work permit             | Introduce a separate identification system for migrants on ART, so they do not need access to their health care insurance cards (or work permits) for ART   |
| Arrest by the police  | Advise the patients to keep extra pills on them at all times, in case they are arrested and kept from their medicines<br>Support from local authorities for ART programmes  |
| Cost of treatment   | Provide all parts of ART for free<br>Support transportation costs   |
| Discrimination  | Provide tools and guidelines for the delivery of ART to migrants<br>Train health care staff on issues of cultural sensitivity and the relationship between migration and health   |
| Language and communication                                  | Use high-quality professional translators<br>Use peer educators who speak the patients' own language, and can relate to the patient's background and situation in the host country<br>Use visual information  |
| Limited sick leave/ability to attend follow-up appointments | Provide written information in the patients' own language<br>Adjust the way ART is given:<br>Give follow-up appointments after migrants' working hours, so migrants do not have to miss work to attend them<br>Show more flexibility and tolerance for migrants who miss regular appointments<br>Provide ART at private clinics, and thereby reduce the distance to health care centres, thus making regular appointments less time consuming<br>Provide ART where the migrants work and live (combine with directly observed therapy (DOT) for tuberculosis if possible) |
| Social support  | Provide peer support groups<br>Eliminate social support as an inclusion criterion for ART (if present)  |
| Taking medicine at work                                     | Provide extra support and attention to adherence during follow-ups<br>Reduce pill burden<br>Use ART guidelines:<br>Careful integration of ART into the patient's daily life<br>Provide education and information on adherence in the patient's own language<br>Create a good relationship and good cooperation between the patient and health care provider<br>Keep medicines in discrete packages so they cannot be recognized by colleagues as HIV medication   |

lead to poor cooperation and poor integration of treatment into the patient's daily life, leading to suboptimal adherence. Information and tools for providing ART to migrants will make health care providers able to provide better treatment to migrants, and make it easier for them to include migrants in ART programmes.

It is also important to improve migrants' knowledge about HIV/AIDS and ART, in the hope that they can learn how to prevent infection, voluntarily choose to be tested and seek proper treatment, if they do test positive. A nurse at the Mae Tao Clinic explained that many pregnant migrants did not receive treatment to prevent

mother to child transmission because they did not return for the results of their HIV tests. Free or cheap HIV tests are often available at public hospitals. There is however a tendency that people only get tested in a late phase of the disease.

Social support was often used as an in/exclusion criterion for ART. However, Spire *et al.* (2002) argue that non-adherence cannot be reliably predicted on the sole basis of a few patients' characteristics, and suggest that doctors should focus on helping all patients adhere properly to ART. They have called for a dynamic approach, focussing on adherence in the continuation phase of treatment. Thus,

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instead of keeping ART from patients with little social support, efforts should be made to provide this through social support groups and so on.

This study has tried to anticipate challenges when providing ART to migrant workers, by conducting FGD with factory/construction site workers with unknown HIV status. The outcomes of these FGD may however not correlate with what HIV-positive migrant factory- or construction-site workers on ART think and experience themselves. No HIV-positive migrant factory- or construction-site workers were available for this study. Migrants constitute a large and diverse group, and it is difficult to anticipate the relevance of this study for other occupational groups, such as sex workers, agricultural workers and seafarers. The FGD were done with men and women together. It is possible that gender-specific differences would have been more pronounced, if separate men's and women's FGD were held instead.

### Conclusions

Supporting migrants' rights in the host country and eliminating their vulnerable position are important long-term goals that will improve migrants' access to health care in general and facilitate ART for migrants. However, short-term interventions with more immediate effects are necessary to manage the current, direct challenges in providing ART to migrants. It is possible that interventions that focus on the delivery of services at health care institutions and the conditions under which ART are delivered, rather than on the migrants' living and working conditions, might bear more immediate results.

Interventions should aim at making ART guidelines suitable for migrants, by adjusting the way ART is provided. Taking into consideration such issues as health facilities' hours of operation, the availability of interpreters and cultural sensitivity training, is a move towards fulfilling some of the ART guidelines. These changes would make it easier for migrants to adhere to ART, and for health care providers to provide ART to migrants.

In-/exclusion criteria should not discriminate, but instead acknowledge and address migrants' difficult situation in the host country. Interventions should reflect the variety of challenges faced by migrants in different occupations in different locations.

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**Accès des migrants à la thérapie antirétrovirale en Thaïlande**

**OBJECTIF** Investiguer l'accès des migrants au traitement antirétroviral (ART) et évaluer l'applicabilité des directives du ART aux migrants.

**MÉTHODES** Six discussions de groupe focalisées ont été menées en Thaïlande avec 74 migrants birmans comprenant des ouvriers d'usine à Mae Sot et à Bangkok, des ouvriers de chantier de construction à Chiang Mai et des migrants VIH positifs sans emploi et non documentés à Mae Sot. Treize dépositaires et migrants principaux ont été interviewés pour la triangulation.

**RÉSULTATS** (1) les critères actuels pour l'inclusion/exclusion limitent l'accès du ART aux migrants. (2) les principales directives du ART ne sont en général pas applicables aux migrants. (3) les migrants sont susceptibles d'avoir plus de problèmes d'adhérence au ART que les patients locaux, ce qui souligne l'importance des directives du ART.

**CONCLUSIONS** Sans directives pour le ART qui prennent en compte les circonstances spécifiques limitant l'accès des migrants au ART, les pourvoyeurs de soin continueront à considérer les migrants VIH positifs comme inéligibles. Des interventions sont nécessaires pour rendre les directives du ART applicables aux migrants et pour surmonter les obstacles limitant l'accès des migrants au ART. Cela améliorera considérablement l'accès des migrants au ART et aidera à sauver les vies de milliers de migrants VIH positifs.

**mots clés** ART, migrants, accès, directives du ART, Thaïlande

**Acceso de emigrantes a la terapia antiretroviral en Tailandia**

**OBJETIVO** Investigar el acceso de emigrantes al Tratamiento Antirretroviral (TAR) y evaluar la aplicabilidad de las pautas de TAR a emigrantes.

**MÉTODOS** Se condujeron seis grupos de discusión focalizada (GDFs) en Tailandia con 74 emigrantes Burmeses: trabajadores de fábricas de Mae Sot y Bangkok, trabajadores de construcciones en Chiang Mai y emigrantes VIH positivos desempleados e indocumentados en Mae Sot. Se entrevistaron trece interesados y emigrantes para realizar una triangulación.

**RESULTADOS** (1) Los criterios actuales de inclusión/exclusión restringen el acceso de emigrantes al TAR (2) Las principales pautas de TAR, en general, no son aplicables a los emigrantes (3) Los inmigrantes son más propensos a experimentar problemas con la adherencia al TAR que los pacientes locales, lo cual aumenta la importancia de las pautas del TAR

**CONCLUSIONES** Sin las pautas de TAR que toman en consideración las circunstancias específicas que limitan el acceso de los emigrantes al TAR, los proveedores de cuidados sanitarios continuarán a considerar a los emigrantes VIH positivos como no elegibles. Se requieren intervenciones, tanto para hacer aplicables para los inmigrantes las pautas de TAR, como para sobreponerse a los obstáculos que restringen el acceso de los emigrantes al TAR. Esto mejoraría el acceso de los emigrantes al TAR y ayudaría a salvar las vidas de miles de emigrantes VIH positivos.

**palabras clave** TAR, emigrantes, accesos, pautas de TAR, Tailandia