Background

Two million migrants live in Thailand. Most of them face serious problems to access Thai health services. MSF worked from 2005-2009 in southern Thailand to increase access to health services for 10,000 Burmese migrants engaged in fishing, construction and rubber plantation work. This included paying for cost of care for unregistered migrants, transport, translation services, organizing mobile clinics, and health education. In addition, MSF provided HIV/AIDS care, including ARV. In migrant populations ARV initiation is often discouraged due to fears of high loss to follow up. In literature we did not find any data on treatment outcomes among migrants. This report describes MSF's project for Burmese migrants under treatment of HIV/AIDS in Phang Nga.

Method

Retrospective review of routinely-collected MSF program data from January 2005 to March 2009.

Results

252 patients were diagnosed as HIV-positive. For only 33% of patients not enrolled through PMCT, CD4 counts were available. Of these 56% showed a CD4 count below 200 and 68% were classified as Stage III or IV according to WHO staging. Overall, 55 deaths out of 252 (22%) were recorded, with a mean time from diagnosis to death six months. Additionally 37% was recorded as lost to follow up, most pre-ART initiation and possibly including underreported deaths. However, among 49 patients on ARV, 78% was still alive and on treatment. Only 4 deaths on 55 (2%) occurred and loss to follow up was 6%. Outcomes overall and for people on ART are provided in table below.

Outcomes of all patients receiving HIV care	N = 252	Outcomes of patients on ARVs	N = 49
In care, not on ARVs	60 (24%)		
In care, on ARVs	38 (15%)	In care, alive	38 (78%)
Lost to follow up	94 (37%)	Lost to follow up	3 (6%)
Transferred out	5 (2%)	Transferred out	4 (8%)
Died	55 (22%)	Died	4 (8%)

Conclusion

This study shows the continued existence of important bottlenecks to ART initiation for Burmese migrants in Thailand. Although for most patients urgent ARV initiation was indicated at moment of diagnosis (CD4 < 200 or Stage III-IV), only 15% had started ARV after one year.
Overall a high death rate of 22% was recorded among these HIV-patients, mainly due to deaths occurred before ARVs were started. A further 37% of

patients were lost to follow up, also most pre-ART; probably many among them have in reality died.

Patients started on ARVs had much lower death and loss to follow up rates, with outcomes of death and loss to follow up similar to the national ARV-programme (estimated mortality at 6% and 4% loss-to-follow-up). However more transfer-outs were noted.
This experience supports the value of timely enrolling patients on ARV, as confirmed by other studies from Thailand. However, in migrant workers accessing HIV care and in particular ARV remains problematic and this despite MSF’s efforts to overcome certain barriers. Many patients in urgent need of ARV died while waiting for ARV initiation.