

Migrations and HIV transmission as experienced by people living with HIV in Lao PDR

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Abstract

Objective: The aim of this paper is to assess the interactions between migration paths and HIV infection risks among and from the views of people living with HIV in Lao PDR.

Methods: Twenty-four in-depth interviews with eight interviewees were carried out by four trained members of the Association of People Living with HIV (APL+), in 2017. The qualitative analysis was done manually to explore the influence of social determinants through migratory paths on the evolution of individual lifestyles, working and living environments, access to information, prevention and healthcare that contribute to HIV infection risks.

Results: Low levels of economic and education lead to migration and also increase risky practices and vulnerability to HIV infection of migrant workers. Insufficient awareness and access to prevention against HIV/STIs in their home country increase risky behaviours during migration. Moreover, inadequate referral system for HIV treatment, stigma, and family relationships contribute to influence the life courses of migrants' post-HIV infection.

Conclusions: Raising awareness and providing access to information on HIV/STIs, both for internal and external migrant workers are crucial in order to diminish the prevalence of HIV infection among the target audience. A reinforcement of the existing collaborative health measures between Lao PDR and Thailand is needed to enhance migrants' access to healthcare services.

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Keywords: HIV, vulnerability, PLWHIV, migration, Lao PDR, Thailand

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Introduction

Lao PDR has a low prevalence of HIV infection with 0.3% among the population aged 15-49 years, although, in the absence of any intervention plan, projections show an increasing rate in 2020 (ASEAN & Secretariat, 2014; UNAIDS, 2016). The majority of reported HIV cases (86%) were from border provinces (Directory of LAO CSO 2014, 2014). HIV prevalence rates in Laos bordering countries are estimated as follows: Cambodia (0.5%), Vietnam (0.3%) and Myanmar (0.7%) (WHO, 2018). Thailand, with a rate of 1.4% has the highest prevalence in the area (HIV / rapid assessment, 2008).

Leaving one's territory is not a new phenomenon in Lao PDR. Since the opening of the country to the market economy from 1990 onwards, migratory phenomena have taken place due to the

government's relocation policies, the economic attractiveness of certain regions (road construction, hydroelectric and mining projects, agri-food industry) (Phetchanpheng & Hancart Petit, 2020).

There is scientific evidence that migration often leads workers to harsh living conditions, unstable financial situations as well as low-paying jobs, insecurity, etc. (Alemayehu, Wubshet, Mesfin, & Gebayehu, 2017; El-Bassel et al., 2016). Most migrants experience poor health during their migration as a consequence of their limited access to the healthcare system in their destination country (El-Bassel et al., 2016; Rai, Lambert, & Ward, 2017; Saggurti, Schensul, & Verma, 2009; UNDP, 2015; Webber, Spitzer, Somrongthong, Dat, & Kounnavongsa, 2012).

Lao PDR is both a migrant worker source and destination country since approximately 11,000

Vietnamese, 300,000 Chinese and 2,000 Thai migrant workers were reported in the country in 2013 (HIV / rapid assessment, 2008; ILO ASEAN TRIANGLE project, 2015). However, many Lao migrant workers are seeking job opportunities, mainly in Thailand and also in other countries (MOH Lao, 2014). In 2013, 926,000 Lao migrants went to Thailand (ILO ASEAN TRIANGLE project, 2015).

The Centre for HIV/AIDS/STIs (CHAS), working under the Lao Ministry of Health in partnership with donors and international organisations implemented various activities to prevent and control HIV/AIDS. However, access to HIV testing, prevention, and care services remain limited, especially in rural areas (UNAIDS, 2016). In addition, Civil Society Organizations (CSOs) play a major role in fighting HIV/AIDS and supporting directly PLWHIV (People Living With HIV) to improve their health status and to help them reach a better quality of life.

The influence of migration on HIV infection is well documented. However, in Laos, little is known about the intimate experiences of migrant people that make them vulnerable to HIV infection. From 2016 to 2018, we conducted the project entitled "Migration, mobility, and HIV/STI vulnerabilities. An Interdisciplinary and Community Based Participatory Research in Lao PDR". Our epidemiological research of 664 people living with HIV from all antiretroviral (ARV) sites emphasises that around 32% of these are migrant workers and 44% were infected in Thailand. For this article, we mobilise especially the data collected within the sub-study that aims to assess the interactions between migration and HIV infection among, and from the view of people living with HIV. The specific objectives of the study were: (1) to explore the difficulty of living and working during and after migration and its relation to HIV vulnerability; and (2) to investigate the change of one's lifestyle through migratory paths and its impact on HIV infection.

Methodology

The results presented here are the findings from ethnographic interviews conducted as part of the project "Migration, Mobilities and HIV/STI Vulnerabilities, an Interdisciplinary and Community Based Participatory Research in Lao PDR". This research aimed to analyse how health with social and migratory paths are interlaced for migrants in Lao PDR. The results presented here are the findings of a sub-study led by representatives of VVIH associations of people in Laos and trained by the IRD in the practice of research. It explores the effects of HIV infection on the life course and examines how and to what extent HIV positive status leads to migration.

Information collected included socio-demographic characteristics, conditions of migration and life in Lao PDR, relational, sexual, and reproductive history, and health-care pathways. It also included the migrants' living conditions, their economic resources (from their work, from a spouse or other family member, state allowance, none) and housing situation (had their own housing, housed by family, associations or hotel's workers, no stable housing). Four sexual partnership types were investigated:

- stable, / A stable partnership was defined as a partnership that lasted at least a year
- casual, casual partnership as one lasting less than a year or reported as short transactional partnerships / as one that was accepted, but unwanted, to obtain housing, clothes, food, papers, or money.
- Paid sex defined as reporting paying someone to have sex

Interviewers' selection process

Four representatives of the CSOs Lao Pha and LNP Plus living with HIV have been involved in the research process as interviewers. They originated from four provinces: Savannakhet, Champasack, Huaphanh, and Luang Prabang. A two-day training session was organised by the research team in Huaphanh and Savannakhet Provinces to train and select the interviewers out of a group of twelve participants.

Data Collection

Within each site selected for the study, interviewers identified people to participate in the study.

The selection criteria for the interviewees were defined as PLWHIV aged above 20 years, living with HIV, taking ARV medicine for more than 5 years, and having had a migration experience. Each interviewer had to choose 2 people from its own network, meeting the selection criteria. Participants were subsidised 50.000 LAK per interview (150,000 in total).

They gave oral information on the study. When the person agreed to participate in the study, the interviewer obtained his oral consent. Interviews were conducted in face-to-face mode and mostly at home of the interviewee in order to ensuring privacy. Each interviewer involved in the data collection followed a common interview guide during in-depth and open-ended interview. Each interviewer conducted 6 interviews (3 interviews with 2 informants) in Lao language.

The question guide contained open-ended questions to facilitate participants' free expression of their lives and experiences as migrant workers including their partners before and after HIV infection. Participants were asked to recall their

experiences chronologically, with references to main events or moments of their life such as marriages, sexual relationships, reproductive events, household changes, professional experiences. They also had to relate their illness

experiences, their experiences of migrant life, and trips home. In the end, various questions were also raised about their experiences with HIV healthcare services and treatment.

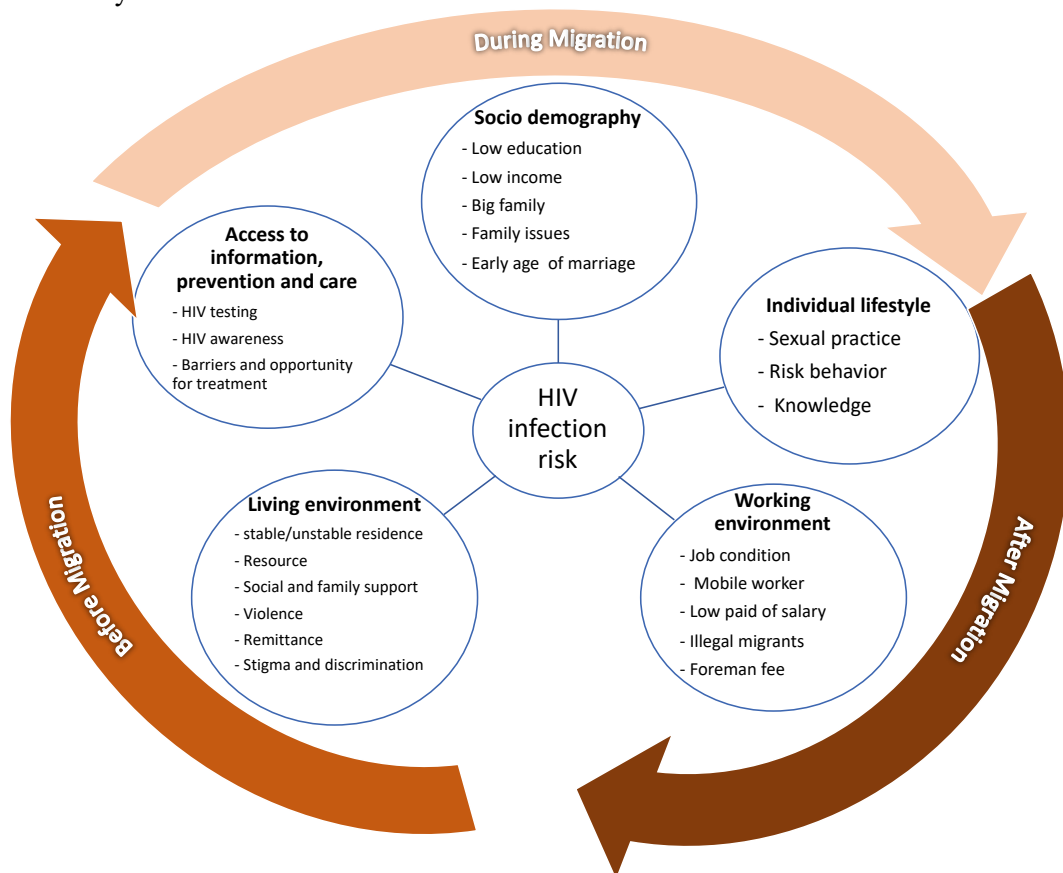


Figure 1: The Detailed Analysis Framework for migration and the risk of HIV infection (Burris, 2008; Lyttleton, 2014; Rai et al., 2017; Saggurti et al., 2009)

Analysis Approach

All recorded interviews were transcribed and translated into English. Data analysis was done by the first author. Both Lao and English transcripts were reviewed and compared to avoid any missing point and misunderstanding in the translation. Coding was done manually with several readings to validate the analysis.

The analysis framework was inspired by social determinants of health approaches and literature reviews on migration and HIV (Burris, 2008; Lyttleton, 2014; Rai et al., 2017; Saggurti et al., 2009). As shown in Figure 1, it explored influencing social determinants contributing to HIV infection risk as migratory paths, changing of individual lifestyles, working and living environments, access to information as well as prevention and healthcare.

Results

The scientific investigation highlighted the complex set of interactions between HIV and a person's life trajectory through the key mechanisms of migration. The results will be presented by

introducing each of the social determinants that were identified as the factors of migrant workers' HIV vulnerability, as well as their interaction with the evolution of migratory paths "before", "during" and "after" migration. In other terms, the data contribute to giving insights on the life of the interviewees before they initiate the process of migration "Before Migration", to explore how and to which extent they experimented their new life as a migrant worker "During Migration" and to document what happened to them at the time they went back and settled again in their village "After Migration".

Socio-Demographics

The samples comprise eight interviewees, 3 men and 5 women, aged between 23 and 56 years. More than half were from low-income families and had low levels of education (below secondary school). Three people were based in the south of Lao PDR and Vientiane Capital. Five interviewees were initially from and based in Huaphanh and Luang Prabang Provinces. They had moved from their hometowns to Vientiane Capital for work and/or study.

Individual Lifestyle

The social structures of working conditions and living status shape an individual's exposure to risk. Our interviewees felt that lifestyles in Lao PDR and in Thailand were clearly different, according to their social status.

Before Migration

Some interviewees already had high-risk sexual practices before migrating to Thailand or Vientiane Capital. These include unstable partners, multiple partners, and men looking for sexual services without protection. They explained that they were too young to have sustainable relationships.

"... After I received my salary, I used to go to the sex worker shop and the money was spent in only 2 days. I slept with a sex worker twice without condoms..." (HP 1 (M, 31 yrs.))

During migration

Our informants reported many HIV/STI risky practices during migration including working in the sex trade, having girlfriends who were sex workers, paying for sex, multiple partners, unprotected sex with sex workers, drug use and needle sharing (for instance for tattoos).

Moreover, we also found that condom use was very low during this period. Many participants chose intentionally and/or unintentionally not to use a condom while having sexual intercourse.

Unintentionally: "... I slept with unknown people many times. When drunk, I often forgot to use a condom..." (CPS 4 (F, 27 yrs.)).

Intentionally: "...I asked the girl not to put the condom on and I felt better. From that time, I would rather not use a condom ..." (CPS 3 (M, 36 yrs.)).

The data also reveals that some migrants were addicted to non-injectable drugs (such as amphetamines). Many of them shared needles for tattoo making with their friends as it was cheaper than going to a real tattoo shop.

"... When there were no customers, we used drugs (amphetamine) with girls in the shop. At that time, we followed the trend of tattooing our hand or waist and used the same injection needle..." (CPS 4 (F, 27 yrs.)).

After Migration

Depending on their health status upon their return, some people ceased any practice related to high-risk behaviour. Others came home as healthy individuals or at least without symptoms and pursued their life with high-risk behaviours.

"... I worked here, I smoked, I took ya baa (amphetamine) with my flatmates. But I did not buy it in Thailand because it was too expensive..." (SVK 1 (F, 33 yrs.))

Working environment

The majority of interviewees had only primary school levels of education which makes it difficult for them to find good jobs in the Lao PDR, and in another country.

Before Migration

Many interviewees were farmers or had no jobs before moving to Thailand or to Vientiane Capital. Some of them went to work in other provinces in garment factories and/or construction companies.

« ... After farming, I went back to Thailand in 1987 because there was no work, and I did not know any jobs in the Lao PDR... " (VTE 2 (M, 48 yrs))

During Migration

Working conditions had changed since there is a larger variety of jobs with no specific requirements available in Thailand. Seven out of eight interviewees were in Thailand as illegal migrant workers. They applied for jobs they considered well paid so they could have enough financial support for both their living expenses there and to secure their homecoming. Moreover, as those migrants usually require the help of a smuggler to cross the borders illegally, a large amount of their income was used to pay it back.

"... During the first month, my salary was 2,000 baht but the Thai smuggler took all of my money for the meal fee during the journey and transportation costs. The Thai and Lao smugglers split my money..." (CPS 3 (M, 36 yrs))

After Migration

Upon returning from Thailand, interviewees' health status became a cause of discrimination in the working environment. It also prevented them from finding a new job.

Living Environment and Stigma and Discrimination

PLWHIV usually experience stigma and discrimination. Following UNAIDS, we will define stigma as the feeling of being treated differently, usually in a pejorative way from the rest of one's community (UNAIDS, 2011).

Before Migration

Two people were infected before their migration; thus, the stigmatisation experience was identified during this period. The stigma was felt at both the healthcare settings and the workplace; this obviously affected adherence to their ARV treatment.

"... I convinced him my partner to get treatment, but he did not go because he was very shy and afraid that he would lose face and be discriminated against by people especially since he was working at a public institution ..." (VTE 1 (F, 40 yrs.)).

During Migration

One migrant living with HIV lost her job because many people in the factory knew about her HIV status, including her boss. She was fired because they were afraid, she would infect others.

"...he said that he could no longer accept me because the staff was afraid of this..." (CPS 1 (F, 48 yrs.)).

After Migration

Most participants decided to disclose their HIV status to their friends, colleagues, and family members. However, community stigma and discrimination had a strong effect over their lives. Some of them even attempted suicide, others moved to another province in order to hide their status or escape the gaze of their neighbours and friends.

"...there was gossip by others when they saw me, and it made me feel as if they didn't want me to live anymore. I decided to buy paracetamol. I thought of committing suicide, I had the entire bottle, around 40 or 50 tablets" (VTE 2 (M, 48 yrs.)).

Access to Prevention, Information, and Healthcare

Working and living conditions could either ease or limit our informant access to healthcare. The ARV medicine was not given to them, due to their illegal status as a migrant worker.

Before migration

Two PLWHIV members of the study had an HIV-positive status and received the ARV treatment before migrating to Thailand.

"...in 2005 the doctor admitted me to take antiviral medicine (ARV) medicine..." (CPS 1 (F, 48 yrs.))

During migration

Opportunities for accessing prevention, information, and healthcare were limited. Because of their illegal migration status, accessing preventive healthcare information in the host country was difficult. One of the participants' applications for receiving ARV treatment was rejected in a Thai public hospital. As she had no passport, she couldn't get the ARV under the agreement between Thailand and Laos on ARV access for legal migrant workers.

"...If you would like to get the treatment here, you cannot if you do not have your passport or ID card..." (CPS 4 (F, 27 yrs.))

This woman then came back to Lao PDR to request a passport, then went back to Thailand where she could both pursue her job activities and get ARV treatment.

Conversely, one migrant worker in the Lao PDR who moved from their hometown to Vientiane Capital had better opportunities to receive HIV awareness and regular HIV testing at a healthcare facility.

"... While I was selling sex in the shop, I was going to get the blood test very often. The project's team was coming to educate us every 3 months... » (HP 3 (F, 23 yrs.))

After Migration

Five interviewees could not work anymore and had no access to treatment so they came back home being HIV positive and ill. However, here they also faced some difficulties in accessing healthcare services, such as long distances from their home to the hospital, reliance on traditional medicine, self-treatment, or even shyness and sometimes shame to receive the ARV treatment.

"... When I was in Savannakhet, it was very difficult because of the accommodation, sometimes I did not go but I needed to go, sometimes I stayed overnight in a relative's house and sometimes overnight in a hotel... » (CPS 1 (F, 48 yrs.))

Discussion

The main strength of our study is the methodology that is still rarely found in Asian Pacific countries while it is found in the Republic of Congo and Mali (Cissé et al., 2016; Kieto et al., 2014). Such methodology is very relevant for conducting qualitative studies on sensitive issues, where research objectives are not always well understood and where informants may feel uneasy talking and sharing biographical data. In Lao PDR, research remains tightly controlled and subject to authorisation from various administrative levels. Sometimes people are contacted upstream and presented to the researcher during his field visit as an observer of the study. Such unexpected changes conducted us to various adaptations in the way we conducted the research. This made it difficult, therefore, to create the bonds of trust and closeness indispensable to the practice of ethnography, the foundation of our discipline. Its principles combine a long immersion in the field, a consideration of the context of enunciation of the collected discourses and a constant positioning of the anthropologist in his field. However, involving peer researchers to collect data among their own social networks still allowed to collect intimate perspectives and sensitive data. This method is the most relevant to explore a new, or little understood, topic, to discover new information and expand existing understanding and to get the perspective of one individual without interference from others.

From our experiences, we observed that there are both positive and negative impacts of having non-researchers collecting the data: on one hand, the

interview bias may have been minimised at some point as the interviewers would not lead the discussion to the expected scientific result. On the other hand, even if the questions and probes were framed in the interview guide, the testimonies given were sometimes too broad and went beyond the study's objectives. The option of having the interviewees known to the interviewer may have either limited or increased the amount of information that the interviewee shared. The limited sample, the impossibility to conduct field observations, and the limited experience of the interviewers are the other limitations.

These data relate the living conditions in rural Laos and the poverty that leads migration to Thailand for work. Interviews show the social and domestic violence, the practices of selling sexual services and the use of illicit products. It reveals the links between migrations and various social forms of vulnerability among migrants. It also shed light on the cycle of migration with multiple departures and returns to the home country. These multiple processes can expose migrants to more risks of HIV contamination.

First, the data shows how low economic family status, low-paid jobs and lack of employment in the country-of-origin cause migration. Poverty forces individuals to seek higher wages and a better quality of life, through internal or external migration. This issue has also been documented recently in a study examining the main reasons for women to migrate to Thailand (Kanchana Thilakoun, 2017). Women with a low level of education and early marriages are more vulnerable to becoming sex workers. Safe economic opportunities for women with low education are rare and low-paid jobs and lack of employment opportunities in Laos cause migration to bordering countries such as Thailand. Supporting alternative work opportunities for women in Laos and align work pays across the region would be an adequate response to unsafe migrations.

Secondly, high-risk behaviours and unsafe sex practices were frequent during migration. We found that most of the interviewees who went to Thailand migrated at a very young age (<18 years old). They were mostly not well prepared to live in a new environment and to limit inherent risks. Discovering new experiences, they were more likely to have high-risk practices such as non-injectable drug use, sharing needles for tattoos, unsafe sex in a commercial sex context, etc. In addition, the migrants' low level of education matched with limited awareness of HIV/STI transmission and prevention. Also, being far away from their families, our informants experimented freedom and various opportunities to engage with sex workers and multiple partners. This observation tends to confirm the work of Chris

Lyttleton who found that there is a significant association between travelling and the HIV risk among men who meet these conditions. The latter are more likely to engage in multiple and unstable relationships and intercourse as the distance from their families gives them the opportunity to do so (Lyttleton, 1999). Recently we also observed a similar pattern among rural young female migrants who supplement their income by working as beer promoters in Vientiane (Sychareun et al. 2021).

Since there are increased sexual risks during migration, the lack of HIV and STI awareness for migrant workers makes it even worse although it could be addressed by an intervention plan.

Finally, we see how illegal migrant worker status limits access to Thai healthcare services. In Thailand, a health insurance scheme exists but it requires specific documents such as a residence permit and/or a labour contract from employers, which only a few can provide (Sychareun et al., 2016; Webber et al., 2012). A study in Champasack province found that legal migrants can access the so-called 30 BATH healthcare insurance system, but this does not cover HIV treatment (Kanchana Thilakoun, 2017). Lao PDR and Thailand developed a referral system in 2016 called NAPHA (National Access to ARV Program for PLWHIV and AIDS) for both documented and undocumented migrant workers to provide them with better access to care and treatment (UNAIDS, 2016). However, the system does not always appear efficient. We observed that many of our informants, who couldn't provide required documentation had to come back to Lao PDR to continue their ARV treatment. Despite agreement between neighbouring countries related to ARV treatment access, migrant workers face difficulties to access the HIV prevention and treatment in their hosting country.

Being illegal migrant can sometimes appear to be more convenient but working conditions as illegal migrant workers in Thailand prevent them from accessing prevention, information and healthcare systems which seem like a possible improvement to the health system. Once contaminated by HIV, stigma and discrimination were observed both during and after migration. People hesitated to get treatment due to stigma and discrimination in the workplace and in their own network. A referral system between the two countries would allow a continuity of treatment during the migration cycle by reducing the stress to start new treatment procedures in each country and help prevent more infections.

Potential conflicts of interest: The authors declare that they have no competing interests.

Author contribution

PHP was the principal investigator of the research study, ZP analysed the data and wrote the article with the support of PHP. PHP, XX and SP conducted training for the interviewers. SP monitored the data collection. All authors read and approved the final manuscript.

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