Regional Meeting Report on

CSO Collaboration on HIV/AIDS for Mobile Populations

25-27 February, 2014
HIP Hotel, Bangkok, Thailand

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**Summary of the Report**

As the largest destination country for mobile populations among Greater Mekong Sub-region (GMS) countries, Thailand hosts 3.5 million migrant workers and their families from the three neighboring countries of Myanmar, Lao PDR and Cambodia. About two-thirds of these migrants, however, are undocumented and have difficulty accessing sexual and reproductive health (SRH) and HIV information and services. Anti-retroviral therapy (ART) for people living with HIV (PLHIV) who are migrants in Thailand is only available for documented workers. Other migrants with temporary status documents and those who are undocumented (who comprise more than half of the total migrant population in Thailand) have very limited access and are dependent on the Global Fund to fight AIDS, TB and Malaria (GFATM) support for ARVs.

Although the Prevention of HIV and AIDS among Migrant Workers in Thailand (PHAMIT) Program under GFATM has played an important role in reaching the migrants in the country, connectivity among source countries and Thailand has not yet been established, raising the question about continuity of treatment and rights to services.

Strengthening CSO Collaboration in Regional HIV Prevention, Care and Treatment Promoting Mobile Population’s Health Among GMS/ASEAN Countries, supported by ADB, is a project under the ASEAN Joint Action Program on HIV/AIDS prevention and care to be implemented at the local level. The overall goal of the project is that mobile/migrant populations in GMS have access to HIV/AIDS prevention, care and treatment, which are affordable to the migrants and the respective governments. The specific objectives are that Civil Society organizations (CSOs) engaged in health promotion and HIV prevention, care, and treatment for mobile/migrant populations in the GMS countries will be able to improve programs at the local, national and regional level through acquiring additional skills, and that inter-country/regional collaboration among CSOs, governments and the private sector will lead to enhanced health programs. Increased cooperation involves regional health referral systems and related policies.

As implementer of the project, the Raks Thai Foundation organized a regional CSOs meeting among GMS countries during February 25-27, 2014 at the HIP Hotel, Bangkok. The purpose of this meeting was to share ideas, experiences, opportunities and obstacles on HIV care, support and treatment for migrants, promoting learning by cross visits in the GMS regions, electronic learning, IEC materials development for HIV/AIDS, and strengthening referrals and communications for continuity of HIV/AIDS care for migrants.

The meeting was attended by 46 representatives from 30 CSOs of GMS countries, including Cambodia, China, Lao PDR, Myanmar, Vietnam, and Thailand, and international organizations such as Care International, IOM, and UN agencies and ADB. During the three-day meeting, participants had good opportunity to learn and share information about their roles, activities, and experience working with mobile populations on health, both within countries and along the border zones. This
summary provides key outputs of the meeting more detail is provided in the full report.

**HIV situation of mobile populations and responses from GMS countries**

All GMS countries have experienced both internal and external migration. The majority of Myanmar migrants cross the border to work in Thailand while a large group of Chinese migrants have flown into Myanmar to work on large Chinese-funded construction projects in the country. These migration patterns also occur in Lao PDR and Cambodia at different locations. As a huge country with over 240 million internal migrants seeking work in cities, China has some ethnic minority groups in Yunnan who have moved across the southern border to Lao PDR and Vietnam, with many eventually ending up working in Thailand. Vietnamese mobile populations also migrate within the country and across the border to work in Lao PDR and Cambodia, and some continue on to Thailand. Some of these migrants and their dependents are vulnerable to HIV infection and lack rights and accessibility to HIV services within the destination countries.

Although HIV prevalence differs among the GMS countries, the pattern of HIV prevalence in Thailand and its closest neighbors is quite similar in terms of concentrated epidemics among specific groups, e.g., sex workers (SW), men who have sex with men (MSM), people who inject drugs (PWID), and mobile populations and their partners. Data from the IBBS in Thailand has shown a general decrease in HIV prevalence among migrants in the country. The highest HIV prevalence among migrants in Thailand by work category in 2010 was 2.34% for those in seafood processing and 1.96% among those on fishing boats, while in 2012 the average of these occupations was 1.84%. HIV prevalence among those migrants attending ANC clinics was 0.7% in 2012. In terms of migrant nationality, the IBBS data show that the HIV prevalence rate of Lao migrants was 0.5% in 2010 and 0.8% in 2012, while HIV prevalence among Cambodian migrants was at 2.15% and 0.9% for those years, and HIV prevalence among Burmese migrants was at 1.16% and 1.0% in 2010 and 2012 respectively. The IBBS studies in 2010 and 2012 used different methodology for data collection. Thus, the data from the two studies may not be fully comparable.

Migrants face obstacles in accessing HIV prevention, treatment, care and support in Thailand or within the home country when they return, most likely due to their deprived background. Mobile/migrant populations also face obstacles to access HIV/AIDS services when they are undocumented, lacking basic health knowledge and facing language barriers. Many migrants cannot access testing, treatment, or continuous ART due to the obstacles just mentioned as well as fear of police arrest, the cost of transportation and losing daily income including inconvenient location and time to access health services. These gaps in HIV services go along with stigma and discrimination on HIV/AIDS which prevents migrant access to HIV services in every stage of HIV testing, treatment, care and support.

During the past years, in addition to a health insurance scheme for migrants, Thailand has amended its social security scheme to include documented migrants. However, participation requires the employer to enroll their migrant employees.
Many migrants don't know their rights to this benefit and, as a result, have no insurance.

Although all GMS countries are following WHO guidelines, there are specific national HIV/AIDS policies in each country. Thailand has the NAPHA extension program to provide ART to 2,200 PLHIV migrants nationwide. Recently, a new migrant health insurance (MHI) program was introduced in August 2013. Under the MHI, all migrants - documented and undocumented migrants including their dependents, can purchase and receive services specified by the scheme including ART. The number of migrants enrolled under MHI is now, however, only about 60,000 at the end of 2013, less than the planned enrollment of at least 300,000 migrants registering, meaning there are many still without insurance.

Cambodia is now using the “Three Zeros” strategy which means zero new infections of HIV by 2020 with priority given to prevention-to-care continuum focusing on Most At Risks Population (MARPS). Prevention is linked to health services, community testing, and focuses on ANC as a link to reproductive health. Myanmar has decentralization plan for health facilities including training local personnel to share responsibility in HIV/AIDS services, as well as an advocacy initiative on migrant health/HIV through the targeted outreach program (TOP). Lao PDR received support from international organizations and donors, although still has insufficient health facilities within the country. Vietnam has now removed restrictions on HIV residence helping to create a more enabling environment for HIV services. China also changed regulations on urban residence enabling more movement for internal migrants, and the government now promotes universal access to health care.

There are official MOU on migration and formal collaborative agreements on HIV bilaterally between Thailand and Myanmar, Thailand and Cambodia, and Thailand and Lao PDR. In practice, many gaps occurred in implementation in terms of different policies, protocol and procedures in treatment, and other relevant issues including political stability in each country.

There is also a concern about the need to track lost-to-follow-up ART clients since it is unknown how many migrant clients return to their home countries. Due to their mobility, it is difficult for hospitals to transfer treatment to other locations. There are major questions about what mechanisms are in place to prepare for these people seeking ART in their home country; and, as for the purpose of this meeting, when they go back and forth to their countries, how are they able to connect with service providers?

Migration route and CSOs mapping among GMS countries
During the meeting, migration routes of mobile populations in the six countries were mapped internally in each country showing origin or source locations of migration, as well as the route toward their main destinations in neighboring countries. Since a final destination of migration route moved toward Thailand, cross border points and existing NGOs working along the border among Thailand and Myanmar, Thailand and Lao PDR, and Thailand and Cambodia were identified and put on the maps.
Migrants from Myanmar are the majority of migrants in Thailand who account for as much as 75-80% of migrants in Thailand or around 800,000 – 1 million registered migrants in 2012-2013 with an unknown number of undocumented migrants. The preferred border crossing sites for these migrants include the following: (1) Tachileik in Shan State connecting to Mae Sai, Chiang Rai Province in Thailand, (2) Myawaddy in Kayin state connecting to Mae Sot, Tak and Kanchanaburi Provinces, and (3) Kaw Taung in Tanintharyi State connecting to Ranong Province. Geographically, many Myanmar migrants can easily cross into Thailand by foot. Many are working in the fisheries and seafood processing industry in Thailand, and in numerous various other jobs.

There are a number of NGOs working on providing HIV/AIDS prevention, care and treatment services among mobile populations. The key NGOs located in Myanmar are PSI, AFXB, PGK, Consortium, Alliance, MBCA, MSFH, UNION, Maltser, IOM, and MAM. Key organizations working on the Thai side include Raks Thai Foundation, PSI, FAR, World Vision, MAP, Mae Tao clinic, Empower, IRC-PLE, ARC, Pattanarak, Safe House, M Plus, Ozone, Aid mission, Agape, and House of Love.

Migrants from Cambodia comprise the second largest migrant population in Thailand with around 200,000 – 260,000 documented migrants in 2012-2013 and many others who are undocumented. The top five source provinces of migration from Cambodia include Prey Veng, Kampong Thom, Kampong Cham, Takeo, and Kampot. Cambodian migrants connect to transit cities in the country such as Phnom Penh, Battambang, Banteay Meanchey, Koh Kong, Poi Pet, and Siam Reap before crossing into Thailand at four main cross border towns: (1) Koh Kong to Trat, (2) Battambong to Chanthaburi and Trat, (3) Poi Pet to Aranyaprathet and Srae ko, and (4) Siam Reap to Surin. They cross over either by vehicle or by boat along the coastline. Once the migrants are in Thailand, they can move easily to other destinations in the country, for instance Bangkok, Rayong and Chonburi in the East, or Pattani in the South. Cambodian migrants are mostly working in deep-sea fisheries, seafood processing, construction, and plantation labor.

The main organizations working for mobile Cambodian migrants in Cambodia are CWPD, CARAM Cambodia, and on the Thai side of the border Raks Thai, FAR and Stella Maris.

Lao PDR has the Mekong River as a natural border with Thailand. Lao migrants can cross the border by various means either at several official check points between the two countries or by boat at certain spots along the border. Around 100,000 documented Lao migrants were in Thailand in 2012-2013 and an estimated 50,000 are undocumented. They migrate internally to transit cities in Lao PDR such as Vientiane, Champasak, Luang Namta, or directly cross the border from cities bordering Thailand. Seven main routes are from: (1) Huay Xai to Mae Sai, (2) Huaphan, Udomxai, Luang Namta to Payao, (3) Hongsa, Xayaburi to Loei, (4) Vientiane, Bolikhamsai and Khammuan to Nongkai, Khon Kaen, Udorntani, Nakornratchasima and Bangkok, (5) Savannakhet to Mukdaharn and Khon Kaen, (6) Salavan to Amnajcharoen, and (7) Pakse to Ubonratchatani, Srisesakes, and
Nokornratchasima. Along these routes, daily transit for cross border migrants to work in agriculture farms is also a common practice.

LPN+, Lao Pha, PSI, NCA and UNFPA are the major organizations providing support in Lao PDR, while, on the Thai side, PHAMIT and its project counterparts, namely AIDSNET, Raks Thai and SDA, are the main organizations providing support to migrants from Lao PDR.

Mobile populations from Vietnam cross the border from Laichau, Sonla, Thanhoa in Vietnam to the northern Lao provinces such as Pongsalee, Huapan, Chiangkhong to work in infrastructure projects, plantation work, and dam construction. Vietnamese can cross the border from the south through Pakse and Uttapue to central provinces. Some of these end up in Thailand, though the number has recently been decreasing. Chinese migrants to Thailand are fewer in number and migrate from Kunming through Mengla – Boten – to Luang Prabang and Vientiane in Lao PDR and then on to Nongkhai and Bangkok. Other routes are from Sichuan and Langan ending up in either Chiang Mai or Chiang Rai, Thailand. These two nationalities are not currently being reached by NGOs in Thailand.

**Role of CSOs in minimizing the gap and obstacles of mobile populations to access HIV/AIDS services**

Civil Society has crucial role in making HIV/AIDS services accessible to migrants particularly due to their ability to work closely with the migrant populations and use informal channels to reach the migrants with information and awareness raising messages on health. Nevertheless, there are gaps among the migrant community in accessing ART treatment mainly due to their non-residential status. As mentioned earlier. Gaps to access HIV services depends on the migrant’s legal status, type of work, language use in communication, basic health knowledge, stigma and discrimination, location and cost to access health facilities and continuity of ART. CSOs have played significant roles in filling these gaps.

There may be some similar HIV services for migrants and PLHIV in each country. This is in terms of support activities provided such as counseling, VCCT, outreach, drop-in centers, and distribution of IEC material. Some different practices however occur in certain areas. For instance, there is the Migrant Health Insurance (MHI) implemented in Thailand but not in other participating countries. There is rapid testing for HIV and STI infection in Cambodia while others have none. There is a formal agreement on referral between Thailand and Koh Kong, and some initial agreement between Thailand and Myanmar but not yet with Lao PDR, Vietnam or China. There are free ART services and supplies for PLHIV residing in their home country - Cambodia, Lao PDR, China, Vietnam and Myanmar, but not for migrants from other countries. MHI in Thailand provides such services for migrants, however this program is still not in full operation due to certain implementation gaps.

Referral of Cambodian HIV patient migrants working in Trat, Thailand, back for treatment at Koh Kong Hospital in Cambodia was raised as a case study leading to formal agreement and procedures in referral between the cross border cities. Other collaboration can be seen as cases of LPN+ assisted Thai PLHIV to receive ARVs from
Thailand via postal service to Lao PDR and vice versa for Lao PLHIV migrants working in Thailand. Another sample case is from Raks Thai staff who helped to facilitate sending ARV from Cambodia to Cambodian PLHIV who were incarcerated in Thailand. These collaborations provided concrete evidence of existing informal collaboration among NGOs in GMS countries.

Many key suggestions were made for improving the collaboration among CSOs and between CSOs and national authorities regarding health promotion and HIV services for migrants. These suggestions include: implementing client-friendly rapid testing by trained NGO staff to increase accessibility to HIV service of at-risk migrant groups; improving IEC material to be more attractive and in migrant languages; increase outreach for testing, care, support and follow up; initiating self-help groups among migrants accompanied by networking; and linking MHI to source countries such as Myanmar and Lao PDR.

**Potential Learning sites and cross visits including workshop among CSOs**

Learning sites are those with good practices and location at which people can learn about HIV/AIDS programs for mobile populations in terms of prevention, care and treatment, cross border collaboration, and referral systems. Three sites along the border of Thailand and its neighboring countries were proposed as follows: Myawaddy and Mae Sot (Myanmar - Thailand), Koh Kong and Trat (Cambodia-Thailand) and Champasak and Ubon Ratchatani (Lao PDR - Thailand). The main reason for proposing these potential learning sites is the good collaboration among related NGOs both in each country and between cross-border countries. A formal referral system has also gradually been set up between Koh Kong, Cambodia and Cambodia and Trat, Thailand.

The issue of cross-visits was raised for discussion in order to be a means of learning from the real situation of migrants and their accessibility to HIV services as well as good practices of existing health facilities and the collaboration among related parties. There are different perspectives toward selection of site/cross visits. Five places in Thailand and several places in other countries are proposed as per details shown in the report. The proposed sites, both for cross-visits and learning sites were not finalized during the meeting. Final decision is awaiting reconsideration of budget and time allocation as well as certain conditions of the country, particularly in terms of hosting organizations and protocol/procedure to entry the country. Raks Thai, as the project implementer will get back to all participants for the final result. Regarding workshop/training, several topics were proposed for information and experience sharing, not for skills development. These include developing coordination mechanisms for cross-country referral, following up lost patients, sharing information, and empowerment of PLHIV networks.

**Dream Website**

As a tool for multiple purposes of CSO networking on HIV services for mobile populations, a website was proposed and key details of the website were discussed. Tentatively, the main audiences of the website are CSOs working for migrant health and HIV program implementers, donors, researchers and other interested persons as well as some core PLHIV networks. Since migrants and PLHIV migrants may not have easy access to the website, the site will be linked to other social media such as
Facebook and Line as a source of reliable data for mobile populations in GMS countries, with basic updates on their situation including HIV related services. Raks Thai was nominated to be the operating host while each country needed to identify members to be focal points for updating information from the country. English and local languages of each country are requested to be the medium of the web content. Since design of the website needs more programming literacy and technical skill, many aspects are left to be considered and arranged by Raks Thai. The name of the website was not finalized from the meeting but should include the key search words of CSO, HIV/AIDS, migrants and GMS

**Strengthening CSO collaboration for health promotion among mobile populations**

In order to strengthen CSO collaboration, the meeting agreed on several key dimensions of cooperation. Although limited by time and budget constraints, all agreed that their collaboration and friendship will not be restricted to only one year of the project timeframe, or only certain activities supported by the project budget. Regular meetings and contact should be a feature of the cross-border collaboration, and facilitated by effective communication within the collaboration cycle such as email network, regional meetings, joint cross visits and workshops, as well as continuous updating from each country focal point. The group should also raise common concerns for co-advocacy at both the national and regional level, for example, universal access to ARV for migrants regardless of their high mobility, bilateral database and referral system, and consensus on guidelines for HIV services for migrants. The ASEAN forum under Myanmar leadership regional cooperation on human rights could be another opportunity for the collaboration.

At the national level, government authorities were most likely to exclude CSO from their MOU or agreement between cross-border countries. Advocacy campaigns to incorporate formal roles of CSOs in government MOU should also be of concern and could be advocated through donor support. Another suggestion was given to advocate for more involvement of CSOs in the implementation process of government, for example, a pilot project from China to gain trust and sharing the benefit of releasing the burden from government responsibility, or using the official language and same formal protocol of the government sector to gain their understanding and acceptance as well as approval of support. Action agreements or signed MOUs among CSOs for collaboration was also raised. In addition, there was the suggestion to report the real situation and work of CSOs on promoting accessibility of migrants to health services in order to provide strong evidence from the ground and valuable input for advocacy.

**Conclusion**

**CSO collaboration on HIV and mobility in GMS** was selected to be a name of the group of CSOs participating under this regional collaboration project. More focus is needed on working together on how to improve accessibility of migrants to HIV services in view of their mobility and vulnerability. With full commitment from all participants, it is clear that the project will have more impact, not just learning from each other, but helping others, particularly migrants, to access friendlier and better quality HIV services within all GMS countries.
The Regional Meeting Report on:

‘Strengthening CSO Collaboration in Regional HIV Prevention, Care and Treatment Promoting Mobile Population’s Health among GMS/ASEAN Countries Project’

25-27 February 2014 at the Hip Hotel, Bangkok, Thailand

Introduction by Sabina Wagle, Raks Thai Foundation

The momentum of migration for work is increasing in the GMS. This labour supply in Thailand is made up of both migrants with official work permits and those who cross borders to work informally or are undocumented. While the migrant populations have produced large economic benefits both for the sending and receiving countries, it is commonly known that the majority of jobs for migrants can be characterized as “3 D” meaning: dirty, dangerous and difficult. On one hand, the 3D jobs range from working on fishing boats, seafood processing factories, rubber plantations, production plants, domestic workers to construction workers. On the other hand, health services and medical treatment are important areas where the needs of migrant workers and their dependents are not being met. The majority of the unskilled workers have problems in accessing adequate health services. The lack of access to health services for many migrant workers is related to their undocumented status; i.e., they are not covered by any form of health insurance. Even then with the possibilities of the new health insurance plan, there are still wide gaps in accessing those health services by migrants.

CSOs in Thailand, which is the largest receiving country in the GMS, have attempted to fill some of these gaps particularly in health care promotion and disease prevention. The Prevention of HIV/AIDS among Migrant Workers in Thailand, or “PHAMIT”, is a good example of CSO intervention where seven CSOs are addressing the needs of migrant communities in 36 provinces through the use of migrant volunteers, drop-in centres and information material dissemination in the languages of the migrants.

C-CHAMP emerged from the Joint Action Program (JAP) that was endorsed by the six GMS countries (Cambodia, China, Lao PDR, Myanmar, Thailand, and Vietnam) in November 2012 as an activity plan to as promote favourable policies and enabling mechanisms; promote community-based strategies that reduce HIV vulnerability, and promote access to HIV prevention, treatment, care and support. This project will also utilize the experience collected from PHAMIT to reduce HIV vulnerability and promote access to prevention, treatment, care and support among mobile populations and affected communities in the countries of the GMS. CSOs collaborating together can make a difference in the lives of these mobile populations to make HIV/AIDS services available affordable, and accessible.
Strengthening CSO Collaboration in Regional HIV Prevention, Care and Treatment Promoting Mobile Population’s Health among GMS/ASEAN Countries, C-Champ, is the joint program from six countries to assist policy-enabling mechanisms and promoting accessibility to health services among mobile populations working in GMS countries. C-Champ will utilize PHAMIT experience to create and promote collaboration among CSOs and health providers in GMS countries.

The goal is to make it possible and the mission is to make it practical.

Raks Thai Foundation is committed to be actively involved in strengthening CSOs to reach the goal to make HIV/AIDS services accessible to the mobile populations in the GMS. The goal is to ensure that mobile populations have equal access to HIV/AIDS services regardless of nationality.

**Welcoming Remarks and Opening Speech**

*by Promboon Panichpakdi, Executive Director, Raks Thai Foundation*

In the meeting organized by JUNIMA and ICAAP, issues of mobile populations and the gaps in accessing health services and care were discussed. About three million of migrant workers from neighboring countries are in Thailand and about two-thirds of them are undocumented. CSOs in Thailand attempted to fill in the gap, mainly by prevention programs such as PHAMIT. Raks Thai Foundation and partners have worked with the migrants very closely while implementing the PHAMIT Project under the support of Global Fund in the last ten years in improving health services and care for migrants. The program has gradually improved the situation of migrant workers in Thailand, as they now can come to work with work permits and are entitled to social with regularized health insurance through Thai law. Thai policy has been a year-by-year registry authorized by the Thai cabinet. Migrants paid for health insurance but this did not include ART. In the past, some funds were utilized to provide HIV treatment for migrants under the NAPHA and NAPHA-X Projects, reaching approximately 3,000 migrants. Though large numbers of HIV infected migrants are still unable to access ART.

CSOs have a key role to help address this shortcoming. With support from ADB, this program is an initiative to promote CSO collaboration in the region and to make sure that there will be improvement in implementation on HIV/AIDS prevention, treatment, care and support for mobile populations at all levels, from the grassroots to the policy level.

Regional learning and sharing best practices among key partners, sharing evidence-based case studies related to CSOs or health care providers in hospitals, and getting to know each other to plan the best implementation through the project in the region are the goals for this first regional meeting. Within the limited project time frame, this meeting was a concrete way to document the key work and active organizations, and to identify gaps and obstacles related to migrant population access to HIV/AIDS health care services. This could be another way to identify the root cause of challenges for people who come to Thailand seeking work, and which could help in putting forward migrant-centered implementation. I hope the three
days of our discussion will bring out the key issues and help us to figure out how we can collaborate and accomplish our goal.

**Country presentation on opportunities and obstacles on HIV/AIDS care, treatment and referral for mobile populations and the role of Civil Society**

**Thailand by Brahm Press, Raks Thai Foundation**

Migrants in Thailand are estimated to number around three million in total including both documented and undocumented migrants. The number of documented migrants fluctuates, as indicated by the total number of registered migrants in 2013 being lower than 2012. Registered migrants by nationality in 2013 are as follows: around 75-80% or 800,000 to 1 million are from Myanmar, around 12-15% or 200,000-260,000 are from Cambodia, and around 6-8% or 100,000 migrants are from Lao PDR. Of these totals, 57% were men and 43% women.

The HIV epidemic in Thailand in 2012 is a concentrated epidemic in some groups, and some places. This includes high prevalence among female sex workers (FSW): 2.2%; MSM: 7.1%; and people who inject drugs (PWID): 25.2%. By location: 6% of FSW in Phang-nga were HIV+, and 31% of MSM in Bangkok were HIV+. There are 8,800 new infections a year and 440,000 PLHIV, of whom 232,816 are adults on ART. There were 21,000 AIDS-related deaths last year.

HIV prevalence among migrants from three countries as of 2010 and 2012 is shown below:

![HIV prevalence among migrants from three countries](image)

**Source**- IBBS - Bureau of AIDS, TB and STI

IBBS data in 2010 and 2012 shows that: HIV prevalence among Lao migrants was 0.5% in 2010 and 0.8% in 2012; HIV prevalence among Cambodian migrants...
decreased from 2.15\% to 0.94\%; and HIV prevalence among Myanmar migrants went from 1.16\% to 1.0\% in 2010 and 2012 respectively.

HIV prevalence in 2010 was 2.34\% for those in seafood processing and 1.96\% among those on fishing boats, while in 2012 the average of these occupations was 1.84\%. HIV Prevalence was 0.7\% among migrant clients at ANC clinics in 2012. The % of migrants who are HIV positive by age and the duration of their residence are respectively given in the graphs below:

![Graph 1](image1.png)

Source: IBBS - Bureau of AIDS, TB and STI

In 2010, data showed that of those who were HIV positive migrants in the 40-44 age group and 35-39 age group had HIV prevalence of 5.6\% and 3.7\% of respectively.

![Graph 2](image2.png)

Source: IBBS - Bureau of AIDS, TB and STI
By duration of residence, 4.2% and 2.6% of HIV+ migrants had lived in Thailand 7-9 years and 10 years or more respectively.

Thailand included documented migrants under the social security scheme which provides health insurance. However, this scheme required employers to enroll their migrants, and many migrants were not aware of this benefit. As a result, many were never enrolled. Thailand has just made adjustments to the Migrants Health Insurance (MHI) scheme. Started in August 2013, this new health insurance policy is available for all migrants in the country, documented and undocumented including dependents and children of migrants, and includes provision of ART. As of latest reports, total of 340,279 were registered in the social security insurance scheme and 403,453 were registered in MHI scheme, with around 60,000 of those under the new scheme. There are still many registered migrants who are uninsured.

PHAMIT has covered migrant workers from three countries: Myanmar, Cambodia and Lao PDR. These migrants are working in 36 provinces of Thailand in ocean fisheries, seafood processing, factories, agriculture, and construction. PHAMIT has reached over 800,000 migrants with direct intervention since 2003 and, over the past 4 years, approximately 8,000 migrants have been tested for HIV and know their results. Raks Thai Foundation is the principal recipient (PR) and an implementer of PHAMIT working with 7 partners and SSR NGOs: AIDS Network Development Foundation (AIDSNET), Foundation for AIDS Rights (FAR), MAP Foundation, Pattanarak Foundation, Stella Maris Center, World Vision Foundation of Thailand, and Social Development Association (SDA). Health partners of PHAMIT are the Ministry of Public Health’s Bureau of Health Administration and district hospitals. Other national NGOs working on migrant health and regional networks are CARAM Asia and Mekong Migration Network (MMN).

The number of migrants on ART under NAPHA-X supported by GF is around 2,200. Out of that number, 1,834 are in provinces covered by PHAMIT. It is unknown how many need ART. Many migrants do not know their HIV status or wait until they become ill with low CD4 because of previous policies that required migrants to pay for ART out of pocket (except for those covered by NAPHA Extension). Some cross-border migrants return home to initiate ART and then return to work in Thailand once they feel stronger. Sometimes they bring their own supplies of ARV and commute, with some running out while in Thailand.

Interviews and reports from the field describe an arrangement at the Thailand-Cambodia border for cross-border referral and access to ART from Koh Kong and some Lao migrants coming to the Thai side to seek ART.

The challenges of migrants’ health in Thailand are mainly from their mobility following job opportunities and having low HIV testing rates as well as late presentation with low CD4. In addition, there is no centralized data system for cross-province or cross-border referral and ART account transfer. However, there is an opportunity for migrants to access ART through the MHI scheme, which costs 2,200 baht per year, and now includes ART. However, the MHI has just started and is not fully working properly. Local providers are afraid of the number of migrants...
needing ART and related expenses regarding migrant health services. Some gaps in this insurance system still need to be addressed to make effective.

Recommendations for this stage are to make health insurance and related benefits portable across provinces and borders as well as affordable to migrants to encourage maximum enrollment and, at that same time, to deter HIV related discrimination. In addition, migrant health workers need to be formalized as part of the Thai health system in their role of communicating in migrant languages to patients, as well as providing community health outreach, referral and counseling.

Additional key points summarized from the open discussion

Regarding Cambodian migrants: Women working in seafood processing had the highest HIV prevalence at 5%. In terms of ART services: CSOs provide referral and counseling and testing, while treatment is done by government health providers.

Regarding IBBS: IBBS is the survey of biological and behavioral indicators. The Thai government has conducted the IBBS in 2010 and 2012 with different methodology. In 2010, information was collected by five occupation categories: fisheries, seafood processing, agriculture, factories and other. Data collection was conducted among a quota sample of 300 migrants per province. Data collection in 2012 was gathered by different occupations and by the density from the area. Thus, the results from the two rounds may not be totally comparable.

Regarding Health Insurance, treatment, and loss-to-follow-up patients: In 2013, health insurance was 1,300 baht per year for documented migrants. Since August last year the government announced the MHI, which increases the annual cost by 900 baht for ART. Under the MHI, documented or undocumented migrants who buy the insurance at 2,200 baht per year are eligible for ART. The government target is that an enrollment of 300,000 migrants is required in order to sustain the system. Currently, only 60,000 migrants purchased the MHI that included ART services.

Thailand follows WHO guidelines for HIV treatment. The criterion of CD4 at 500 cells will begin in October 2014. Currently the threshold for ART initiation is at 350. There is now no exact data on loss-to-follow-up (LFU) patients. Data from NAPHA-Ex shows around 20% LFU. There is however no confirmation on this figure. In particular, it is unknown of how many migrants return to their countries. Due to their frequent mobility, it is difficult for hospitals to transfer treatment to other places. Major questions were raised on projected increased migration to Thailand, and what mechanisms are in place to prepare for the potential increased ART caseload? Also, when migrants go back and forth to their countries, how they are able to connect with service providers?

Regarding health translators: Health facilitators especially health translators are important and help to implement the migrants project effectively. It is still not clear whether the CCMs of Thailand will formalize the role of the migrant health worker since the Thai government has restrictions on jobs for non-Thais from the Ministry of Labor (MOL). This is a legal and process barrier. CSOs can help advocate explore
opportunities for new funding models to incorporate the skills criteria, including migrant assistance.

**Cambodia by HengTola, Cambodian Women for Peace and Development (CWPD)**

There is no specific program regarding HIV services for cross-border migrants in Cambodia. Most of programs have been done with internal migrants in the country. Estimated data from the National Institute of HIV/AIDS under MOH shows that HIV prevalence of adults aged between 15 and 49 years was 0.7% in 2013, decreasing from 0.8% in 2011 and 2.5% in 1998. Figure below illustrates the estimation and projections of HIV/AIDS in Cambodia 2010-2015.

**Figure 1. Projected Number of New HIV Infections and Number of People Living with HIV**

FSWs who have more than 14 clients or more/week had an HIV prevalence of 13.9% in 2013, while those with less than 14 clients/week had an HIV prevalence of 3.9%. HIV prevalence among MSMs was 2.1%, TG 9.8%, and PWID 24.4% in 2007. The number of PLHIV on ART was 49,701 as of the third quarter of 2013. Of these, 8.5% were under 14 years old.

HIV incidence was first detected in Cambodia around 1993. After 1995 the prevalence decreased from year to year. The number new infection in 2015 is projected to be 1,000 cases.

National level organizations on HIV/AIDS in Cambodia are the National AIDS Authority (NAA) and National Center for HIV/AIDS, Dermatology and STI (NCHADS). In line with the 3 zeros declaration from UNAIDS in June 2011, NCHADS declared New Standard Operational Procedures. This 3 zeros strategy, released in late 2012, is to decrease new infections to zero by 2020.
Cambodia’s strategies include: (1) Boosted Continuum of Care (CoC) and treatment as prevention (TasP), (2) Boosted CoPCT, the continuum of prevention, care, and treatment, focusing on MARPS prevention linked to health services, and (3) Boosted Link Response: systematic linkage between HIV and reproductive health services, focusing on ANC.

In terms of CSOs, CWPD has implemented an HIV/AIDS program since 1999 and currently has one project called “SMART Girl”. The project is branded and franchised from the USAID since 2004 and is currently supported by UNFPA, USAID, KHANA and the Global Fund. The project aims to eliminate discrimination FSW who society views as lacking intelligence or morals, and who are low-class. In this project, the word smart means they know about HIV/AIDS, they have knowledge about health related issues, and they can access health services whenever they want. The project has currently covered around 20,000 (19,379) entertainment establishment workers in Cambodia in different entertainment venues including karaoke (KTV) lounges, casinos along the border between Cambodia and Thailand. The project reaches the FSW working as street-based freelancers, including beer promoters and massage services providers. The target area covers 14 provinces in Cambodia.

Activities implemented by CWPD include: BCC, outreach education with IEC material distribution, training peer educators, home visits, drop-in centers, Smart Girl Club, condoms and lubricant distribution, STI screening, HIV testing and counseling. Trained staffs are able to perform HIV rapid testing. Those who have a positive result are sent for confirmation at government hospitals.

Challenges for working with the HIV Program are: difficulty to reach target group, no studies on cross border migrants, and no collaboration at the regional level. In addition, the working situation in Cambodia recently has changed from having high international funding and few implementing agencies to less funding but many implementing agencies.

Strong support from the national, international and community levels are however an opportunity to work with the domestic HIV program and its expected expansion to cover cross-border migrants. Long-time experience in working in HIV/AIDS and updating strategies at the national level will benefit the continuity of work.

*Additional key points summarized from open discussion*

In the past, VCCT services could be accessed only at certain government hospitals or health centers. Now, this service is more convenient via rapid testing provided by trained NGO staff working in the area as well as basic pre-post counseling and referral of the positive cases for confirmation at government hospitals. The testing service is provided for free and for all nationalities in Cambodia, including Vietnamese migrants. The number and proportion of HIV-tested and untested groups are however not available.

Sex work is illegal in Cambodia. FSW are usually called entertainment workers and have to be tested under standard operating procedures for all target groups. If their results are positive and CD4 are between 350-500, they will get ART and check-ups...
repeated every 6 months. There is no data on the number of Cambodian female entertainment workers working in Thailand.

In terms of drop-in centers, the project initiated some services, such as hair salon services and nail art to attract the target population to come to the centers and use that opportunity for providing IEC material, health education, and VCCT.

**Myanmar by Dr. Aye Aye Thet, Malteser International, Myanmar**

Myanmar has a long border with Thailand and Lao PDR. Most of the cross-border migration is between Myanmar and Thailand. In Myanmar, there are five states with towns located around the border. Three main towns are the main transit points: (1) Tachileik in Shan State connecting to Mai Sai in Chiangrai Province of Thailand, (2) Myawaddy in Kayin State connecting with Mae Sot, Tak, and Karnchanaburi Provinces, and (3) Kaw Thaung in Tanintharyi opposite Ranong Province.

HIV prevalence in Myanmar was 0.5% in 2013 but there is no incidence data available. It is estimated that there are around 60,000 cases of infection and ART coverage is 54% countrywide.

The HIV/AIDS program is promoted by the national level as well as by INGOs and NGOs at the local level. Preventive measures focus on awareness raising and condom promotion, which is conducted for key populations in most affected groups including migrants. The PLHIV network has been strengthened as well with strong commitment of community participation. In addition, services for VCCT and collaboration between public and private sectors also need to be strengthened in order to bring about effective prevention and treatment as well as eradication of stigmatization and discrimination among key affected populations and general communities.

Since 2013, Myanmar has scaled up ART centers, increasing and providing ART sites in country with plans to decentralize ART centers for easier access by communities. These sub-centers will have midwives and other facilities to provide both VCCT and ART services. The plan also includes networking with national AIDS program as well as INGOs and NGOs.

In addition to availability of and accessibility to CD4 testing sites, uninterrupted supply of ARV is also a key component for long-term treatment including OI and STI treatment. Capacity building and human resources to cover more remote areas as well as financial support from international donors are also strongly required.

In terms of systematic and standard treatment, the National AIDS Program is responsible for providing guidelines and policy under the National Strategic Plan (2011-2015) together with the National Sexual and Reproductive Health Plan (2009-2013). In 2014, ART guidelines were revised to be in line with WHO new guidelines as well as developing the standard operational procedures for decentralization. NATALA, or administration at the local level, is also planned for the coming years.
In terms of mobile populations or migrants at cross-border areas between Myanmar and Thailand, there are policy updates and agreements as follows:

- The GMS MOU (2011) on HIV vulnerability and population movement signed by Thailand and Myanmar
- Thailand and Myanmar developed a Joint Work Plan on Disease Surveillance, Prevention and Control in Border Areas (2011-2012) in Tachileik, Myawaddy, and KawTaung
- An MOU was signed for cross-border collaborative health activities between Myanmar and Thailand in September 2013
- Cross - border meetings were convened between twin cities

According to the agreement concerning HIV/AIDS issues, one significant meeting was the November 2013 “Consultative Meeting Thailand-Myanmar Partnership on Universal Access to ART for Migrants” with representatives of two towns of the two countries. This became a road map and future plan for bilateral partnership. In addition, there is a signed agreement on referral of 150 PLHIV Myanmar migrant workers from ART treatment in Thailand to Myanmar (from Mae Sai to Tachileik Hospital). This, however, has not yet been fully implemented.

Regarding ART treatment, there are 14 organizations including INGOs and Local NGOs working in Myanmar as given in table below:

<table>
<thead>
<tr>
<th>International/National NGOs providing ANTIRETROVIRAL THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. MSF (Holland)</td>
</tr>
<tr>
<td>(Yangon, Lashio, Myitkyina,Phakant , Sittwe)</td>
</tr>
<tr>
<td>2. MSF (Swiss)</td>
</tr>
<tr>
<td>(Dawei, Insein)</td>
</tr>
<tr>
<td>3. MDM</td>
</tr>
<tr>
<td>(Yangon, Myitkyina,Moegaung)</td>
</tr>
<tr>
<td>4. AFXB</td>
</tr>
<tr>
<td>(Yangon)</td>
</tr>
<tr>
<td>5. AMI</td>
</tr>
<tr>
<td>(Yangon)</td>
</tr>
<tr>
<td>6. Consortium (Save The Children , CARE ,MSI, MNA )</td>
</tr>
<tr>
<td>17 Townships</td>
</tr>
<tr>
<td>7. IOM</td>
</tr>
<tr>
<td>(Mawlamaing , Myaw Wa Di )</td>
</tr>
</tbody>
</table>
Since migrant workers are mobile populations, wide coverage and referral systems need good collaboration both inside the country and with Thailand in terms. This means communication among GMS countries needs to be strengthened, as well as instituting procedures for referral and standard ARV guidelines and management in GMS countries. Importantly, the cabinet of the two countries should understand and provide support to the process.

Due to the unstable political situation of the countries, there are gaps in identification and stability of mobile populations. The information systems still lack essential data. Many migrants lack family care or secure career opportunity, and face stigma and discrimination in their work. Thus, client-friendly HIV treatment is required for migrants as well as PLHIV network members, with community support.

Gaps in HIV and AIDS treatment care and support include limited access to diagnosis, treatment and care due to lack of work permits, irregular funding for life-long free ART, lack of family care/care taker, psychosocial problems among migrants and lack of referral mechanisms.

In terms of research concerning mobile populations, HIV assessments related to mobile populations in Kayin and Mon are conducted by IOM. A risk and vulnerability assessment for HIV infection in migrant and mobile populations of Kayin State and Eastern Shan State is currently being conducted by Malteser International. In 2014, there will be a countrywide population census which may provide more information on mobile populations and migrants.
This regional meeting will benefit participating countries in sharing information and there should be regular follow-up after the meeting. Bilateral dialogue between the source and destination countries should also be encouraged to continue.

Additional key points summarized from open discussion

National strategic plan on national reproductive health has neither specific guidelines nor strategy on migrants. The result from this regional meeting will be a crucial input to set up facilities for migrants. Since the government services cannot cover all the need for ART, local NGOs and INGOs are also providing ART. From 2014 onward, the national AIDS program will authorize more NGOs to provide ART in order to have more coverage, to reach 80% of the need.

LAO PDR by Vieng Akone Souriya, Lao Positive Health Association

The number of Lao migrants coming to Thailand for work has been increasing over time. The Thai government estimated there are at least 50,000 illegal Lao laborers working in Bangkok and other interior provinces. Another 45,000 Lao migrants are working along the Lao-Thai border. Lao migrants include women that have been trafficked for sexual slavery, most of whom suffer from conditions in the workplace as well as the treatment received when they return home.

The number of PLHIV in Lao PDR is 5,890 cases and the number of people who have died of AIDS is still high. The figure shows the number of HIV positive cases by year:

![Number of HIV+](image-url)
This is because PLHIV go for testing too late in the course of infection. Cumulative AIDS deaths from 1990 to mid-2013 are 1,453 cases. This situation needs intervention in terms of increased prevention, VCCT and ART services in order to bring down AIDS mortality. Although general population migrants seem to be less impacted, certain sub-groups of mobile populations such as sex workers, MSM, or transgenders are more likely to be affected. Presently, housewives are accounting for an increasing proportion of new HIV infection. In terms of prevalence by province, main cities along the border have higher HIV rates especially Vientiane (VTE), Sawannaket, Champasak and Kammuan. Approximately, the data on Lao PLHIV working in Thailand who receive ARV treatment in 8 centres in Laos is given in the figure below:

Eight existing ART treatment centers in Lao PDR are operated by the government with funding from international organizations. The number of patients who received ARV treatment in 2013 is 2,559. ARV is provided for free with support from the Global Fund not only for Lao nationals, but also for migrants in the country. In terms of migrants, there are nine drop-in centers to provide services for sex workers and four centers for MSM and TG. One youth-friendly clinic and hotline is also available for youth in Vientiane. There are 14 support groups of PLHIV in 12 provinces with 707 members.

The main obstacles of the HIV program in Lao PDR are the lack of access to information about health care and ARV treatment among migrant workers. The poor referral and follow up system in the country also widens the gap in HIV services. Additionally, there is high stigma and discrimination on migrant workers who are perceived to be at risk for HIV/AIDS. LNP+ provides support for the migrant returnees for HIV services.

CSOs in Lao PDR have conducted community advocacy for improvement of ART and health care services among migrant workers. Although they have many years of experience, CSOs in Lao PDR were only legally approved starting in 2009.
Additional information summarized from open discussion

Data on the number of migrants who received ARV came from peer counselors who collect data from migrants who have returned home and seek ART service, as well as from core PLHIV groups in each province. A pilot method of sending ARVs to patients via postal service has been initiated in Sawannaket. Patients provide address and money for the cost of ARVs and parcel delivery.

Regarding Vietnamese working in Champasak, a growing city and tourist destination, the number of migrants has increased year by year. There is funding from ADB for the government sector, but not CSOs. Because of the lack of funding, there is limited support in terms of HIV prevention for Vietnamese sex workers in Lao PDR.

Assistance for ARV services between Lao-Thai migrants was provided by LPN+ which helped an infected Thai who could not return to Thailand due to fraud charges against him. The Thai PLHIV could not receive ARV from Lao hospitals due to the hospital regulations. Thus, LPN+ staff arranged with a Thai CSO to send ARVs via postal service to the Thai PLHIV residing in Lao PDR and the ARV drugs were delivered by the Thai Red Cross.

Vietnam by Vu Tran Dung, Vietnam National Network of People Living With HIV

Number of HIV/AIDS cases within Vietnam is 274,000. There were 14,000 new cases during 2009-2012. National ARV coverage in 2013 for key affected populations is: IDU 11%, FSW 2.7%, MSM 4.9%, and male SW 19.8%. There is no definite information on mobile populations for either HIV prevalence or ARV coverage.

Strategies and activities to scale up implementation on HIV prevention, treatment and care are focusing more on prevention activities. The most effective one is a policy on removing restriction on entry, residence and stay related to HIV which is providing a more enabling environment for PLHIV to receive treatment and care without barriers. Nevertheless, some gaps still exist in the implementation.

VNP+ is a core network working on many HIV activities partnering with Ministry of Health, Union of Science and Technology Association, and more than 60 self-help groups. Its international partners include EU, AusAID, APN+, Robert Carr Foundation, Treat Asia, USAID and BABSEA.

The work of the network is also targeting infected mobile populations who migrate from the countryside to cities and across borders to neighboring countries. A major area of concern is the border between Vietnam and China and Cambodia. China construction companies have also brought Chinese workers to work on big construction projects in Vietnam. These Chinese migrants stay and work for several years.
In implementing the HIV-related activities for mobile populations there is good coordination among network partners, trained grassroots volunteers, and CBOs. There are not enough studies on mobile populations and migration to help support the development of existing strategies. Along the border, many areas have no rivers or mountains, and people can cross to the other country very easily. This has made it difficult for the countries, governments and CBOs, to control cross-border movement. Thus, assistance from self-help groups peer educators, and community support is needed for mobile populations.

Gaps in HIV/AIDS treatment, care and support are mainly due to inconvenient travel to the facilities. There is no specific estimate for the total number of mobile populations, as well as no strong CBOs to reach this high-risk group. The national network needs to be strengthened on a larger scale to increase access to ART treatment. Working with target groups such as sex workers also face some difficulties from police who view the prevention campaign activities, e.g., distributing condoms, as promoting commercial sex.

Research on mobile populations is needed to provide more information about the link between migration and HIV. Conducting research on mobile populations requires more motivation and support, especially research for improving implementation of ART and services. There is a need to identify migrant-friendly policies for implementation.

There is a draft plan in Vietnam to send PLHIV back to the area they registered in order to get ART. This is obviously to control and manage the caseloads and reduce overload in urban areas.

It is recommended that CSOs have specific guidelines to work with mobile populations. Cooperation between CSOs and government should be strengthened and research or reports should be made at regional level to have stronger influence.

Additional key points summarized from open discussion

Regarding border area with China, HIV transmission is mostly among PWID. Research has identified movement of PWID who come to work across the GMS, and inject drugs along the China-Vietnam and Myanmar-China borders. It is interesting to note the cross-border link between the population of Myanmar and Vietnam, though the scale of movement and interaction is not known.

**China** by Assoc. Prof. Songyuan Tang, Yunnan Health and Development Research Association

China is a huge country, having mobile populations both internally and externally. The number of migrants moving from rural areas to seek work in the cities in 2013 was about 240 million. Internal migrants account for 14% of the total population. Chinese are also migrating to neighboring countries as well.
The number of internal migrants has significantly and sharply increased in the past several years. The number of female migrants is also rapidly increasing and in 2012 is half of the total migrant population. About 65% of female migrants are employed. Mobile populations are mostly in the sexually-active age group as two-thirds are between 20-45 years.

Urban migration has increased because the government discontinued (in 2000) the Hukou system of requiring urban residents to be registered.

In the past, the Government household registration (Hukou) system, implemented since the 1950s, created severe rural-urban health disparity. Individuals were bound to their rural and urban birthplace and could only receive health care benefits where their Hukou was located. Urban residents were entitled to government subsidized housing, health insurance, medical care and state employment through National Labor Unions and the Ministry of Organization, the Urban Employees Basic Medical Insurance or the Urban Resident Basic Medical Insurance system. Rural residents could access the Cooperative Medical Scheme (CMS) and village clinics for health care. However, after the collapse of the collective economy, the program was dropped and over 80% of rural residents had no health insurance of any kind between 1985 and 2000. Rural to urban labor migrants are not eligible for the services that the permanent residents in the cities enjoy.

The first case of HIV/AIDS reported in China was in1985. Currently, the estimated number of PLHIV is about 840,000 including 125,000 cases of AIDS. Sexual transmission has been the primary mode of HIV transmission in China (79.0%). China has no national data specific to mobile populations. However, there is some data reported by provincial CDC or specific studies conducted at the provincial or even county level showing that more than half of HIV infected cases are mobile populations. For instance, in Shanghai the proportion is 74.4%, and in Beijing it is 85.4%. It seems that the more cities develop, the more cases of HIV/AIDS emerge. Another factor is that large cities like Shanghai and Beijing have VCT services that make it easier to be diagnosed.

China has four free policies on HIV/AIDS. These are: free VCT, free ARV treatment, free mother to child prevention, and free education for children of PLHIV. In addition, there is also a One-Care policy to subsidize patient family income and reducing stigma. The One Care policy is quite difficult in practice due to unwillingness of patients to disclose their serostatus.

Regarding supporting an enabling policy environment, there is a 1994 law and regulations on health protection of mother and infants, the strategic plan of HIV/AIDS prevention and control (2001-2010 and 2011-2020), and other policies that gradually established a legal system to provide solid guarantees for migrants. The law on population and family planning in 2001 and its updated version in 2009 has specified family planning for the mobile populations and other issues addressing health including HIV/AIDS and SRH for migrants.

ART was introduced to China in 2003. So far 434,000 PLHIV receive ART, however it is estimated that half of the PLHIV in need are not yet on ART.
Factors influencing migrant access to HIV/AIDS services such as care, treatment and referral include socioeconomic factors such as low education, low income, low awareness; geographic factors such as transportation cost and inconvenient access to health care facilities; administrative factors such as service management and opening hours of facilities, and attitudes of service providers; and other cultural barriers such as language, gender, and ethnicity.

Regarding opportunities, China has a policy on building a harmonious society emphasizing social equality and justice including universal access to public resources and services. With better incomes, the children of migrants are now having advantages by living in the cities. Smart phones are quite popular for everyone, and this is a good opportunity for easy access to HIV-related knowledge through social media. Some pilot projects demonstrate how to disseminate health promotion messages by smart phone, and the results were effective.

In order to improve HIV-related work on migrants, action research is recommended in areas of needs, issues, steps, strategic and cost-effectiveness analysis. In addition, utilizing the new social media is recommended as well. Sharing experiences learned from the projects with a focus on mobile populations and rights is also of benefit.

Additional key points summarized from open discussion

Civil Society and NGOs have been developed in China for the last 30 years. However there is need for more expansion of CSOs since the central government used to freeze the number of NGOs with many regulations. At the provincial level, local governments are still suspicious of NGOs. Additionally, since China has become strong in terms of economic development, the Western world perceives that China is rich and has shifted their development support to other, poorer countries in the GMS such as Myanmar. However many provinces in China are still poor and need help from international society.

Nevertheless, in terms of accessibility to VCCT in China, mobile populations can get it for free, but not migrants between China and Myanmar. The country has diversity of policy among different areas. The number of PLHIV in China is not much compared to the whole population; therefore the government can support free ART. If infected parents die, grandparents and relatives can provide care to their children.

The main challenge in working with mobile populations is that it is hard to get an estimate of the total number of migrant workers and proof of their inaccessibility to ARV.
Migration route and CSO-mapping

Procedure
All participants were divided into four groups in accordance with countries sharing borders. Each group had a one-hour discussion following key objectives in learning and finding out about migration routes among GMS countries. Group representatives provided their output to the plenary group. Members of each group helped to facilitate questions and answers according to the group presentation.

Migration Routes and CSO Mapping between Cambodia and Thailand

Cambodia has 23 provinces and one capital city, Phnom Penh. Top five provinces of migration from Cambodia to Thailand are Prey Veng, Kampong Thom, Kampong Cham, Takeo, and Kampot.

The first main migration route is from the home provinces to Phnom Penh, onto Kampot and then to Koh Kong at the border, before going straight to Trat Province in Thailand. Many migrants may later go further to Rayong, and Pattani Provinces. Main work for these migrants is in deep-sea fishing and the fisheries industry.

The second route is migration from other provinces to Phnom Penh and then to Battambong before crossing to Chantaburi and Trat Provinces in Thailand. The migrants may also move to Rayong and Chonburi Provinces to work in fisheries or factories.

The third route is from other provinces to Phnom Penh before moving to Banteay Meanchey and to Poi Pet, then crossing to Aranyapratet and Srakeo Provinces in Thailand. The majority go straight to Bangkok, Samut Prakarn, Chonburi, and Rayong Provinces. Most of this group works in factories and construction.

The fourth route is migration from Siem Reap, Cambodia, to Surin Province in Thailand and further down to Bangkok to work as laborers in construction.

Phnom Penh is also the main transit and destination point for migrant workers in Cambodia because of the volume of construction in the capital city. Koh Kong is similar to Phnom Penh in terms of being both a transit and destination for Cambodian workers. There are a lot of factories as well as casinos in this border town with Thailand.

Being both transit and destination points can also be applied to Battambang as well as Banteay Meanchey in Cambodia and Chanthaburi in Thailand. Cambodian migrants daily commute from Banteay Meanchey to Srakeo Province in Thailand, in order to work as laborers in the agriculture sector. Migration for agriculture work in Srakeo also extends to Chanthaburi Province.

There is also a flow of migration from Vietnam to Cambodia, but there is not enough information to specify the pattern.
Main organizations working for mobile Cambodian migrants in Cambodia and Thailand are CWPD, CARAM, and Raks Thai and its PHAMIT counterparts. Most of these NGOs conduct HIV prevention, outreach education, as well as distributing condoms and IEC materials. In Cambodia, HIV rapid test by finger prick is available by trained NGO staff for free, along with pre-post-test counseling before sending those with positive results to a public hospital for confirmation. VCCT in Cambodia is then provided by both public hospitals and NGOs, while NGOs in Thailand only facilitate these services through public health care providers. The cross-border referral system between the two countries has been implemented via agreement between provincial authorities of the two countries. Raks Thai Foundation, as PR and implementer of PHAMIT project supported by the GF, is the main organization to help initiate and facilitate this cross-border referral system.

Additional key points summarized from open discussion

KHANA, Khmer HIV/AIDS Network Alliance, is the key HIV/AIDS-related organization in Cambodia. It is a network providing technical support to other operating organizations. The other two key organizations in relation to HIV/AIDS programming are Family Health International Organization (FHI) and PSI, which is called PSK in Cambodia.

Both governmental and NGO clinics have supported ART for HIV-infected Cambodians. However, there is limited distribution of NGO clinics that receive support from USAID through its flagship program in Cambodia.

Migration Routes and CSO Mapping between Lao PDR and Vietnam

Migrants from Lao PDR move to Northern provinces in Thailand across the Mekong River, while Vietnamese migrants cross the Cambodian border. The main routes of migration can be seen through cities along the Lao-Thailand border as follows:
- From Huay Xai in Lao PDR to Mae Sai – Chiang Rai in Thailand and then further down to Payao and other provinces
- From Huaphan, Udomxai, Luangnamta in Lao PDR to Payao in Thailand
- From Hongsa, Xaiyaburi in Lao PDR to Loei Province in Thailand.
- From Vientiane, Bolikhamsai and Khammuan in Lao PDR, to Nongkhai, Khon Kaen, Udorntani, Nakornratchasima and Bangkok, Thailand
- From Savannakhet in Lao PDR to Mukdaharn and Khon Kaen in Thailand
- From Salavan in Lao PDR to Amnajcharoen in Thailand
There is also daily transit of people across border from Lao PDR to Thailand. Certain provinces as Nongkhai, Khon Kaen, Udonthani, Nakornratchasima, Ubonratchatani and Srisaket can be transit points to other provinces in Thailand.

Mobile populations from Vietnam cross the border from Laichau, Sonla, Thanhhoa in Vietnam to the northern Lao provinces of Pongsalee, Huapan, Chiangkhong. In Lao PDR, there are many infrastructure projects, plantations, and dam construction projects. Vietnamese can cross border from the south, via Pakse, Uttapue and on to central provinces. Some of these migrants end up in Thailand, though the number is decreasing.

There is more variety in the means of the mobility between Lao PDR and Vietnam but migrants move largely by land transport and boat across the Mekong River. When they are in Thailand, many travel by train.

Regarding HIV services provided for migrants, there is an integration of VCT and ARV services in Lao PDR, but it is not comprehensive, and not in every province. Only some provinces provide ART services. LNP+, LaoPHA, PSI, NCA and UNFPA are major organizations providing support in Lao PDR, while, on the Thai side, PHAMIT and its Project counterparts are the main organizations providing support to migrants. In Lao PDR, their activities include drop-in centers, drug user clinics, hot line counseling, and referral for STI treatment. VCT and ART are also provided by the VCT and ART centers.

Migration Routes and CSO Mapping between Myanmar and Thailand

Movement of migrants in Myanmar to Thailand mostly occurs in four main routes from four states. First is the migration in Shan State, crossing from Tachileik to Mae Sai in Chiang Rai, Thailand. The second route is in Kayak State, to Mae Hong Son and Chiang Mai, Thailand. The third main route is from Mawlamyine, Myawaddy in Kayin State, to Mae Sot, Thailand. The last one is in Mon State, from Kaw Taung to a southern province of Thailand, Ranong. Mae Sot and Ranong are also transit points for Myanmar migrants to move further to other destination in Bangkok, Samut Prakarn and Samut Sakorn.

The HIV program in Myanmar at the border includes prevention, care and support. The main organizations working in the source towns near the border are as follows:

- In Myawaddy: PSI, AFXB, PGK, Consortium, Alliance, MBCA
- In Tachileik: PGK, MSFH, UNION, Malteser
- In Kaw Taung: AFXB, IOM, MAM

In Thailand, most of the private sector agencies are working on HIV prevention care and support while treatment is mostly provided by the government sector. In major destination points as mentioned above, there are many organizations working on the issue. The HIV Program covers prevention, care, and support as well as some support for referral to ART.
Organizations working in main destination sites on the Thai side are as follows:

In Mae Sai: World Vision, Empower, IRC-PLE
In Sangklaburi: Pattanarak, ARC, Safe House
In Ranong: World Vision
In Mae Hong Son: IRC for HIV prevention but there is a clinic that operates in a camp and provides ART.
In Chiang Mai: MAP, Empower, M Plus, Ozone, Aid mission, Agape, House of Love
In Mae Sot: World Vision, MAP, Mae Tao clinic
In PobPhra: IRC
In Samut Sakorn: Raks Thai Foundation
In Bangkok: PSI, FAR

Additional key points summarized from open discussion

In Myanmar, related organizations are working geographically in specific areas. If PLHIV fall outside the working area, they will be referred to other responsible organizations. Patients will decide whether they will continue their treatment by coming back to the organization in their own area or receiving services from the organization they were referred to in another area.

For infected migrants returning from Thailand to Myanmar, it is unlikely that they will be able to continue ART as received in Thailand. In certain areas like Mon State, however, it is possible to obtain comprehensive treatment through certain program arrangements.

Consortium Myanmar has no immediate plan to set up services to work along the border or to provide ART services for returnees under referral cooperation with Thailand. The main reason is that there is no guarantee that they will be allowed to continue implementation for an extended duration in the country. What the organization has done is to promote accessibility to existing facilities for VCT and CD4 testing.

In Myawaddy, there are certain guidelines for providing ART to new patients especially ones returning from Thailand. For instance, the person has to be a newly diagnosed case of HIV infection and with the testing done in Myawaddy, and treatment must continue at that site indefinitely.

Some criteria are applied to cases in Mon State as well. The decision on providing ARV for patients depends upon a certain period of residence in the area and the patients need to be available to come for check-ups at the clinic once a week. If the patient has irregular working conditions, such as going offshore periodically, he is not likely to be able to start ART. For returnees who need to continue their ART from Thailand, an understanding is established with them about drug resistance and willingness to strictly adhere to the treatment regimen.

This issue used to be a big problem in Thailand as Thai hospitals denied giving ARV to migrants because they could not assure the long-term use of treatment. With
active involvement from NGOs, they are now providing ARV to migrants more easily. Still, about 20% of migrant PLHIV drop-out of the program. The mobility of migrants is part of the problem and this requires further discussion to find better solutions.

In Myanmar, not only migrants but locals have difficulty accessing ART due to the distance from their home to ART clinics. Only those who can reach one of the existing seven positive networks in the country can access health providers for ART.

Concerning CD4 of patients who start ART, most PLHIV migrants return home for treatment when they are sick and their CD4 count is low. Thus, it is important to identify these PLHIV earlier in the course of their infection. Regarding a Contingency Plan in Myanmar for 2014, there is a plan to triple the 34 existing ART centers under its health decentralization strategy. This means people can have more access to the service.

A study in Thailand shows the main reason that Myanmar PLHIV do not seek ART in Thailand is because of the language barrier. In addition, although Myanmar and Thailand agreed to refer 150 PLHIV Myanmar migrants to Mae Sai Hospital, only 40 went. Of these migrants only 10 were able to continue their ART after returning to Myanmar in October 2013 due to the ineffective referral system.

A recent meeting between Myawaddy Hospital and Thai NGOs focused on patient referral from Mae Tao clinic and other NGOs working on the Thai side back to Myawaddy Hospital. The problems raised in working out this referral system included limitations of budget as well as human resources. In addition, many patients are low-income and transportation to the service site is not good, making it difficult for patients to attend health facilities on a regular basis. Collaboration with other local NGOs to support the logistics issues and other facilitation such as an outreach team was discussed.

There was a suggestion for pre-departure training for Myanmar migrants. The training will help them have basic knowledge about HIV prevention, treatment, reproductive health and family planning, as well as other valuable information in relation to the destination country. In fact, there do exist three migrant resource centers at origin points of migration from Myanmar to Thailand. The center provides pre-departure training for this purpose. Collaboration between Myanmar and Thailand in terms of pre-departure services should be elaborated for better preparation for migrants.
Migration Routes and CSOs Mapping among China, Myanmar, Thailand, Lao, and Vietnam

Migration routes among China, Myanmar, Lao and Thailand are summarized below.

The first route is from Kunming to MenGla to Boten and then Luang Prabang and Vientiane in Lao PDR before migrating further to Nongkhai and Bangkok in Thailand. Another route is from Kunming to Hekou to Lao Cai and then to Hanoi in Vietnam. The third route is from Kunming to Ruli in China.

Another long migration route starts from Sichuan in China through Kunming – Boten – Chiang Khong in Chiang Rai and then to Chiang Mai in Thailand. The routes through the Mekong River are from Yangon to Chiang Rai and from Lang Can to Tachileik to Chiang Rai. The last route is from China to Chiang Saen, with destinations including Mae Sai, Chiang Rai and Chiang Mai.

Organizations in Kunming are as follows:
• YHDRA- is doing research, training, and advocacy on HIV/AIDS prevention and control;
• Ministry of Health, State Population and Family Planning Commission, Ministry of Education, Women’s Federation, Youth Union; other NGOs;

Organizations in Myanmar are shown below:
• Kachin State- NAP and MSF Holland are working on HIV care and treatment, VCCT and STI screening and treatment;
• North Shan- NAP and MSF Holland are working on HIV care and treatment, VCCT and STI screening and treatment; MSF is also working on prevention programs while PSI is working on interventions with FSW and MSM;
• Eastern Shan- NAP, Malteser, World Vision, PSI and ASG are working on HIV care and treatment, VCCT and STI screening and treatment. MSF is working on prevention programs and PSI is doing interventions with FSW and MSM.
• PSI is an organization working on condom promotion, HIV/AIDS/TB prevention, community-based health education, harm reduction among IDUs and needle exchange;
• Save The Children is also an organization working on HIV intervention programs, including those for PWID; and
• Health Unlimited is working on HIV/TB/Malaria, building up basic health systems for Wa State, and malaria control among Chinese migrant workers in Myanmar.

There are various categories of Chinese migrants to neighboring countries and they are diverse in terms of migration pattern, knowledge and need. For instance, migrants from Shanghai to Kunming and migrants who cross to Thailand have different needs in terms of HIV knowledge and health educational knowledge. Another category of migrants is those who are living in certain areas, sharing a common culture with neighboring countries. For example, an ethnic group called Tai
speaks a language very similar to Thai. Therefore, they prefer working in Chiang Mai, Thailand to Kunming, China.

Big construction companies in China go to Myanmar and Lao PDR to build dams and other big construction projects. These companies bring Chinese migrants to work in those countries and in large groups. The companies have organized some pilot projects and interventions for health education for these groups.

Another category of Chinese migrants is migrants who cross borders for drugs as well as work. These migrants have no knowledge about the destination and situation they are going to. These different groups of migrants require different interventions, though the work objective is the same on HIV prevention, care and support.

**Additional key points summarized from open discussion**

Ethnic groups, especially the Tai from Yunnan, cross the border to work in the western part of Thailand. Many Burmese also cross to work in jobs related to the entertainment industry, particularly multi-purpose massage. Now, there are many Tai and Yunnan migrants working in many Thai provinces because communication with Thais is easy for them.

In terms of HIV prevalence in Chinese cities, although no definite data on migrants exists, one study in Sichuan found that 23 cases of HIV+ housewives were infected in one year, and 22 of these cases were infected by a husband who had worked in Thailand.

_All migration routes and CSOs mapping presented here are plotted onto Google Map and can be seen at the Raks Thai website, as illustrated below._

Role of Civil Society to minimize the gap and obstacles in referral and communication for continuum of HIV/AIDS services for mobile populations

Procedure
All participants were divided into four groups in accordance with countries sharing borders. Each group had a one-hour discussion following key objectives in learning and finding out about problems facing migrants in accessing HIV/AIDS services and what collaborations are needed. Key RTTR (recruit, test, treatment, and retain) concepts to evaluate the situation of migrants concerning HIV services in four stages of the services were considered. Roles of CSOs were also explored to fill in the gaps as well as indicate a way forward for their collaboration to initiate and promote better access of mobile populations to HIV services in those four stages.

After discussion, group representatives provided their outputs to the plenary group. Members of each group helped to facilitate questions and answers according to the group presentation.

Group presentation and discussion
Cambodia

Recruit:
Obstacles migrants face in accessing HIV services are mainly due to their limited knowledge and accessibility to necessary and informative sources. Most pre-departure migrants have no HIV knowledge and no pre-departure advice. Most information in the destination country, i.e., Thailand, is in the Thai language.

Role of CSOs to improve collaboration between the two countries are, as earlier pointed out, described in the CSOs mapping session. A key issue that should be emphasized is to ensure that migrants can access information in their own language. The media for information dissemination should also be attractive and of value in order that the migrants will keep and share it. Suggestions were made to invest in new designs, new key messages, and usefulness of the media/pattern that conveys essential knowledge for migrants.

Testing:
HIV testing among migrants is difficult due to inaccessibility of health facilities. Common problems are in terms of location, time, and financial support for transportation cost and compensation for their workday wage. In addition, migrants are afraid of getting caught by police if they are undocumented. In addition, migrants are afraid of knowing the test result for fear of discrimination against PLHIV. In addition, there is the language barrier. Although HIV testing is provided free of charge in Cambodia, this is not the case in Thailand, particularly for migrants who do not have MHI. A suggestion was made to CSOs in terms of mobilizing support to assist migrants in pre-post counseling, screening, and using rapid testing prior to sending the HIV+ migrants to public health hospitals for confirmation and treatment.

Treatment:
Key problems are related to ARV supply and location of ARV treatment. These include personal conditions such as job mobility and limited time available for ART.

Retain:
Several problems of HIV+ migrants are: drug resistance and non-compliance with the ART regimen. These result from mobility of migrants and, in many cases, misunderstanding or lack of knowledge about adherence. Many patients stop ART after they feel well. Another problem is that changing the ART regimen is not easy in Thailand.

Additional key points summarized from open discussion
Koh Kong and Trat have an agreement on cross-border referral. Koh Kong Hospital prefers to provide ART for patients who started treatment there. However, if registered patients are referred back to Cambodia, the hospital agreed to provide ART for two months at a time. Migrants can come back and forth for ARV supply in Cambodia but there is no information on the standard operating procedures for this system. Migrants also face difficulty in crossing borders, in terms of a guarantee for coming back to work in Thailand, cost of transportation, and concern of arrest if they
are undocumented. The decision to seek ART from Koh Kong Hospital depends on the migrant’s assessment of the cost and benefit.

There is one example of collaboration for HIV+ migrant prisoners in Thailand. Raks Thai staff helped to coordinate with CSOs in Cambodia and arranged for an ARV supply to be delivered via postal service from Cambodia.

Regarding MHI in Thailand, the total cost of 2,200 baht per year covers ART but seems to be too high an expense for healthy migrants. This new MHI system needs to be elaborated for better implementation since there is reluctance from both migrants and hospitals to participate in this insurance system. On the one hand, hospitals are concerned about financial stability according to the number and health status of migrants who buy into this system, since the whole system can only be sustained if there are at least 300,000 migrants purchasing the MHI. However, at present, only 60,000 migrants have enrolled. On the other hand, healthy migrants want to save money and buy the less expensive insurance.

Participants also observed that health care is also the responsibility of the migrants. The destination country cannot protect them all the time. In the case of MHI, healthy migrants who buy MHI can help themselves as well as their friends and relatives in terms of shared responsibility and care. Instead of waiting for external help, networking and purchasing MHI by healthy migrants are possible ways for this self-help concept.

In terms of MHI sustainability, it was recommended that there needs to be a more affordable MHI price to motivate healthy migrants to buy it. If there are records of location that have high and low MHI purchases, NGOs can help to advocate the selling of MHI through those hospitals as well as to employers to participate in this system.

Myanmar participants observed that promoting the MHI should also be conducted in the source countries. Migrants can then buy the insurance, for instance in Myanmar, before migrating to Thailand.

Participants from Lao PDR observed that Lao migrants do not purchase the MHI due to lack of knowledge about its benefits. Compared to the cost of returning home for ART four times a year, buying MHI is more convenient and beneficial.

Myanmar

Recruit: Myanmar migrants lack contact information for service providers and patients. There is no effective referral mechanism, as well as lacking trust in the service system. Common problems lie in weaknesses of the cross-border HIV program, legal status of migrants, and language barriers. CSOs should promote advocacy to follow up the MOU and collaborate with national programs as well as collaborating among cross-border NGOs. Their work should also reach newly arrived migrants in
Thailand. A bilateral database system and referral system in a tri-lingual referral letter and patient identity card should also be set up (Burmese, Thai and English).

Testing:
On both sides of Myanmar and Thailand, there is limited capacity and resources for VCCT service, CD4 and viral load for migrants. There are inconsistencies in VCCT procedures between governments and CSOs. A one-stop service will make it more convenient.

In Thailand, most Myanmar migrants cannot afford to buy MHI, or to go for testing. In addition, migrants have no information about MHI, its cost and benefit. In order to make testing accessible for migrants, strengthening collaboration between CSOs and government as well as empowering the PLHIV network will be of great benefit. These are in terms of providing information and support to general population migrants as well as sharing standardized VCCT guidelines.

Treatment:
Gaps in different services and protocol exist between Myanmar and Thailand. Common problems are lack of treatment history, interrupted supply of ARV and OI drugs, inconsistent guidelines, LFU cases, and affordability of MHI.

The national HIV programs from both countries should therefore support the implementation process: technically, informatively, and willingly. Sharing feedback of migrant services from the grassroots to policy level could promote more effective implementation. Decentralization of ART service and sharing standardized treatment guidelines between countries will facilitate the service.

Retain:
Migrants have inconsistent addresses. To retain ART clients requires a willingness of health officials to cooperate with CSOs in a cross-border referral system. Confidentiality of migrant patients is also basic practice. Legal status and work security are also key factors for HIV+ migrants to sustain their treatment.

Negotiation with local check-point authorities is crucial for supporting undocumented migrants to continue their treatment and care in their home country. Supporting associated costs as accommodation and transportation is also helpful for migrants who are referred back home.

In order to do so, advocacy for migrant-friendly policies are needed. This includes a bilateral database system and employer involvement. Translation of IEC materials into migrant languages is necessary.

China, Vietnam and Myanmar

Recruit:
Many factors affect migrants in receiving HIV/AIDS services. Language barrier is a common problem. Migrants do not have enough information or opportunity to gain necessary information relevant to health services. Discrimination is widely
experienced. Lack of trust of services providers is also a key factor. Additionally, law enforcement impedes migrant access to facilities and the services. Capacity building for health staff in this regard is crucial.

**Testing:**
Obstacles and gaps of HIV testing are as mentioned above. In addition, there is the lack of pre and post counseling. Test kits are also insufficient and, in some areas, the testing cost is not affordable for many people. Traveling for the test is not convenient, and there is an ineffective referral system to treatment for the ones whose test result is positive.

**Treatment:**
Problems come from drug availability and accessibility to ART. In Vietnam, many migrants have to pay for counseling and testing, though Vietnam nationals receive free service. The language barrier is also major obstacle in the treatment process. Family support is less available when people become migrants as few migrate with their families. There are differences on ART guidelines among countries and this presents problems for referral.

**Retain:**
For the in-country population, lack of basic home care is a main factor for retaining PLHIV in the treatment program. For migrants, lack of counseling on side effects of ARVs plays a key part in retaining ART. It is also difficult to follow up migrant patients due to their mobility. Improper referral and bilateral trust among cross-border countries are other crucial challenges.

The role of CSOs, therefore, should be working directly with target groups. Solving language problems will help facilitating the whole process of HIV/AIDS services to migrants. Eliminating discrimination through the use of peer groups should be encouraged. In terms of sustainability of support, mapping CSO/health providers and self-help groups founded among migrants will be very useful. Additionally, increasing more chance to connect migrants and related parties will facilitate the HIV/AIDS-related activities. Income generation and micro-finance support will empower migrants’ ability to adhere to their ART regimen and increase their opportunity to live healthier lives.

Solutions for these gaps in the HIV program are: operating a referral system between source/destination countries, setting up resource centers for migrants, obtaining regional funds for support for mobile populations, and advocating at the policy level to make bi-lateral agreements to make these proposed solutions a reality.

One-stop services for migrants are more convenient, as is good cooperation among cross-border hospitals, or focal points, in helping the follow-up process. Strong connections among cross-border NGOs is key to encourage better outcomes. Raising awareness in the community and among stakeholders is also helpful.
Lao PDR:

Recruit:
In Lao PDR, the government information system has no data for mobile and migrant populations.

Crossing the border into Thailand is easy and can be done without legal documentation. Language barriers exist in terms of reading and writing. Lao PDR and Thai speak nearly the same language and this makes it easier for Lao migrants to work in Thailand. At the same time, this similarity makes it more difficult to access and work with them. Trust and confidence are the main barriers between Laotians and Thais. In particular, regarding their illegal status, Lao migrants have little trust in officials who approach them. Stigma on HIV infection has also inhibited access to those at risk.

To minimize the gap, information provision at pre-departure, or in Lao PDR, is essential.

Testing:
There is poor information on HIV-related health services including difficulty in accessing the service, no time and lost daily income to go for the HIV test. Location of the facilities is also far from places of migrant residence. Moreover, there is fear of police, among migrants, depending on their legal status, as well as fear to inform others about the results of their HIV test.

Education with more information is needed to provide rapid tests in the workplace or migrant communities. Provision of VCCT through mobile clinics by peer counselors is another effective alternative for migrants instead of going to see a doctor at the hospital.

Treatment:
To access better treatment, campaigns to increase enrollment in MHI should be strongly encouraged. CSOs need to work with health providers to expand their marketing while working with mobile populations to motivate them to buy MHI and share their risk and gains.

Retain:
Migrants are more likely to stop taking ARVs when they are feeling healthy. This causes drug resistance. To minimize this problem, a follow-up mechanism should be set up with collaboration among groups including CSOs. Communication with these migrants varies depending upon their work and living conditions. They are likely to receive information from radio, but there are many other channels of communication to reach more people.

Additional key points from open discussion

There should be standard operational guidelines for participating NGOs under the regional collaboration project. In order to make a more enabling environment for
HIV-related services, an MOU with the private sector and business owners, should also be initiated.

The Myanmar government has a decentralization plan for testing and training more people at the midwifery level. It is estimated that staff of 40 NGOs will be trained in 2014.

In Cambodia, HIV status confirmation by rapid test can be done while the client waits, or on the same day. There are test managers to be responsible for the confirmation and follow up. However, the concern is about LFU cases.

High-risk groups are normally unable to access blood testing and the high cost or related costs of treatment. NGOs can help to fill the gap with their collaboration with health providers. Outreach teams have to be trained by public health providers and be skillful enough to provide testing and counseling. The finger prick rapid test provided by trained staff in Cambodia has been quite successful due to its accessibility and user-friendly environment.

Regarding maintaining confidentiality of clients, a carefully-selected approach to avoid the possibility to disclosure of serostatus was suggested by the members.

Importantly, many persons die of AIDS without ever knowing that they were infected. Migrants should therefore realize that testing and knowing their HIV status could save their lives. NGOs should pay more attention to this stage of VCCT and have techniques to deal with the positive test results of their target groups.

In sum, the key elements of the role of Civil Society to minimize the gap and obstacles in referral and communication for the continuum of HIV/AIDS services for mobile populations are as follows:

**Gaps and obstacles in HIV/AIDS services:**

- Insufficient knowledge regarding transmission of HIV/AIDS, accessibility of VCCT and ART;
- Conditions that prevent migrants from accessing HIV-related knowledge, services and facilities, include language barriers, availability of health provision, economic and working condition as well as attitudes, fear, stigma and discrimination against migrants and PLHIV;
- Not enough coverage for client-friendly VCCT and ART services for migrants;
- Different HIV related services and standards of basic procedures in referral of PLHIV within and between countries in the GMS;
- Different protocols among countries in dealing with the issue of cross-border migrants and HIV issues;
- Limitations of health insurance for migrants in the GMS countries;
- Mobility of migrants, which can undermine adherence to ART and result in LFU cases.
- There is no systematic database of migrants and PLHIV.
Role of Civil Society

- Facilitate migrants to access HIV-related services in terms of language translation, liaison between migrants and health providers, and advocating health authorities to improve access of migrants to client-friendly HIV-related health services;
- Create or provide assistance to national authorities to set up a migrant and HIV-related issues database within and among GMS countries;
- Provide existing examples of cross-country referral systems to be promoted and expanded to other needed areas along the border;
- Assist the implementation of MHI by promoting its benefit to migrants and help authorities to minimize the gap of uncovered costs from insufficient registered migrants;
- Decrease discrimination; and
- Map CSO/health providers and self-help groups founded among migrants for collaboration.

Identification of potential learning sites and site visits to strengthen CSO collaboration

Procedure
Participants were divided into three groups to discuss potential learning sites, site visits, workshops and training, in order to strengthen roles and collaboration among CSOs in GMS countries. After discussion, group representatives provided their suggestions to the plenary session. Members of each group helped to facilitate questions and answers according to the group presentation.

Group 1: Learning sites: Good practices of HIV/AIDS-related activities for mobile populations including prevention, care and treatment, cross-border collaboration, and referral systems

Myanmar and Thailand: Myawaddy – Mae Sot

Reasons for selection:
- Lots of migrants and many services from GOs and NGOs for cross-border migrants.
- Good collaboration among NGOs (Mae Sot- MAP, World Vision, IRC, Mae Tao Clinic, Myawaddy- public hospitals, IOM, HIV groups)
- Having CSOs working in Myawaddy

Coordination:
IRC coordinates with SAW and the Mae Tao clinic in Thailand and IOM in Myanmar.

Main Contribution:
- Sharing experiences and lesson learnt
- Referral
- Formal and informal exchange of information

Benefits:
CSO/government service providers and migrant workers

Cambodia and Thailand: Koh Kong - Trat

Reasons for selection
- Lots of migrants crossing the border to work in Thailand
- Being a transit point to other destinations in Thailand
- Good practice on cross-border collaboration and referral systems
- Covers all key related issues on HIV/AIDS services for mobile populations
  - Prevention (PHAMIT, CWPD, MRPS)
  - Care and treatment (hospitals in Trat and Koh Kong)
  - Health insurance (Thai hospitals)
  - Referral system (agreement between Thai provincial health office and hospitals and Koh Kong Hospital)
  - Sexual and reproductive health (MSIC)

Coordination:
Raks Thai, hospitals and stakeholders

Main contribution:
- Sharing good practices (PHAMIT, Raks Thai, hospitals)
- Sharing IEC (CWPD, LSCW)
- Referral and follow up/results sharing

Benefits:
- Site visitors (learning and sharing experiences and information)
- Hospitals and stakeholders
- Target groups (migrant population at source country)
- Indirect benefits to other groups

Lao PDR and Thailand: Ubonratchathani + Champasak

Reasons for selection:
- Covers all key related activities on HIV/AIDS for mobile populations
  - Prevention (Raks Thai, government sector, Lao Pha, Rainbow Sky)
  - VCT (government and Lao Pha, VES),
  - ART (hospitals in Champasak and Ubonratchathani)
  - Follow up (Lao Pha, government and health service providers, Lao PN+)
- Provincial committees in both countries have close collaboration on various issues including anti-trafficking, and are able to raise support for HIV funding and work with migrants.

Coordination:
Cross collaboration in terms of meetings, sharing information and resources, referral
Benefit:
Participating organizations, Civil Society, CBOs, migrant population

Group 2: Cross visits - To learn good practices and share experiences among sites visitors and host organizations

There are different perspectives toward selection of site visits. Five places in Thailand were proposed for cross-visits, including the following:
- Samut Sakorn (Myanmar migrant workers)
- Ubonratchathani, (Lao-Thailand cross-border)
- Trat, (Cambodia-Thailand cross-border)
- Mae Sai, and Mae Sot (Myanmar-Thailand cross-border)
- Ranong (Myanmar-Thailand cross-border)

Additional suggested site: Chiang Mai (cross-border Lao-Thailand)

Other country sites are also mapped for further visits.

Vietnam: Hanoi, Hai Phong, Dien Bien, Thai Nguyen, Hua, Da Nang, Ho Chi minh City, Can Tho
- (Testing campaign, PLHIV legal rights empowerment, condoms – IEC material campaign, raising awareness on prevention and treatment)

Lao PDR: Savannakhet, Champasak, Vientiane: Care and support (treatment center, self-support groups, ARV center) drop-in center (FSW/MSM/TG), CSOs and INGOs program (APL+, LaoPha, World Vision, PSI, PCCA)

Myanmar: Shan State: Thachileik, Mon State, Mawlamyaing, Kayin State: Myawaddy, Tanintharyee Div., Kaw Thaung (prevention, STI screening, HCT, PLHIV networking, DIC/Top center, Care and treatment: ART/OI/STI/HBC, psycho-social support)

Program for visit:
- HIV prevention for migrant workers
- Care, support and treatment
- Drop-in center
- Cross-border referral system
- Health insurance for migrants

Regional team
Lao team (10 persons): CSO leaders, peer HIV leaders, National AIDS Authority
Myanmar team (15): Representatives from the National AIDS Committee, parliamentarians, related department staff, NGOs, CSOs, migrant representatives
Vietnam (15): National AIDS Program, National AIDS networks (5), MOH, MOP, INGO, CBO, governmental representatives from areas having a high number of mobile populations [3]
Cambodia (5): LSCW, CWPD
**Group 3: Workshop and training for information and experience sharing (not for skills development)**

**Workshop:**
- Learning of best practices from CSO partners (e.g. solving problems of rape cases of the Mae Tao clinic could become a standard procedure of implementation for rape case management in other areas);
- Developing coordination mechanisms for effective referral system. Two scenarios about collaboration that should be discussed:  
  1) Different ART regimens and protocols between Thailand and Myanmar – suggesting that the problem can be easily solved by talking/exchanging information with authorities;  
  2) Sending ARV drugs by post across borders as a suggestion for joint action among stakeholders in GMS countries;  
- LFU cases and referral systems;  
- Regular CSO meetings (international donors and UN representatives should be invited). One of the key topics should be how to work with government, health centers, and doctors; and  
- Empowerment of PLHIV networks in each location.

**Additional key points from open discussion**

PLHIV don’t know about signs or symptoms of AIDS and appear too late for ART to be effective. Training for basic knowledge on treatment literacy should be provided.

The purpose of the project is to make sure that the services have good quality and people need to be convinced of this. The information system should not be limited only to NGOs but also for people who need it.

Should cross-visit teams comprise all nationalities or be by nationality, or by same interest, or smaller groups?

There was also the suggestion to change the name of “learning site” to “learning and sharing center”.

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**Image:** Workshop participants engaged in discussions.
Dream website: What should the website look like?

Procedure
Participants were divided into four groups, according to nationality and group interest, to discuss a potential website as a practical tool for multi-purpose networking and providing important information on mobile populations and HIV services in GMS countries. After discussion, group representatives provided their input to the plenary session. Members of each group helped to facilitate questions and answers according to the group presentation.

Presentation by group country/Interest
As a tool for multiple purposes of CSO collaboration networking on HIV services for mobile populations, a website was proposed and key details of the website were discussed. Tentatively, the main audiences of the website are CSOs working for migrant health and HIV programs, donors, others interested persons as well as some core PLHIV networks. Since migrants and PLHIV migrants may not have easy access to the website, the site will be linked to other social media such as Facebook and Line as a source of reliable data and services for mobile populations in GMS countries. Raks Thai was nominated to be the operating host of the website while each country needed to identify members to be focal points for providing updated information. English and local languages of each country are requested to be the medium of access to the web content. Design of the website needs programming literacy and technical skills; this will be considered and arranged by Raks Thai. Though the name of the website was not finalized, it was agreed that the key search words would include CSO, HIV/AIDS, migrants and GMS.

Specific information suggested by group presentations

| Target audience:                   | • CSOs working on migrants and HIV/AIDS  
|                                  | • Donor/UN/policy maker/ researchers/academy  
|                                  | • Government/health sector  
|                                  | • PLHIV  
|                                  | • Job seekers  
| Information/IEC/ resources on the Internet | • Introduction/ Background  
|                                  | • Country context: social cultural, traditions, beliefs  
|                                  | • Migration information: current/update migrant situation and statistics of migrant population, migration routes and situation of migrants in GMS countries, Demographics of migrant- Nationality/route, migrants living with HIV, difficulties of migrant- issues, social context  
|                                  | • Services for mobile populations- HIV/AIDS prevention, treatment, care and support  
|                                  | • Migrant policy update, social welfare/health insurance for migrants  
|                                  | • Legal and safe migration- Guidelines for migration, pre-departure orientation, post-departure training  
|                                  | • Updates on policy related to migrants and migrant rights  

**CSO Collaboration on HIV/AIDS for Mobile Populations**

- Updates on news - media, labor law, law for migrants
- Mapping of NGOs working for migrants, networking and their projects including PLHIV or peer networks in the area
- Projects and CSO experience, shared information of success stories, video clips and photos
- Contact and services for CSOs in the network and mobile populations/ CSOs working with HIV/AIDS, information and name of CSOs, contacts
- Link to important websites
- Related IEC material
- Health issues- HIV/AIDS, OIs, medical guidelines, health insurance coverage, referral mechanisms
- HIV-related basic information, and information for PLHIV, e.g. co-infection, ARV treatment (information and location), counseling information, ART and rights of migrants, updated number of cross-border PHLIV, referral information, contact details of peer support groups, peer network information and contact number, hotline number/office number

<table>
<thead>
<tr>
<th>Language:</th>
<th>Multi-language (English, Thai, Burmese, Chinese, Lao, Cambodian)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focal point for each country:</td>
<td>Myanmar- Save The Children, Care, Malteser Cambodia- not available Lao PDR-not available Vietnam- not available Thailand- Raks Thai Foundation Yunnan- Assoc. Prof. Songyuan Tang (Yunnan Health and Development Research Association, China) PHA: Focal point in each local area but managed by the network</td>
</tr>
<tr>
<td>How to connect with audience:</td>
<td>Web board (real time), forum on specific issues for communication and sharing information among the CSO network, SMS,</td>
</tr>
<tr>
<td>Suggested names for the website:</td>
<td>GMS migration, GMS save mobility, GMS Mobility and sexy network/ Sexy GMS migrants Network, GMS CSO network, GMS health and mobile populations, Healthy mobile populations/ Healthy Mobile GMS, C-CHAMP/HIV4MP HIV collaboration for mobile populations GMS HIV/AIDS CSO network HIV migrant Network</td>
</tr>
<tr>
<td>Others</td>
<td>Central page for everyone to add/update information</td>
</tr>
</tbody>
</table>

*Additional key points from the open discussion*
The content of the website could be provided from the collaborating CSO members from each country. It should have a center page describing all available information and level pages for each country with updated information.

Content of the website should be accurate and become an online resource center. The website is most likely useful for persons working in relation to specific issues who require more data. In many cases, the website might be useful for finding financial support since donors may use the website to learn more about the working of the organizations. The website should be linked to social media such as Facebook and Line. HIV+ migrants have difficulties in accessing even email. In Myanmar, in particular, it is difficult to access the Internet or even mobile phone contact.

The website should be specific about the target audience. For example, it could be portrayed as a resource center for all CSOs under the project. It will also be more practical if the Facebook page is linked to the website, and be set up as a Line group in order to be an informal communication tool among participating CSOs.

In terms of GMS country background information, the website content should be comprised of context of the country, culture and attitudes influencing behavior and life style, reproductive health and HIV-related information.

**Strengthening CSOs collaboration for mobile populations health promotion**

**Procedure**

Participants were divided into four groups, to discuss about strengthening of CSO collaboration, priority, and action agreements. After discussion, group representatives provided a summary of their discussion to the plenary group. Members of each group helped to facilitate questions and answers according to the group presentation.

In order to strengthen CSO collaboration, the meeting agreed on several key dimensions of cooperation. Although limited by time and budget constraints, all were agreed that their collaboration and friendship will not be restricted to only one year of the project time frame. Regular meetings and contact should be a foundation for cross-border collaboration and a means of effective communication within the collaboration cycle such as email network, regional meetings, joint cross-visits and workshops, as well as continuous updates of information from each country focal point. The group should also raise common concerns for co-advocacy at both national and regional levels, for example, universal access to ARV for migrants, a bilateral database, referral system, and agreed guidelines for HIV services for migrants. The ASEAN people’s forum at Myanmar, and the regional cooperation on human rights could be other opportunities for collaboration to address migrants’ needs.

Government authorities tend to exclude CSOs from their cross-border MOUs or agreements. Thus, there is a need for advocacy campaigns to incorporate the formal role of CSOs in government MOUs. Another suggestion was to advocate more involvement of CSOs in implementation processes of government, for example, the
case of the pilot project in China to gain trust and sharing benefits of releasing the burden from government responsibility, or using the same official language and formal protocol of the government sector to gain their understanding and acceptance as well as approval of support. Action agreements or signed MOUs with CSO collaboration was also raised. In addition, it was suggested that the real situation and work of CSOs be documented on the ways they promote accessibility of migrants to health services in order to be strong evidence as a basis for advocacy.

**Specific recommendations summarized from the group presentation**

In order to enhance the CSO collaboration, CSO representative in this meeting recommended further action for country roles and the role of CSO collaboration as follows:

**Myanmar:**
- Provide feedback of this meeting to parliamentarians, health authorities, and community groups.
- Advocate HIV-related issues on migrants through the existing seven PLHIV networks.
- Working together with health providers in Myanmar to gain trust from Myanmar migrants as well as increased channels and quality of HIV services.
- Holding technical support and regular meetings.

**Lao PDR:**
- Focus on the time frame and conduct regular meetings/trainings/sharing.
- Need commitment from staff working as focal points and prepare for their rotation to other organization.
- Plan to advocate formal roles of CSOs in agreements/MOU at the country level.
- Advocate through donors as a strategy to have more impact.
- Need action agreements among CSOs.
- Create database between twin cities, including documentary clips about working experience in working across borders.
- Translation of existing IEC materials into migrant languages.

**Cambodia:**
- Make collaborative agreements or MOUs among participating CSOs.
- Co-advocacy on the short or immediate gap in HIV services for migrants that already exist, e.g., advocate for sufficient ARV services for migrants.
- Advocate other stakeholders to support public media for migrants, e.g., radio broadcasting.

**China, Vietnam, Thailand:**
- Set up strategies to advocate:
  1) Research with strong evidence and using official language for better understanding and negotiation for the proposal
  2) Conduct pilot projects and carefully evaluate success including cost-effectiveness
3) Negotiate with government authorities to scale up the work given the CSO’s ability to help public sector in terms of time and location.

- Beware of sensitive issues or wording
- Collaborate with other networks and share information for better understanding in more expanded networks
- Use social media to advocate education

Future Plans of the Project

The Project will end at the end of 2014. A plan has been set up for cross-visits, training/workshops, and another regional meeting for information exchange and conducting social media and website information dissemination. Since the budget is limited, all suggestions given during the meeting will be considered in relation to budget and timeframe. Site visits may begin in May or June (2014??) with feedback to all participants participating in this meeting. Other suggestions for interesting things/places to see when going to the countries are welcome and will be included in the implementation plan. Leaning sites have more detailed description and people can learn from websites in various formats, e.g., text, clip videos, etc. Accordingly, these sites may be excluded from site visits. The site visits will be planned for 2-3 towns in the country for 8-9 people per visit. The locations may focus more on the interior of the country and demonstrate the connection to migration, e.g., pre-departure programs.

With regard to a site visit to Myanmar, there should be adequate time for preparation (about 2-4 weeks). The Myanmar authorities, including the Ministry of Health, National AIDS Program and other concerned ministries and migration authorities should also be informed. In terms of a host organization, Dr. Aye Aye Thet agreed to consult with Myanmar authorities and provide feedback to Raks Thai in terms of places for the visit and possibility of host organizations.
Conclusion

**CSO collaboration on HIV and mobility in the GMS** was selected as the name of the groups participating under this regional collaboration project. More focus is encouraged on working together on how to improve accessibility of migrants to HIV services in regard to their mobility and vulnerability. As a commitment from all participants, it is clearly shown that the Project will have more impact, not just from learning and knowing each other, but from helping others, particularly migrants, to access friendlier and better-quality HIV services within all GMS countries.

At last, the organizers would like to thank all participants for being a valuable part of the Project with a mission to contribute to the benefit of mobile populations. We hope our journey together will be productive and fruitful to meet our common goal of having a healthy and happy migrant society.

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