Chapter 1

Introduction

1.1 Background of the Study

Thailand is known to the home for migration of low skilled labors from neighboring countries in Mekong region due to its stable and prosperous economy in the region. Moreover, Thailand hosts large number of migrations which includes not only refugees but also asylum seekers and low skilled labor migrants from neighboring countries such as Lao People’s Democratic, Cambodia and Myanmar, approximately two million of migrant labors and their companies are considered be a part of Thailand’s growing economy. Many of them are supposed to engage with menial jobs those are also known as (3Ds= Dirty, Dangerous and Difficult ) jobs such as fishing, factory, sex industry, entertainment industry, agriculture sector and domestic work while native Thai people are unwilling to engage with such kind of uninspiring jobs

HIV prevalence among Myanmar migrant workers are considerably higher than that of native population due to their high risk behavior and vulnerability to HIV/AIDS infection. Survey conducted in 1999 has proved that 17.4 per cent of migrant population is being infected HIV while survey implemented in 2000 at particular four provinces in Thailand, Samut Sakorn, Ranong, Songkhla and Trat has shown a prevalence rate of 16.1 per cent. In 2008, an approximate total HIV prevalence among fishermen in Thailand was in between 2.5 and 9 per cent respectively. (aidsdatahub, 2009).

1.2 Research Problem

Due to the long running civil war, poorly recorded human right abuse, lack of job opportunity, economic hardship and political instability tens of thousands of Myanmar citizens of diverse social backgrounds are fleeing their home land resorted to settle in neighboring country, Thailand. Most of them are ethnic minorities from rebel held areas such as Karan state, Shan state and Kachin state in search of better lifestyle, political freedom and higher income in economically better off its neighbor Thailand. There are also pull factors which contributed migrants to seek job opportunity in Thailand being the fact that some of them are persuaded by their relatives who have already existed in destination country. Moreover, relatively higher income also attracts migrants to settle down in Thailand.
Thailand became a home to 2 to 6 millions of Myanmar migrants. However, A large number of migrants are believed to be Burmese (Yang, 2007, p.488-489) while 1.25 million had registered in 2004 (IOM, 2007). Obviously, migrants are products of the economic mismanagement and political instability of the country ruled by military junta for over a numbers of decades (SUR – International Journal on Human Rights, 2009).

In 2004, Thai government had introduced a registration program for migrant population to be easily regularized and controlled their status. In the same year, as many as 1,280,000 migrants had registered through Ministry of Labor of Thailand in which 814,000 of migrants had applied for work permits (Yang, 2007, p.506). In addition, migrants are also allowed to purchase National Health Security System Insurance at the cost of Baht 1,300 for annual fees and Baht 600 for health examination. Most of the migrants have purchased National Health Security System Insurance since they believed that health benefits covered in its program is more comprehensive treatments and services (Raks Thai Foundation, 2011). In 2004, every migrant who had officially registered through Ministry of Labor of Thailand is basically entitled to access health care services such as disease control, rehabilitation, minor cases and even regular check-ups services through Compulsory Migrant Health Insurance (CMHI) program health care coverage of CMHI is the same as Thailand’s Universal Coverage Scheme (UCS or locally known as 30 baht scheme) with small amount of fixed co-pay system for inductive health care services and minor cases while migrants have to bear for major cases. However, provision for free antiretroviral therapy (ARV) treatment for migrants living with HIV has not covered yet in the package whereas Thai nationals are entitled free ARV treatment under the coverage of UCS (Universal Coverage Scheme) and even every pregnant woman is also granted ARV treatment for as part of Protection of Mother To Child Treatment, (PMTCT) regardless of their citizenship status or legal status in order to eliminate children born with HIV infection in year 2015 to accomplish United Nation’s initiated one of the Millennium Development (THR, 2004,p.45-46). In 2011 72% out of total population excluding migrant population have received free ARV treatment it means the achievement of free access to ARV treatment for its own citizens is quite dramatic compared to only 8% of total population in year 2002(HIV/AIDS – Research and Palliative Care, 2013) while only 2300 migrants living with HIV have already received ARV treatment through Global Fund Project (UNAIDS, May 2012).

Migrants have never undergone HIV testing in their home country before, most of the female came to aware their HIV status through pregnancy test in which HIV testing is mandatory for the purpose of HIV Prevention for Mother to Child Program( PMTCP) whereas some migrants have undergone HIV testing when their body shown symptomatic HIV infection such as having numerous sores on their bodies, suffering from severe diarrhea, pus,lesion on female genital track and serious illness. It has already reached at the later stage of HIV infection by the time they came to know they are exposed to HIV virus. Similarly, there are also many HIV related complication such as having insufficient ARV drug when patients are in serious need. At the same time, ARV treatment is being prioritized for Thai citizens as of the national health care policy so called National Access to Antiretroviral Program for People living with HIV and AIDS (widely known as NAPHA extension) funded by Global Fund Project. Under this program only handful of Myanmar migrants living with HIV virus are considered eligible enough to receive ARV drug for the replacement of Thais living with HIV who died off HIV/AIDS related disease or who voluntarily dropped out of the ARV treatment.
regimen while provision of ARV treatment is being prioritized for pregnant women with HIV virus in order to eradicate HIV transmission from mother to child regardless of nationality or legal status to fight against HIV related child mortality rate in year 2015.

Moreover, according to culturally rooted gendered assigned roles and responsibility of male power relation over female, condition and challenges of accessing HIV services vary from person to person and contextual.

1.3 Rationale of the Study

A lot of theses have been written about cross-border migration and HIV/AIDS issues on global scale, regional scale and even in the context of Thailand and its own citizens. Similarly, countless numbers of articles and journals have also been written about migrant population in Thailand including largely constituted migrants, Myanmar of different ethnicities, Cambodian migrants and even Laotian migrants’ HIV/AIDS related issues and access to HIV health care services by them in the context of Bangkok area, Samut Sakhon, Chaing Mai and even Northeastern region of Thailand, Issan on the aspect of most high risk groups such as sex workers, men who have sex with men (MSM) and Intravenous drug users (ID) and even HIV to mother to child transmission.

However, the reason Mae Sot is chosen as a study area is that the town itself is considerably exotic and heavily constituted with migrant workers. Therefore, the problems and issues arise from these groups of people vary from person to person. Not just that, no research paper had written especially on the issue of the most vulnerable group of Myanmar migrants living with HIV virus from different social backgrounds of highly marginalized group of people are lacking access to HIV health care services and even in utilization of HIV health care and treatment services encounter many difficulties in receiving quality health care services. As far as HIV/AIDS and cross-border migrations issues are concerned. Free ARV treatment is provided to Myanmar migrants living with HIV by a very handful of hospitals and clinic through donor funded free ARV delivery program on limited health care settings by the support of Thailand ministry of health.

Therefore, this study is aimed at analyzing the availability of HIV health care services for migrants living with HIV and to identify numbers of PLWHA Myanmar migrants who currently receiving ARV treatment in Mae Sot area from gender perspective. This study will also not only explore for how many community based organizations are supporting to which extent to migrants living with HIV who are in serious need of care, support and treatment .Furthermore, findings of this study will be beneficial for addressing HIV issues among Myanmar migrants living with HIV, in this sense, donors, stakeholders, NGOs, community based organizations and policy makers can also take it into consideration on these findings in order to design and implement the most effective and equitable HIV health care policy for these most marginalized group of people.

1.4 Research Objectives

The objective of the study is to understand and analyze utilization of HIV health care services and treatment of Myanmar migrants living with HIV in Mae Sot area of Thailand

1. To provide recommendations based on the finding of the study.
Chapter 2

Literature Review

2.1 HIV in Global

According to UNAIDS’s Global Fact Sheet 2013, globally there were an estimated 3.5 million people living with HIV in 2012 and an estimated 75 million people have infected HIV since the beginning of the outbreak of the epidemic. The highest HIV related deaths had been happened in 2005. Estimated 2.3 million died from HIV globally. (UNAIDS, 2013 Global Fact Sheet).

2.2 HIV in Thailand

There are estimated 495,000 people are living with HIV in Thailand (Thailand AIDS response progress report 2012). HIV infection among young people is alarmingly higher because of their sexually active behaviour at their earlier age and unprotected sexual behaviour. Young people involved in high risk groups such as injecting drug users, men who have sex with men and sex workers. There are also 194,000 women living with HIV in 2011 while estimate 10020 people newly infected HIV annually. Moreover estimated 24,500 have died from HIV in 2011 (Thailand AIDS response progress report, 2012).

There are also 3 million migrants workers in Thailand including migrants from Myanmar, Cambodia and Laos in which larger numbers of migrants are from Myanmar. Basically HIV infection among migrant population in Thailand is higher even though there is no statistical evidence and proper research have not been found due to Thai government’s surveys have never separated migrant population when they conduct HIV prevalence in Thailand. Sexual liberty and unsafe sex practice has increased vulnerability and high risk to HIV transmission among migrant population (Thailand AIDS response progress report, 2012)

2.3 HIV in Myanmar

According to country review 2011, Myanmar has discovered its first HIV case in 1988. However, in 2009 HIV prevalence has dramatically decreased from 0.8 per cent in 2001 to 0.6 per cent in 2009 among general population, aged 15 to 49. In 2009, there were an estimated number of people living with HIV around 240,000 and Myanmar was regarded as the third highest HIV prevalence among in the region of Southeast Asia (Country Review, 2011 p.2). According to the HIV Sentinel Surveillance (HSS) which was conducted in 2009, the most high risk groups are injecting drug users (IDUs), men who have sex with men (MSM) and female sex workers (FSWs) in which 34.6% of HIV prevalence have found among (IDUS) while 22.3% have found in (MSM) and 11.2 have found in (FSWs) respectively (Country Review, 2011 p.3).

There are also draconian laws which obviously hindered to implement the prevention of HIV infection among high risk population such as Myanmar still exercising Section 377 of Myanmar penal
code, act 45/1860 against Sodomy which has been imposed since the British colonial time in which the act of same sex is criminalized up to maximum 10 years of imprisonment and life sentence. Similarly, drug users are also criminalized in jail term up to five years in prison when seeking treatment. Furthermore, sex work is also considered illegal and severely criminalized in Myanmar. Its national laws limit the efficacy of implementation for HIV prevention as well as HIV treatment and health care services. In the mean time, these so called most at risk populations are being undergrounded and discouraged to seek proper HIV health care and treatment. (Country Review, 2011 p.10).

Work Permits

According to Dannis Arnold, migrants in Thailand have to pass three steps in order to obtain an official permit. Firstly, they have to register for police registration record secondly, once they have done for police registration, they are asked to go to referred hospital to have their blood test and the result is mentioned in the card. Therefore, as a final stage, official work permit is issued upon receipt of blood testing card.

2.3 HIV/AIDS Risk and Prevalence Rates of Migrants

Thailand government has always actively adopted any kind of progressive policies involved with HIV/AIDS since Thailand has been in the position of being one of the most HIV infected countries in the world. Basically, inadequate data of actual prevalence rate of HIV/AIDS among migrant workers population in Thailand prepared by some of the local Thai officials is only available with uncertainty. The result of prevalence rates and data are not reliable as it is supposed to have been used improper methodologies and survey has not also been done on regular basis. Unlike other countries around the world, there was no mandatory HIV testing for employee as whole including migrant workers of all walks of life from different countries whereas only HIV sero-surveillance which focuses only on particular high risk of HIV/AIDS infection such as for those who engage in fishing board (fishermen), entertainment industry, brothel house and sex industry (sex workers) on general population as a whole. It means that there is no specific surveillance which is particularly surveyed for migrant population alone and data for that group are also covered Thai population in general as well.

According to Brahm Press (Raks Thai Foundation), survey made among Burmese migrant workers in Samut Sakhorn Province in 2001, total account of 1.4 % (316 migrants) infected HIV. Similarly, in 2003, 35 migrant women (1.4 percent) out of 2435 who tested HIV via ANC clinics were being diagnosed HIV positive. In the case of fishermen, they tend to be on a boat for longer period time by without engaging sexual relation with their spouses or intimate partners for over the long period. When they are off the sea, drinking and visiting to sex workers are accustomed to fishermen life as this kind of practice is socially accepted among fishermen community. On the other hand, their drunkenness strengthened fishermen to use condom improperly and inconsistently. Additionally, according to some surveys, condom use is rarely practiced among fishermen migrants. Furthermore, there is also a huge misconception about conception about condom use among Mon ethnic group, Burmese and Cambodian because they normally decided whether they should use condoms is basically depending on sex workers’ personality, physical appearance and skin colour.
Another riskiest practice and wrongful perception is enlargement of their penises by putting glass beads under the foreskin of their penises when they are on boat in order to intensify sexual pleasure of women while having sex (Martin Foreman’s AIDS and MEN). Some places where neighbors of fishing ports, construction sites and factories are mostly abundant with many karaoke bars, massage parlors and coffee shops and array of brothel houses being occupied with migrant women staff. Factory and construction works tend seek commercial sex workers who speak the same language of them.

2.4 Health Care Service to Migrant Workers and their Health Care Seeking Behavior

Not having had certain knowledge and proper education has been one of the most disturbances to attain quality healthcare for migrant population. When it comes to minor health problem among migrant workers, they tend to follow traditional way of treatment such as using drug or herbal medicine rather than seeking western medicine whereas Thais prefer to seek health care facilities from government scheme. Furthermore, Karen migrants are said to have been strong believers in worshiping spirits and believers in herbal medicine treatment among diverse ethnicities of migrants from Myanmar. As many as over millions of migrant workers living the Thai border illegally or legally and at the same time they tend to endure deteriorating living condition, addiction to drug, poor sanitation and lack of proper education make them prone to having enormous health risk than the rest of the Thai citizens. In Mae Sot, primary health care services providers available for migrant community there are 1) The Government Hospital 2) The Mae Tao Clinic and 3) Private Clinics respectively. When it comes to seeking health care, majority of migrant population especially male migrant workers prefer to seeking health care services at Mae Sot hospital, even though Mae Tao Clinic basically provides the health services with migrants’ common language in urgent needs for migrant population, due to the fact that migrants feel safe and relaxed since health care providers in Mae Sot hospital keep anonymity profiles of health care seekers whereas in Mae Tao Clinic migrants are ashamed of being known their medical results by health care providers who speak same language while seeking test for sexually transmitted diseases (STIs) especially HIV/AIDS testing (Arnold, 2004). However, when seeking general health care, Mae Tao Clinic also known as students’ clinic remains the most popular health care provider among migrant population in Mae Sot (Arnold, 2004, p.44).

2.5 Stigma and Discrimination

HIV/AIDS related discrimination can be found in three levels of settings such as 1) family and community setting 2) Institutional setting and 3) national level setting respectively. However, in the context of family and community setting, people living with HIV are being ostracized by their community for example women are forced to return to their relative when they are being diagnosed HIV. Moreover, they are being excluded from society by experiencing verbal harassment, gossip, denial of physical contact, verbal discrediting, abandoned by their own family and even denial of funnel rites when they died off. When it comes to institutional setting, discrimination against HIV/AIDS is commonly found in workplace, government office, hospital, school and social welfare settings by experiencing in reduce of standard of care, HIV is forced to test without having consent from particular individual, data are not kept in confidential manner and health care providers’ negative attitude towards people living with HIV. Moreover, their employment opportunity is being
denied based on their HIV status. Likewise, policy for compulsory HIV testing and denial of entitlement for their benefits of pension and social safety net, refusal of children entry to school and dismissal of teacher from school due to their HIV status. Sometimes, inmates living with HIV positive are being segregated in Jail from others. (UNAIDS, 2005).

2.6 Barriers for Accessing HIV Health Care Services

There are also a numbers of barriers can be found when it comes to accessing HIV health care services. Regulation of HIV health care service for itinerant groups of people such as SWs and migrants is available only at designated local health care setting, where they registered. In this case, referral service is also not available for migrant under the Compulsory Migrant Health Insurance (CMHI) and the Social Security System (SSS) (Churcher, 2013).

Likewise, scarce of health care resources, fewer financial support, lack of access to transportation and culturally accepted women responsibility to taking care of ailing children hindered women access to HIV health care services. Moreover, poverty, poor education, unemployment condition and lack of HIV related knowledge, women living in inner city poor neighbourhoods commonly faced poor access to prevention and treatment.

2.7 New Health Insurance for Migrant Workers in Thailand

Thailand announced new health insurance scheme for migrant workers in January 2013 and however, slightly revised it in August 2013. It seems that it does not make any difference from previous one (PHAMIT 2 staff, 2014). It is also a requirement to pass a health screening for all migrants who applied work permit. Migrants are supposed to pass seven types of diseases such as 1) tuberculosis, 2) malaria, 3) elephantiasis/ filariasis, 4) syphilis, 5) leprosy, 6) drug addiction/ alcoholism and 7) intestinal worms. Moreover, pregnancy test is also included in the scheme while HIV test is notably not included in it.

Migrants basically obtained health insurance card and apply health benefits once their health status is passed at the same hospital they registered and underwent health screening test. In the mean time, insured migrants are also entitled basis health care services including voluntary counseling and testing (VCT), opportunistic infection (OI) and that offered in migrants’ health care scheme. The new migrants’ health insurance scheme additionally included provision of ART (antiretroviral therapy) and dental services for migrants. Another notable change of new migrants’ health insurance scheme is that all migrants regardless of documented and undocumented migrants are allowed to purchase the scheme at the cost of 2,200 Baht for annual fee and 900 Baht for health examination fee. Previously, annual fee for health insurance cost 1,300 Baht while health examination fee was only 600 Baht. In addition, only 30 Baht per visit is required to pay when receiving health care facilities and treatments per visit. However, price for annual health insurance now has increased to 2,200, which is considered almost twice the price of previous cost. Similarly, health examination cost also increased up to 900 Baht from 600. Normally it is common practice the fact that the fee for entire cost is paid in advance by employers and will be monthly or annually deducted the actual fee from migrant wage later. There is also a health insurance package for migrant children, which costs only 365 for children up to 7 years of age while children of 8 years and above will be charged at adult health insurance rate.
In reality, Social Security department failed its efforts to all migrants to affiliate the system. So far Social Security provides passports for migrants who entered into Thailand formally under the Memorandum of Understanding (MOU) in which migrants also have to undergone National Verification process. Accordingly to current political changes being taken placed in Myanmar, bi-lateral cooperation is greatly improved between Myanmar and Thailand, being that estimate one million migrants have now already obtained passports in hand but in which, only one third of those (estimated 340,000) have formally registered under Social Security scheme while approximately 700,000 migrants do not have health insurance since they have not registered under Social Security scheme even though they are holding passports (PHAMIT 2, 2014). The reason why large numbers of migrants have not registered is that because of its complicated enrollment system in which both employers and employees contribute to the fund on monthly basis despite the fact that migrants are not entitled to benefit for retirement and unemployment. Another thing is that migrants working for so called informal sector such as agriculture, seafood processing, domestic work and fishing industry have notably excluded from the health coverage of Social Security scheme. Therefore, mostly employers intentionally have not registered their employees under Social Security scheme which is associated with National Verification process. This is the reason why large numbers of migrants do not have health insurance even though they are holding passports. In this regards, Thailand’ National Verification policy prevents migrants purchasing MHI (migrants’ health insurance). It becomes problematic for hospitals once the migrants purchasing power to MHI has significantly dropped since Social Security is implemented based on reimbursement system. In the end, on the ground reality, hospitals are not able to provide preventative health care services adequately as of coverage mentioned in health insurance for migrant population as a whole.

To my analysis based on information gathered from PHAMIT 2 and Mae Sot hospital. Thailand’s New Health Insurance for Migrant Workers has failed in a way because of particular factors.

- Lack of media coverage, a handful of people aware of new scheme and most of the health care setting in Thailand were not well informed about it.
- Highly bureaucratic nature of the Ministry of Health (MOH)
- Lack of Communication and co-operation between Institutional level policy makers and local level health care settings.
- Prohibitively high price to purchase New Health Insurance for Migrants, registration has significantly dropped and cannot generate budget to provide HIV health care because of reimbursement system
- Migrants lack of knowledge about exercising their rights and poor knowledge about host country’s laws and regulation
- Health care seeking behavior shaped by their culture behavior in which generally migrants from Myanmar do not seek general health care at clinic instead they usually get advice from their colleagues or relatives take suitable medicine or pill given by their co-workers and family members. Some ethnic minorities normally exercise traditional treatment rather than seeking western medicine. (Thus, they do not necessarily think they need to buy the scheme and importance of the scheme).
- Even migrants who hold passports do not have social security scheme because their employers do not register due to complicated regulation and procedure.
• Policy makers have excluded migrants working at informal sectors (fishing, domestic, agriculture and construction) where enormous numbers of migrants are heavily constituted (Key informants of PHAMIT 2, 2014)

Therefore, Implementation of social security scheme for migrant workers unmet the needs of migrant population on the real ground. It has failed because policy contradicts with implementation level in ground reality.

2.8 In-Depth Interviews with Respondents

During the data collection trip made in January and first two weeks of February 2014, In-depth interviews were being conducted with twenty (20) male Myanmar migrants living with HIV and twenty (20) female Myanmar migrants living with HIV on heterosexual context. Prior to that I was personally introduced by key-informer of Mae Tao clinic to male PLWHA peer counselor who is very helpful and patient to personally introduced with the rest of the required numbers of PLWHA respondents, those are currently taking ARV drug and HIV treatment at their respective designated hospitals and clinics at local setting.

According to his advice, he brought most of the respondents to SAW’s safe house where he and respondents themselves considered safe venue with privacy since most of the respondents feel insecure and unsafe to conduct interview at their own place due to family members and relatives within families while some of the respondents afraid of their neighbors knowing their HIV status. However, there were also a few exceptional cases because some of the respondents could not come over to meeting spot at SAW's safe house due to time constraint and their very busy schedule while some PLWHA respondents were not able walk at all since they are partially paralyzed due to the side-effect of ARV drug and living in far-flung area of Mae Sot. In this case, me and peer counselor made a prior appointment and eventually visited their places to conduct interviews with them.

2.9 Provision of ARV Treatment for Migrant Population at Different Health Care Settings in Mae Sot area

According to Mae Tao clinic, provision of ARV comprehensive treatment for migrant population was initiated by Medecins Sans Frontiers (MSF) in 2005. MSF was one of the first non-governmental organizations to provide urgently needed medical assistance and to publicly bear witness to the plight of the people (MSF, 2008). Initially, MSF offered treatment for not only living with HIV but also who had already co-infected with Tuberculosis or Hepatitis C. Migration living with HIV and co-infected diseases were pleased to be receiving treatment at MSF since MSF provide not only free service for co-infected disease but also provide transportation fees plus a few kilos of rice and onions for economically worse of migrants. May 2007 Mae Tao clinic initiated first referral to Mae Sot Hospital for ARV treatment. In fact, Mae Tao clinic is a community hospital which has provided good quality healthcare to migrant population on the grounds of non-discrimination. However, in 2007, The National Access To People Living With HIV/AIDS (NAPHA) extension program had implemented in order to provide ARV treatment to migrant workers and ethnic group (who are not being granted Thai citizenship). Eventually, in the end of year 2009 MAF was being stop operating to
deliver ARV treatment to its existing patients therefore MSF handed over its patient to Mae Sot Hospital and Phot Pha hospital respectively.

2.10 Provision of ARV Treatment in Mae Tao Clinic

When it comes to offering ART program, Mae Tao clinic cooperates with Mae Sot hospital under the name of national program for migrants, financially supported by Global Fund. Ever since initiation of this program 105 clients have referred to receive treatment at this program. According to data collected by Mae Tao clinic in 2009, 36 people living with HIV virus are receiving Anti Retroviral treatment at Mae Tao clinic. Which was the maximum capacity since the clinic is not being able to provide the drug. Among them, 15 patients out of total patients have sought for ART while on the other hand, they are co-infected with Tuberculosis, also have sought opportunistic infection (OI) treatment. In the same year, additional patients enrolment in Mae Sot is strictly limited due to the lack of financial constraint even though a couple of dozens of PLWHA patients were being lined up to access ART at the clinic. Only waiting list patients could substitute to access ARV once existing patients either drop out or died of HIV/AIDS (Mae Tao clinic). Moreover, according to the nutrition program for HIV patients, in 2009, initially Mae Tao clinic designated to deliver necessary food supplies such as rice, oil, condiments and dried fish to two hundred families every month through peer counselors who delivered many less fortunate families who were not able to travel remotely and financially disadvantaged people since the program itself was designed to favour for certain group of people who are exposed to HIV and potential families who are in dire need of nutrition. Eventually, they stop delivering the nutrition supplies due to insufficient amount of budget and substantially increasing numbers of HIV patients every year.

However, Mae Tao clinic is currently offering so called home based care and social support to patients with greatest social need. Particularly for women who are in dire need of clothes, blankets, shelters, subsistence foods and even no relatives to take care of her. In this case, Mae Tao clinic is currently appointed 6 counselors to visit 30 households per month who are exposed to HIV and considered under privileged.

With regards to current ART treatment, based on data collected from Mae Tao clinic which is considered one of the key informants of my study area, total of 103 HIV infected patients are receiving the treatment from Mae Tao clinic. In fact, the clinic has divided into two groups, Group 1 and Group 2 respectively. Group 1 has comprised of total of 39 patients who initially have received ARV treatment from Medecins Sans Frontieres (MSF) even before MSF has stop its operation in 2009 is now financially backups by Thailand’s National Access to Antiretroviral Program for People living with HIV/AIDS (NAPHA). Meaning, all 39 PLWHA patients are now receiving ARV treatment at Mae Sot hospital by the support of NAPHA extension. In addition, Mae Tao provides not only transportation fare for patients who seek the treatment at the clinic in particular assigned day but also offers translation service for PHWHA migrant community.

Similarly, group 1 consists of another 33 patients who are also receiving from Pho Phra hospital under the support of National Access to Antiretroviral Program for People Living with HIV/AIDS (NAPHA). However, ARV treatment is officially provided by Pho Phra hospital through Mae Tao clinic. Mae Tao clinic delivers the treatment for all 33 patients on behalf of Pho Phra hospital in order for migrants to be conveniently able to receive ARV treatment. In this case, migrants need not to worry for fear of being arrested by local polices, language barrier, forgo daily wage for not working, time
consuming and discrimination based on citizenship status. Patients have to receive ARV treatment at Mae Tao clinic once in three months while CD4 count is tested once in every six months at the clinic.

In this similar sense, group 2 constitutes with 30 PLWHA patients. Currently, patients from group 2 received ARV treatment through Mae Tao clinic by the financial support of AIDS Ark organization, in fact, the organization is based in France. The aim of the organization is to fund the supply of “generic” ARVs, to those of their most needy patients who are unable to access it. So far, AIDS Ark is not able to provide ARV for additional PLWHA patients in Mae Sot due to its insufficient funding even though Mae Tao clinic received the enrolment of additional 10 more patients in last year 2013.

2.11 Gender Dimensions of Patients Received ARV Treatment from Mae Tao clinic by AIDS Ark

Total of newly tested 30 PLWHA patient are being designated to receive treatment from AIDS Ark, France based organization starting from 2012. According to Mae Tao, AIDS Ark selected the eligible patients of who have CD4 count level less than 350 (≤ 350). In this case, all receivers have to meet with criteria of AIDS Ark and Mae Tao clinic in order to be eligible enough to be granted ARV. Moreover, receivers are also being in a position of immediate need of the drug. Nevertheless, due to insufficient amount of funding, no additional patients are entitled to receive the ARV treatment. To be able to analyse this data from gender dimension, female patients outnumbered male patients. In percentage, 60% (18 respondents) of male and 40% of female respondents are being granted ARV treatment. Which is obviously explained that more female are being tested HIV virus as well as more female who exposed HIV virus are in serious need of ARV treatment in the ARV program that that of male PLHIV migrants in study area.

2.12 Eligibility to ARV Treatment

ARV treatment should be eligible to people living with HIV who have CD4 T cell count level 500 cells/mm³ or less which applied to every country around the world (WHO, 2013) while according to the recommendation laid out in 2010, people with CD4 T cell falls 350 cells/mm³ or less. However, 90% of the countries in the world are still following guideline of WHO 2010 (WHO, 2010). Nonetheless, countries such as Brazil and some of the developed countries already exercised WHO’s 2013 recommendation. During my field trip to my study area in Mae Sot, local health care settings which provide ARV treatment to migrant population set a rule that all migrants living with HIV who have CD4 T cell count level 300 cells/mm³ or less are eligible to provision of ARV. In theory, eligible migrants in serious need of ARV must also be living in nearest location of local health care settings. However, in reality, substantially increasing numbers of eligible patients outweigh the capacity of local health care settings in which clinics are able to provide very limited amounts of ARV to those who are in need due to insufficient funding and ineffective health care policy being implemented by institutional level (Mae Tao clinic, 2014).

One of the barriers I found out during my field trip study is that ARV delivery is also strictly restricted based on adherence to ARV regimen regardless of their CD4 T cell count level. In this case, eligibility of ARV treatment is subjected to breach or deny if found frequent failure of adherence to ARV. In
the context of migrants’ adherence to ARV in Mae Sot are, female patients are more disciplined, well-followed and serious in a way of utilizing life-long ARV treatment than that of male migrants living with HIV. Basically, failure of adherence to ARV is frequently found among male migrants due to their careless behaviors such as excessive drink of alcohol, frequent unprotected sexual relation with their spouse also living with HIV and illegal drug use etc. Eventually, the result of these behaviors can cause drug resistance for those who have been utilizing ARV. In consequence, their CD4 T cell level has decreased to larger extent and they are resorted to get second line ARV treatment which is obviously far more expensive than first line ARV and not readily available either. In terms of Myanmar society and culture, men are helpful, co-operative and supportive each other especially when they are in normal condition but when get drunk, they become unconscious and all of the sudden, the shout and fight against each other for no reason.

2.13 Implication of Current Political Changes in Myanmar

Myanmar political landscape has changed since quasi civilian government took office in October 2010. Alongside of political changes in Myanmar, on the other hand, Mae Tao clinic encountered financial difficulty since international funding for migrants and displaced populations in Thailand border area has ended in the end of 2013. Around 20% of Mae Tao clinic’s funding, in the past approximate $AU 500,000 has been annually provided by Australian Government. Since the end of December 2013, funding priorities have shifted towards from Thailand’s side to Myanmar side in order to provide life saving health care treatment especially for those living in Thai-Myanmar border areas (Dr. Maung C, 2014). In the mean time, life saving health care treatment for migrants living with HIV/AIDS is precarious since migrants currently receiving ARV drug and treatment financially funded by Global Fund project as part of the program expanding access to particularly vulnerable groups such as those with HIV and pregnant women (Mae Tao clinic, 2014). However only small numbers of migrants living with HIV who are in serious need of ARV drug are eligible compared to larger numbers of migrants who are in desperate need of HIV health care due to insufficient funding. Moreover, lack of modern equipment at Mae Tao clinic is also a huge barrier for both health care providers and health care seekers. In light of this, health care services provided by the clinic is considered way inefficient for health care seekers including migrants who are in serious need of HIV care and treatment. In this case, CD4 T cell testing, viral load testing, delivery service for pregnant women, long stay for inpatient care and AIDS treatment are always referred to Mae Sot hospital by the recommendation of Mae Tao clinic. Moreover, migrants who have already undergone HIV testing are supposed to wait at least a day or a couple days due to ineffective regulation and lack of modern health care equipments. In consequence, this inefficient health care service negatively effects to migrants, one of the marginalized groups especially migrants who are in dire need of HIV health care because in order for them to be able to have HIV testing, they are supposed to take leave from their daily wage job and their daily earning is forgone for keep waiting at the local health care setting for about half day with many other patients. Inefficient health care service is not only created economic hardship but also compounded by the problem like discrimination against their legal status in a sense that migrants are often being arrested and extorted money by the local polices on the way to clinic because of not being able to prove their legal status. However, eventually migrants resorted to offer bribes to local police in order to escape from the arrest. For this discrimination against legal status and HIV status, respondent number 2, who has no ability to
read and write Burmese language has recalled his bad experience especially how he was being treated because of his illegal status and HIV status.

**Finding**

On the ground reality, in utilization of ARV treatment for Myanmar migrant population is unfavorably limited due to fear of arrest and deportation, discrimination and social stigma, lack of information resource, lack of financial resource, forced confinement, illegal status (undocumented status), lack of HIV/AIDS knowledge and language barrier. Eventually, they are potentially to be died of AIDS disease for the result of the denial of ARV treatment on above mentioned discriminatory basis. Moreover, lacking general knowledge about health care and how to exercise their rights are commonly found among migrant population in study area especially even among registered migrants.

Furthermore, according to the in-depth interview with HIV infected migrant group, financial challenge is considered to be one of the biggest problem among PLWHA Myanmar migrants. On top of that, transportation costs to clinic, costs for additional treatment, daily income for their daily survival, house rental, financial difficulty for their children education and for those patients who take leave from their works for receiving ARV drug at appointed date forgo their daily wage. Another determinant of migrants affect to the development of severe drug resistance and experiencing rapidly increased viral load is not accessing ARV treatment in due time even though they are eligible to take the drug due to very limited provision of ARV delivery by the donor funded organizations. According to Thailand’s generic brand ARV’s guide line, patients are advised to be taken the drug every 12 hours on daily basis. In this case, it is obviously a lot much easier said than done situation for migrants who work long hours at factories to take a few minutes off from their assigned duties in order to take the drug on time due to fear of being laid off by their employer because of their HIV status.

Majority of migrants have very low level of HIV/ADIS knowledge because it would be the effect of their poor education back ground and very low level of sexual health knowledge which is shaped by their gender ideology and cultural norms.

After having in-depth interview with PLWHA Myanmar migrants, a few numbers of them have desire to go back to their native country if the drug is readily available and provided in free of charge basis whereas some HIV positive migrants have no intention to go back to their native land even though ARV is readily available and freely provided for them because of HIV/AIDS related social stigma in the society and even within family, violation of human rights, land confiscation, not having legal documents such as their national identification cards and household registration. The crucial part of the the issue is obviously there are no job creations and opportunities are still being taken placed in those far-flung areas so far. As a consequence of current political changes being taken place in Myanmar, many of the donors’ funded HIV/AIDS projects have shifted to Myanmar. In light of this, funding from Australia government has stop providing Mae Tao clinic and started shifting to Myanmar in order to provide provision of ARV regimen to Myanmar living in Myanmar who are in serious need of the drug, therefore, whether life-long provision of ARV treatment for migrants utilizing the treatment for migrants living in Mae Sot area is still a question mark. However, ARV
provisions are currently being implemented in city and township levels while most of the resources poor far-off areas are still lacking access to health care, education, infrastructure, water sanitation, communication, job opportunity and ongoing civil wars. Most importantly, ineffective new health care policy negatively affects the improvement of health care coverage for migrant population and health care financing for migrants. Deeply rooted culture of corruption practice among employers and authority of the host country weaken in country rule of law and it also created exploitative condition and appalling records of violation of human rights. Therefore, social protection for migrant population is non-existence. Furthermore, culture of highly bureaucratic system among policy making level and policy implementers impeded in achieving to improvement of migrants access to quality health care is compounded by the poor health care in sending country, poverty, poor human right record, lack of job opportunity, lack of government spending in health care and current political transition discouraged migrants seeking HIV health care in home country. Their illegal status compounded by not having mobile HIV delivery and treatment services for the most marginalized group of people who are in serious need of HIV health care services and treatment.

**Recommendation**

Migrants from all walks of life in Thailand should be able to access ARV treatment regardless of their legal status. Therefore, eligibility of ARV drug should be delivered to migrants from all walks of life those are in serious need of the drug on equitable manner.

People living with HIV positive should be appointed as peer counselors among their peer group especially for HIV voluntary counseling and testing service and outreach program in order to well inform about the importance of HIV testing, ARV treatment, adherence of ARV regimen will also affect their lives in healthy way in longer terms. In the mean time, by employing PLWHA people part of ARV delivery program is a way of empowering them and giving a sense of hope and belonging in the community. In this sense, social stigma and discrimination against HIV/AIDS and people living with HIV will also be alleviated to some extent. Furthermore, providing mobile phone text message to people living with HIV in poor resource setting such as economically worse off patients who live in far-flung area and always have a transportation cost problem would benefit the enhancement of the adherence to ARV treatment by improving viral load suppression through the service of mobile phone text message in order for the PLWHA patients not to be miss out the dose on daily basis. Beside substantial numbers of well trained nurses and health care providers for HIV treatment are needed in order to cope with inadequate numbers of nurses offer larger numbers of HIV/AIDS patients including marginalized population. Ministry of Health should draft that kind of effective health care policy and health care financing which caters migrant friendly registration procedure which aims at the improvement of migrant population access to health care scheme and to increase access to ARV for marginalized group who are in serious need of the treatment.

Health care house for men living with HIV or shelter should be established to reduce obstacle and burden of migrant utilization in ARV drug and to change migrants’ health care seeking behavior. With regards to reducing HIV stigma and discrimination, people living with HIV should be employed at outreach program or as peer counselor in order to give them a sense of hope, make them feel they are important, visa and employment based on HIV status should be eliminated.
Policy makers should seriously take it into consideration for the fact that the importance of sensitization to the situation of migrant in ground reality when it comes to designing health care finance and new health care policy for migrants in which migrants are working at so called informal sectors where large numbers of migrants are heavily constituted and contributing the development of Thailand’s economy should not be neglected and excluded.

Policy makers, policy implementers such as local health care settings, hospitals and community based clinics, donors, NGOs, CBOs and border police unit should be effectively taken collective effort in combating deeply rooted corruption cases and providing appropriate training health care providers and police to eliminate stigma and discrimination which heavily impede in fighting against HIV/AIDS as well as implementation of UN Millennium Development Goals in which combating HIV/AIDS is highly prioritized.

Last but not least, right based approach to HIV testing and counseling should be promoted among health care providers and patients in order to improve the importance of people’s perceptions on the benefit of HIV testing and counseling in which patients’ confidentiality should be strictly protected. Post HIV testing should be done regularly and to promote HIV testing and counseling to accelerate its momentum till reach the target to Universal Access.

References


