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Displacement and HIV: Factors Influencing Antiretroviral Therapy Use by Ethnic Shan Migrants in Northern Thailand

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Abstract

Migrant populations face increased HIV vulnerabilities, including limited access to antiretroviral therapy (ART). Civil conflict in Myanmar has displaced thousands of people from the minority Shan ethnic group into northern Thailand, where they bear a disproportionate HIV burden. To identify barriers and facilitators of ART use in this population, we conducted a rapid ethnographic assessment and case study with a clinical sample of Shan migrants receiving treatment for HIV in a district hospital in Chiang Mai, Thailand, Thai nurses providing their care, and health care administrators ($n = 23$). Barriers included fears of arrest and deportation, communication difficulties, perceived social marginalization, limited HIV knowledge, and lack of finances. Facilitating factors included hospital-based migrant registration services and community outreach efforts involving support group mobilization, referral practices, and radio broadcasts. These findings provided a contextualized account to inform policies, community interventions, and nursing practice to increase treatment access for minority migrant groups.

Keywords

antiretroviral therapy; case study; ethnic minorities; HIV treatment; migrant populations; rapid ethnographic assessment

The health of the world's estimated 232 million international migrants and 740 million internal migrants continues to be one of the most salient challenges facing health care

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systems globally, and geographically displaced populations are at greater risk of acquiring infectious diseases, including HIV (International Organization for Migration, 2015; Joint United Nations Programme on HIV/AIDS [UNAIDS], 2015b). Migrants who are living with HIV infection in several countries across multiple regions also face vulnerabilities associated with health care inequity, including host country restrictions, economic obstacles, and other barriers limiting access to effective antiretroviral therapy (ART; UNAIDS, 2014). ART use by persons living with HIV (PLWH) is key to reducing mortality, progression to advanced HIV disease, and viral transmission to others (UNAIDS, 2012). International programs to scale up access to ART have yielded increasingly positive results on a global scale, but there has been less success in migrant populations, particularly in those that are undocumented (UNAIDS, 2012). For these reasons, the Joint United Nations Programme on HIV/AIDS lists unrestricted health care access for undocumented migrants as a top priority to achieve by 2020, in order to meet its vision of ending the AIDS component of the HIV pandemic by 2030 (UNAIDS, 2015b).

With an adult HIV prevalence of 1.1%, Thailand is the only country in Southeast Asia currently exceeding 1% infection in the general population (World Health Organization [WHO], 2014). Although new HIV infections continue to decline, the pace has slowed. In 2014, there were 7,700 new infections in Thailand, reflecting a 23% reduction from 2010, compared to a 65% reduction in new infections between 2000 and 2010 (National AIDS Committee, 2015). Thailand is doing better than most of the world regarding ART coverage, including most other countries in Asia and the Pacific. Thailand and Cambodia are the only two countries in the region with more than half of PLWH currently on ART, according to limited data from UNAIDS (2015a); Thailand's coverage is estimated at 57%. This compares to 33% coverage in Southeast Asia as a whole, and only 36% globally (WHO, 2014). Regrettably, migrants in Thailand have not benefited from ART scale-up efforts to the same degree as the native Thai population. In spite of recent policy initiatives by the Ministry of Public Health to augment health care coverage for migrants, including for HIV, these populations still have limited access to HIV treatment and care (National AIDS Committee, 2015).

An estimated 3.7 million migrants are living in Thailand, the vast majority from neighboring Myanmar (also called Burma), Cambodia, and the Lao People's Democratic Republic (i.e., Laos). The largest number, approximately 2.3 million, is from Myanmar (United Nations Thematic Working Group on Migration in Thailand, 2014). The Shan people, or Tai Yai, are the second largest ethnic group both in Myanmar and among Burmese migrants in Thailand, behind the Burman ethnic group, or Bamar (Suwanvanichkij, 2008; United Nations Thematic Working Group on Migration in Thailand, 2014). In Myanmar, the Shan historically have experienced violence and human rights abuses from eras of conflict with a militarized government, comprised principally of the dominant Burman ethnic group (Suwanvanichkij, 2008). These struggles, increasing political unrest, and economic development disparities between Myanmar and Thailand, which began intensifying in the 1980s and 1990s, stimulated a flow of mainly undocumented Shan migrants into northern Thai provinces. The 2,500 kilometers of largely porous border between Myanmar's eastern Shan State and northern Thailand have facilitated this migration (Eberle & Holliday, 2011). Additionally, the many Shan migrants who have not been granted refugee status by the

United Nations or the Government of Thailand are considered illegal undocumented laborers. This precludes their receiving shelter in the displaced persons camps along the border and the prescribed legal protections that accompany refugee classification (Suwanvanichkij, 2008).

There has been substantial HIV-related research in migrant populations in Southeast Asia overall, but a recent systematic literature review found an underrepresentation of studies in Thailand and Myanmar (Weine & Kashuba, 2012) and relatively little is known about the large number of migrant Shan living in Thailand (Grundy-Warr & Yin, 2002; Guadamuz et al., 2010; Latt, 2011; Verma, Su, Chan, & Muennig, 2011). Even in studies of migrant populations in Thailand, including those of Karen, Mon, Laotian, and Khmer ethnic groups, many have excluded the Shan or aggregated them together in Burmese or “other” categories (Ford & Chamrathirong, 2007; Mullany, Maung, & Beyrer, 2003). The small number of studies that have included the Shan suggested that they were at increased risk of HIV infection, and that those living with HIV were largely undetected by surveillance systems in Thailand (Chantavanich et al., 2000; Verma et al., 2011). Indeed, epidemiologic data on HIV in this population are scarce. One study reported HIV prevalence in a Shan migrant sample in Chiang Mai Province at 4.9% (Srithanaviboonchai et al., 2002). This was more than twice the prevalence observed in two sentinel surveillance populations that represented the general Thai population in the same area: pregnant women (2.1%) and young male military personnel (2.3%). In another study, HIV prevalence was 8.75% among Shan living in rural Thai hill tribe communities, higher than all other ethnic groups included in the analysis (Beyrer et al., 1997). Considering continued migration patterns from Myanmar into northern Thailand (United Nations Thematic Working Group on Migration in Thailand, 2014), it is also noteworthy that the highest HIV prevalence in Myanmar has been clustered in Shan State (see Figure 1) – an area with large populations at increased risk, including female sex workers, men who have sex with men, and injection drug users (Beyrer, Razak, Labrique, & Brookmeyer, 2003).

As with other migrant groups in Thailand, the Shan have had significantly diminished access to primary Thai health services, including sexual health education, screening for HIV, and ART (Suwanvanichkij, 2008). However, largely due to a lack of qualitative research, little is known about the specific challenges faced by HIV-infected Shan migrants needing ongoing ART, and how those challenges are successfully navigated. We conducted a study to address these gaps in knowledge. Our purpose was to identify barriers and facilitating factors for ART use in Shan migrants receiving treatment for HIV in Chiang Mai Province, Thailand.

Methods

Participants and Data Collection

We employed a combination of rapid ethnographic assessment and case study design over a 2-month period. Our intention was to respond to local needs, so we chose this design after consulting with local researchers in Chiang Mai University's Department of Community Medicine. These advisors indicated that an understanding of factors affecting ART use among Shan migrants was a priority in need of immediate attention. Rapid ethnographic assessment (Scrimshaw & Hurtado, 1987) allowed us to respond quickly to local need and to

communicate our findings expeditiously to the Chiang Mai community. Variations of this method have been used effectively in previous HIV research in Thailand (Wattayau, Wenzel, & Panchareounworakul, 2015). However, accommodations to dominant Thai social and cultural forms, to a degree, have rendered the Shan increasingly invisible as an ethnic group in northern Thailand (Latt, 2011). This, combined with prevalent HIV stigma in migrant groups, has made HIV-infected Shan a hard-to-reach population (National AIDS Committee, 2015).

To address this challenge, and for efficiency, we also used a case study approach (Stake, 1995) to identify a medical facility with Shan patients who had successfully managed the challenges of accessing ongoing ART. We selected a local district hospital as our core study site after initial fieldwork and consultations with our study advisors at Chiang Mai University indicated that it provided ART services to a greater proportion of Shan migrants (9% of all ART patients in the hospital) compared to other medical facilities in the region. We thus considered the hospital as the most suitable case to illuminate ART use by HIV-infected Shan patients. By observing how ART and care were provided to this hard-to-reach immigrant population in larger clinical, institutional, and sociocultural contexts at a single site, we used the case study method to deepen our understanding beyond what we would have acquired through interviews alone, or by attempting to gain superficial observation data across multiple sites, with smaller populations of Shan patients, in a relatively short time. Case studies and ethnographic methods, including rapid assessments and mini-ethnographies, frequently occur together in health research when the goal is to understand outcomes, processes, or behaviors in context (Storesund & McMurray, 2009). This combination approach has often been applied in hospitals and other clinical settings to inform HIV care, nursing practice, and other health services (Mackintosh, Humphrey, & Sandall, 2014).

Data collection included direct observation and qualitative interviews with a clinical sample of Shan migrants receiving treatment for HIV at the hospital ($n = 16$), Thai nurses providing ART to Shan patients ($n = 5$), and local health care administrators ($n = 2$). The Shan patients, ages 18 to 65 years, were all first generation from Myanmar, had come to northern Thailand as undocumented migrant laborers, and had overcome existing obstacles to successfully procure ART. Recruiting participants who already have managed to access ongoing treatment has also been used in research to identify barriers to HIV care for marginalized migrant and refugee populations (Othieno, 2007). To acquire provider and administrator perspectives, we recruited an additional, exhaustive sample of the five Thai nurses who provided direct ART services to the Shan patients, and two local health care administrators: one affiliated with the hospital site and one a local government health official.

Interviews followed a semi-structured format; were conducted in a private room at the hospital by the first author, who was assisted by an interpreter proficient in the northern Thai dialect spoken by both Thais and the Shan patients; and were digitally audio-recorded. Interviewees were given a basket of snack foods for their participation (approximately \$5 USD). We engaged in direct observations of clinical interactions between the Shan patients and Thai clinicians from a nursing station in the HIV/tuberculosis ward for the duration of 7 days of 6-hour sessions. A Thai nurse and interpreter were present to assist the first author

with communication. In total, this generated 20 pages of observation field notes. Observations and recruitment for interviews were concluded after data saturation was achieved, and variations in newly collected data were negligible based on preliminary analyses. All participants provided informed consent, and institutional review board approval was granted from California State University, Fullerton, and the hospital's medical ethics committee.

Analysis

Audio recordings of interviews were translated and transcribed verbatim from Thai into English. The transcripts, together with field notes from direct observations, were analyzed in ATLAS.ti 7 qualitative analysis software using an adapted grounded theory sequence in three stages: open coding, axial coding, and selective coding (Corbin & Strauss, 2007). Although grounded theory originated in medical sociology, it has been used across social science and health disciplines to analyze qualitative data (Morse, Stern, & Corbin, 2008), including those derived from ethnographic field work, rapid ethnographic assessments, and case studies (Casimiro, Hall, Kuziemy, O'Connor, & Varpio, 2015; Springgate et al., 2009). Open coding and axial coding began in the field, as the first author cycled between data collection and preliminary analysis, and continued after returning to the United States. Open coding involved the analysis of raw field notes and unprocessed transcripts to identify meaningful concepts and organize them into distinct categories. Axial coding then allowed for comparisons between concepts identified during the open coding process, and we refined hierarchical relationships between categories and subcategories based on their properties and dimensions. Lastly, we used selective coding, which was completed after returning to the United States, to integrate major categories into a larger analytic story, thereby establishing valid and meaningful findings, the middle-range “theory” of the grounded theory process that is associated exclusively with and grounded in study data (Glaser, 1998). By employing constant comparison throughout this process, we worked collaboratively to evaluate data within and across data sources and participants to refine, expand, and re-conceptualize codes, categories, and findings.

Results

Selected sociodemographic characteristics of the study sample are presented in Table 1. Qualitative results were derived from triangulated interview and observation data. Emergent findings are presented in two major categories denoting barriers and facilitating factors for ART use.

Barriers to Antiretroviral Therapy Use

Pervasive fears of arrest and deportation—Shan participants perceived hospitals as potential points of contact with Thai authorities. They feared that seeking mainstream Thai medical services as an undocumented migrant could prompt arrest and deportation back to Myanmar, a country in which all Shan participants described experiences of conflict, violence, and psychological trauma. Commenting on this topic, one Shan male patient said, “I was afraid to go to hospitals. I thought I had no rights as a Tai Yai to receive help from Thais. I was fearful that Thai officers would make me leave to go back to Burma.” An

excerpt from our observation field notes provided additional evidence of the Shan's deeply rooted wariness of Thai law enforcement, which persisted despite a migrant registration program at the hospital:

9:20 a.m.: Was informed by Nurse A this morning that the Thai police have set up a roadblock down the street from the hospital. They have a random safety checkpoint. Nurse A tells me that very few, or possibly no Shan will come today for this reason. Update, 2:33 p.m.: Interviewed more nursing staff today. As predicted by Nurse A, not a single Shan patient arrived at the hospital for their ART disbursement and check-up.

Communication difficulties—While the northern dialect of Thai and the Shan language are closely related, tonal discrepancies and differences in pronunciation caused confusion during important clinical interactions. This problem was frequently reported by both Shan participants and Thai nurses at the hospital, leading to mutual frustration in the clinical encounter and even incorrect adherence to medication. One Shan female patient illustrated, “Sometimes I have a hard time speaking to Thai nurses. I cannot explain my problems. Nurses ask me, ‘What are you saying?’ and I get frustrated, too.” A veteran Thai nurse stated, “I need to listen very carefully to Shan patients. There are some words that they pronounce wrong.” Another nurse reported that some Shan patients had been, “... taking medicine wrong. This is caused from the problem of communication.”

Perceived social marginalization—Strong feelings of being marginalized in Thai society were present among Shan participants. For example, one Shan female patient stated,

I was worried that the hospitals would not want me because of where I come from. It feels like ... I have struggled greatly, and if people don't understand that, then they will make poor comments about me.

There was significant social value for the Shan in being able to share their migration experiences with clinical staff. Social value and personal value were closely linked, so feelings of being unacknowledged, misunderstood, or misrepresented by Thais, particularly Thai health care providers, decreased self-efficacy in the Shan and created a barrier to initial ART use and treatment adherence.

Much of this marginalization was rooted in stigma attached to both the Shan's HIV infection and local perceptions of them as mainly “economic migrants.” HIV-related stigma was most commonly reported in the context of work, resulting in harassment by supervisors and coworkers and termination of employment. A Shan female patient provided an example of how this discouraged adherence to ongoing ART:

When I had just learned of my infection ... I was very weak. I took many days off for the medication, so I had to tell my boss about the illness. He told me that I could continue to work there only 1 month, and then I needed to find a new job.

A Shan male patient attributed stigma leveled against him in the workplace to a combination of education level and conservative Thai attitudes:

Educated people, they know; and they don't hate me. But those who are uneducated? They don't know, so they insult me. Like my ex-boss, when he knew I had it, he detested me My second boss, he knows ... and [my coworkers] don't hate me They don't think I am disgusting. Mostly, Thai people who are conservative, they can't accept us.

The government's designation of many Shan as illegal, undocumented laborers reinforced local Thai perceptions of the Shan as generally economic migrants. This was a pejorative classification, referring to people who relocated to Chiang Mai for jobs and higher incomes, in contrast to migrants who relocated for what were regarded as more sympathetic reasons, such as civil conflict. Most Shan participants in our study acknowledged that poor economic prospects were a significant push factor in their decisions to leave Myanmar. However, most also had other motives, such as relatively better access to health care in Thailand and ethnic persecution and human rights violations by Burmese military personnel in Myanmar. This included having individual dwellings and entire villages burned, forced labor and donations, physical and psychological torture, and forced relocations. One Shan female patient discussed feelings of exceptionalism in Thailand, even compared to other ethnic groups from Myanmar:

I feel that when people see Tai Yai in Thailand, they think “laborer,” just someone who is after money with no skills. We are treated differently than others from Burma who flee from the government. I am not sure why this is, but I know it is different. We are left to fight for ourselves here.

Limited knowledge about HIV—Low functional knowledge of HIV was apparent in the Shan patients during observation sessions and in interviews, and there was consensus by the nurses on this finding. Misconceptions about prevention and personal risk, including modes of transmission, and lack of knowledge regarding HIV treatment options available to the Shan created a dual problem. It delayed diagnosis and presented a barrier to early initiation of ART, which is currently recommended as a best practice in HIV treatment and associated with better clinical outcomes (WHO, 2015). A Shan female patient recounted:

I didn't know about it [HIV], how to get it, or if I was in danger. I had never heard of the illness before I came to the doctor and he told me I had acquired it. I did not know where to get help when I started feeling ill. I had never had to see doctors in Thailand before. Someone told me they cure Tai Yai here, so I came. I knew about it after I was sick.

Similarly, a Shan male patient stated:

When I came to Thailand, I felt okay; but I got very sick one day and didn't know where to go. I never thought I would be able to see a doctor because I was Tai Yai. For a while, I didn't try to get help. Then I became so sick I needed help from doctors. Other Shan said to go to this hospital, and the doctors asked me, “Will you allow me to check your blood?” They could offer me the curing I didn't know much about the sickness, but the nurses taught me.

A majority of Shan participants referred to “curing” HIV as a viable prognosis. Some believed that HIV was transmitted by mosquitoes, saliva, or through touching. These misconceptions underscored a fundamental misunderstanding about the virus. One Thai nurse explained:

Before we discuss treatment with medication, we ask them pretest questions that show how much they know about HIV. We test them and ask, like, “What is HIV? Do you know it?” Most of them don't know. They know that they have HIV, but they don't know the deeper information about the disease. Like how it is contagious They don't know at all about HIV reducing immunity.

Lack of finances to afford sustained treatment—A common barrier to ART use was the cost of treatment, which was prohibitive for many Shan patients until they were able to participate in the special migrant registration program at the district hospital in Chiang Mai. Migrants in the program received a health card, which granted access to the Thai health care system and made ART affordable. One Shan male patient discussed this:

If you have no registration card, you need to pay for everything. You don't register; you come and get advice from the doctors, and they give you the HIV prescription. You will have to pay all by yourself. It's too much.

A health care administrator interviewed for the study cautioned that the system in place at the district hospital was unique. He explained that such registration services were more often “detached from the medical system” and lacked effective promotion.

Facilitating Factors of Antiretroviral Therapy Use

Migrant registration services offered in a hospital setting—As noted previously, the most salient example of migrant registration services was the unique migrant registration program offered at our hospital study site. The program served two important functions. First, it linked Shan patients into the mainstream health care system in Thailand, granting affordable ART comparable to benefits received by Thai nationals. One Thai nurse explained the program and how ART was practically free for Shan patients, requiring only a 30-baht (\$1.03 USD) copay:

We have a registration program that allows them to get the HIV medication for free the very next day, just like Thais. Without this program, they would have to pay the full cost. This is why we treat so many Shan. They know we are friendlier to them than other regional hospitals.

Second, upon program registration, Shan patients were legally established for employment in Thailand. As another Thai nurse stated, “We serve as like a ‘one-stop’ service.” This had several effects that were associated with increased ART engagement. Having jobs increased economic resources to spend on treatment. Being a registered migrant reduced fears of arrest and deportation, which changed the Shan perception of a hospital from a potentially dangerous point of contact with Thai authorities to a welcoming place to receive care. It also buffered feelings of social marginalization, which increased self-efficacy to initiate and continue treatment. Study data indicated that registered Shan patients were highly motivated

to capitalize on their new legal status and to follow through on newly accessible ART regimens and general medical check-ups. As one Shan male patient described:

You can apply for a job or work in places if you have [migrant worker registration] cards; but if you don't have the cards, they reject you. Because of this, I can get access to HIV medication just like Thai people do, and I can also work without being afraid of being sent away.

Shan community outreach efforts—These efforts included mobilization of a Shan-inclusive HIV support group, Shan radio broadcasts advertising migrant HIV services in the region, and chain-referral practices by Shan community members. To a limited degree, gender was a factor in determining whom these efforts reached. Shan female participants more often cited the benefits of a large social support group, organized by the district hospital and comprised of both Shan and Thai women living with HIV. The Flower Group, as it was called, had 350 members, 50 of whom were Shan migrants. One Shan female patient explained:

We meet once a month with other women living with the illness. Some are Thai, and some are Tai Yai like me. This hospital is very supportive of us I have made good friends who also take the medication here. We endure our challenges together, and I even bring my daughter with me.

Data obtained from direct observations indicated that participants who attended the support group derived a sense of “shared endurance” from this type of engagement with HIV-infected peers, which was conducive to ART adherence.

There was no support group specifically for men at the hospital. Shan male patients generally cited local Shan radio broadcasts and direct referrals from Shan friends and community members as the primary sources of information leading them to seek ART at the hospital. A Shan male patient discussed this:

I work in an iron factory and was not registered as a migrant for a long time. I was there and heard a Shan news channel on a little radio at work. They told me about this hospital, and I came.

A Thai nurse confirmed:

There are two Tai Yai radio DJs in the city. They have a station where they broadcast information for migrants. They refer people to migrant-friendly health care like our hospital. Then, many friends – for example, Shan A talks to Shan B, and they find out this way.

Such chain-referrals by Shan community members reached both men and women. One nurse explained, “They talk to one another, and that gets the word out in the community.” As another Shan male patient stated, “I applied for the registration card because I heard from other Tai Yai that I can get it at this hospital.”

Discussion

Studies in Thailand have established that Burmese migrants faced barriers to health care and that HIV disproportionately affected the Shan compared to both the general Thai population and other ethnic migrants from Myanmar (Grundy-Warr & Yin, 2002; Saether, Chawphrae, Zaw, Keizer, & Wolffers, 2007). Our study built on this work by identifying factors that influenced ART use by Shan migrants living with HIV in northern Thailand. To our knowledge, we were the first to do so.

According to Thailand's 2015 AIDS Response Progress Report (National AIDS Committee, 2015), the country is taking the HIV-related vulnerabilities of its migrant populations seriously. The National AIDS Strategic Plan for 2014 - 2016 included a target to reduce discrimination against PLWH and key populations, including migrants, by half. Reported progress in meeting this commitment has included reductions in legal and policy barriers for migrants, intervention development, and scale-up initiatives to reduce discrimination in health care settings and ensure culturally competent services. Furthermore, health plans offered to migrants now cover an array of HIV prevention, treatment, and care services (UNAIDS, 2015b). Registered migrants have access to health insurance benefits through one of two plans: the Social Security scheme or the Migrant Health Insurance (MHI) plan. In 2013, the Ministry of Public Health enacted a policy that extended coverage through the MHI plan to non-registered migrants. Within a year of the policy's enactment, 1.4 million new migrants had enrolled in the plan, which included coverage for ART (National AIDS Committee, 2015).

A key strategy of the government's new MHI plan is to expand the one-stop service model whereby unregistered migrants can enroll in health insurance and become registered migrants simultaneously (National AIDS Committee, 2015). At our case study site, we found that such a dual registration program was a major facilitator of ART use for the Shan. Beyond connecting Shan patients directly to health care and treatment subsidies, it had several other positive effects, including increased access to jobs and income; reduced fears of arrest, deportation, and hospitals; decreased feelings of social marginalization; and increased self-efficacy to start and remain adherent to ART regimens.

These potentially positive effects will be limited by the degree to which the new MHI plans are rolled out successfully. Despite progress, management and financial challenges in hospitals have inhibited full-scale implementation of MHI services, and gaps in coverage still exist. For hospitals, the MHI plan can mean increased administrative complexity, producing fiscal strain on the health care system (National AIDS Committee, 2015). When this occurs, some Shan migrants who need ongoing ART will be unable to access it. Moving forward, it will be important to incentivize hospitals nationwide to adopt the MHI plan. This should limit gaps in ART coverage and geographic disparities for growing and increasingly dispersed migrant populations. One possible strategy is to establish health sector policies and fiscal mechanisms to limit the financial risk that hospitals perceive as associated with implementing MHI plans.

Research has reported bidirectional HIV transmission between native Thai nationals and Shan migrants in Thailand (Sriphanaviboonchai et al., 2002). This suggests that theoretical limits on the spread of HIV associated with insular sexual and injection drug use networks in bounded population groups (Oster et al., 2011; Young, Jonas, Mullins, Halgin, & Havens, 2013) have not played a significant protective role between Thais and the Shan, despite what we found regarding Shan perceptions of social marginalization. This maintains a potential for rapid HIV dissemination, which has been documented repeatedly in border areas throughout the history of Thailand's epidemic (Lyttleton & Amarapibal, 2002). Therefore, in addition to the importance of ART in reducing mortality and progression to advanced HIV disease, its role in reducing viral load, and therefore transmission (UNAIDS, 2012), will be crucial for entire communities in Thailand, irrespective of migrant status, country of origin, or ethnic group. Since the mid-1990s, aspects of Thailand's response to its national epidemic, including a 100% condom use policy in commercial sex venues, have been highly regarded internationally as prevention models (Ainsworth, Beyrer, & Soucat, 2003). A nuanced understanding of factors driving and constraining ART use in migrant populations is now increasingly vital to HIV prevention in the region and will help Thailand continue as a prevention leader among Southeast Asian countries.

Additional research is needed to develop and test culturally-tailored interventions to reduce the barriers and scale-up facilitators of ART use identified in our study. For example, the migrant registration program offered at our hospital study site can be adopted or adapted for use in other hospitals, clinics, and human services institutions. Outreach efforts, based at hospitals or in nongovernmental organizations in migrant communities, might target increased HIV knowledge and awareness of migrant-friendly ART programs. Hospitals and clinics with HIV treatment services could recruit migrant community members as patient navigators. These navigators would help other migrants gain access to existing health insurance programs, which would make sustained ART affordable. The same health care facilities would benefit from enhanced interpretation and other language services to improve point-of-care communications between migrant patients and clinical providers, especially nurses, who had the most direct interaction with Shan patients in treatment. Based on our results, we predict that such interventions would likely combine to increase social support, reduce migrants' feelings of marginalization and fears of arrest and deportation, and promote migrant engagement with local HIV and other health care services through increased self-efficacy. Future research also should explore treatment adherence by Shan migrants receiving ART in Thailand in greater depth and, using a prospective design, determine whether the facilitating factors described in our study have a significant effect on long-term adherence.

Limitations

Our study's limitations should be considered when assessing the implications of its findings. Our results were derived from data collected at a single hospital in one Thai province. Although the sample of nurses in our study was exhaustive in the HIV/TB ward, the Shan patients with HIV infection comprised a clinical sample, and the two health care administrators were recruited purposively for their expert knowledge and broad perspective on the issues under examination. Although commonly used in qualitative designs, such

nonprobability sampling limits the generalizability of our results. Interview data are limited by participants' self-report of stigmatized topics, so our study was susceptible to reporting bias. Limitations to observation data included reactivity based on knowledge of being observed and social desirability bias, but the first author tried to minimize such effects by selecting unobtrusive positions in observation settings to encourage natural behavior. A longer-term ethnographic study of 6 months or more would have generated a larger amount of richer data. However, we selected our design combining rapid ethnographic assessment and case study for the specific reasons discussed in the Methods section, and found that it yielded novel, insightful data more than sufficient to meet our purpose.

Conclusion

Data from Shan migrant patients at a district hospital in Chiang Mai Province, nurses who provided ART services to the Shan patients, and local health care administrators indicated five major barriers to Shan ART use: pervasive fears of arrest and deportation, communication difficulties, perceived social marginalization, limited knowledge about HIV, and lack of finances to afford sustained treatment. We also identified two major factors that facilitated ART among Shan migrants: first, migrant registration services offered in a hospital setting; and second, Shan community outreach efforts, which comprised three main activities – mobilization of a Shan-inclusive HIV support group, Shan radio broadcasts advertising local migrant HIV services, and chain-referral word-of-mouth practices by Shan community members. These findings provided a locally contextualized account that can inform new efforts to build upon and improve the recent policy initiatives enacted by the Thai Ministry of Public Health (National AIDS Committee, 2015), particularly in terms of tailoring ART scale-up strategies for the Shan. Additionally, though we do not advocate generalization, our results can be applied to developing culturally appropriate host country policies, community interventions, and nursing practice to increase HIV treatment access for Shan in other diasporic countries in the region, such as China and Laos, and other minority migrant groups who share similar circumstances in other settings, particularly populations without a political state of their own. In Southeast Asia, these include the Rohingya, Hmong, Karen, Akha, Yao, Thin, and other hill tribe groups, to name only a few. Several countries in Europe, too, recently have encountered increasingly urgent challenges in meeting the health care and other human services needs of large numbers of migrants from Syria, Afghanistan, Iraq, Pakistan, and elsewhere (Soares & Tzafalias, 2015). Although migrants living with HIV in these groups clearly do not share the specific geographic, cultural, and social contexts of the Shan in northern Thailand, many of the barriers to effective HIV treatment and care, and demonstrated strategies to overcome these, are similar (UNAIDS, 2014).

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Key Considerations

- To maximize access to and sustained use of ART by ethnic minority migrants living with HIV, hospitals and clinics should consider onsite migrant registration programs, patient navigators, and community outreach to increase HIV knowledge and awareness of migrant-friendly ART services.
- Nurses and other health care providers should use enhanced interpretation services to improve point-of-care communications with migrants living with HIV.
- Nurses working in HIV care are positioned to play a crucial role in advocating for policies, engaging with local migrant communities, and designing and implementing clinical protocols in their workplaces to reduce barriers to ART in minority migrant groups.

Figure 1.
Study location in geographic context.

Table 1
Sociodemographic Characteristics of Study Participants (*N* = 23)

Shan Patients (<i>n</i> = 16)	
	<i>M (SD)</i>
Age (years)	35.6 (6.9)
Time since HIV diagnosis (years)	3.0 (1.9)
Time since migration to Thailand (years)	11.7 (4.7)
Gender	<i>N (%)^b</i>
• Male	6 (37.5)
• Female	10 (62.5)
Occupation in Myanmar	
• Subsistence farmer	12 (75.0)
• Other ^a	4 (25.0)
Occupation in Thailand	
• Construction	8 (50.0)
• Housekeeping	4 (25.0)
• Manufacturing	2 (12.5)
• Street vending	1 (6.3)
• Unemployed	1 (6.3)
Method of migration	
• Foot	10 (62.5)
• Automobile	5 (31.3)
• Boat	1 (6.3)
Mode of HIV infection	
• Heterosexual contact	13 (81.3)
• Unsterile acupuncture procedure	1 (6.3)
• Sexual assault	1 (6.3)
• Unknown	1 (6.3)
Thai Nurses and Health Care Administrators (<i>n</i> = 7)	
	<i>M (SD)</i>
Age	44.3 (10.2)
Employment in HIV field: years (<i>SD</i>)	14.6 (6.8)
Gender	<i>N (%)</i>
• Male	3 (42.9)
• Female	4 (57.1)

^aOther responses included monk, university student, commercial truck driver, and military nurse.

^bSome percentages do not total to 100 due to rounding.