Thai migrants' access to HIV/AIDS treatment in Japan

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Introduction

The Thai government has implemented the National Access to Anti-retroviral Program for People living with HIV/AIDS (NAPHA) since 2002. Anti-retrovirals (ARVs) have been provided to people with HIV/AIDS free of charge. According to the national monitoring program, from February 2001 to December 2004, 85 per cent of the cases received ARVs treatment at implementing hospitals were continuing to take ARV medicine (Chasombat et al., 2006). When treatment with ARVs was included in the universal health scheme in 2005, over 100,000 people had access to ARVs (Chasombat et al., 2006).

Participation from various groups such as the People living with HIV/AIDS (PHA) group, non-government organizations at both national and international levels, and community-based organizations leads to good progress in the program (Lyttleton et al., 2007). The legal and political advocacy of the Thai Network for PHA has played a central role in expanded ARV provision. PHA groups move from activities focused on reversing local stigma to constitute a new social movement that is increasingly prominent in Thai civil society. A new challenge for the movement is to broaden access to marginalized groups who remain excluded from these services. Many ethnic minority groups without full Thai citizenship and immigrant workers have not yet gained full rights to access health services including ARVs. Thailand has made some progress in protecting people's rights to access basic medicines within its territories (MSF, 2005). However, many Thai migrant workers abroad do not yet have the same access to health care systems as locals.

This article explores health care access of Thai migrants in Japan with particularly focus on HIV/AIDS patients who are mostly illegal migrants. Research was carried out over four months
in 2007 through interviews and field observations with various people and organizations working on HIV/AIDS treatment and health rights including doctors, NGOs, volunteers, Thai embassy personnel in Tokyo, academics, and HIV/AIDS patients, both living in Japan and returned to Thailand. Field data collection and observation in Tokyo, Kanagawa, and Nagano focused on treatment services and assisting systems for patients.

This research aims to provide some lessons for dealing with health and living conditions of immigrants, one of the main issues raised in the process of globalization. Receiving countries, including Japan, can apply some lessons to deal with the problem of access to treatment for other immigrants. The Thai government can also apply the lessons to other countries where Thai workers migrate to improve their quality of life.

Health status of immigrants in Japan

Since the economic boom in 1980, migrant workers have flooded to Japan in pursuit of better pay and a better life. Over 1.5 million foreigners are now estimated to be residents. At the end of 2004, some 2,150,000 people from overseas were reckoned to be living in Japan. Of them, 1,973,000 were registered and 207,000 were undocumented foreign residents (JCA, 2010). Although the Immigration Control and Refugee Recognition Law disallows labor migration, there are some exceptions in technical and educational fields. Because of a high demand for people to do dirty and dangerous work, immigrant workers were admitted without being granted residence status. According to Angsuthanasombat (2005), "They strive for survival and surrender to exploitative and risky situations, especially in terms of their health."

Thailand is among many countries in Southeast Asia that provides unskilled labor to overcome the labor shortage in Japan (Kuwajima, 2006). According to Ruenkaew (2001), in 2000 the number of Thai workers overstaying visas was approximately 100,000 of which about 60 percent were women. But Japan’s immigration office recorded only 8,460 Thai overstayers in 2007. However, Ruenkaew (2001) found that that many Thai workers enter Japan “in unlawful entries and disguised entries with passports of other nationalities.” So, the true figure of Thai overstayers must
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be higher.

In 2003, when there were only 20,000 PHA in Japan, many Japanese were not very aware of problems related to HIV/AIDS. Newly reported HIV infections and AID diagnoses have climbed steadily, and the number of infections was predicted to reach 50,000 by 2010 (*San Francisco Chronicle*, 17 March 2003). More migration across national borders is a key cause of the increase. Among migrants from South and Southeast Asia working in Japan, 80 percent of those HIV-positive are Thai.

**Health care access and treatment**

Most Thai workers in Japan come from the northeast and north. Most of them have low education, low skills, and limited ability in the Japanese language. Many of them entered Japan illegally or overstayed their visa.

Although the Japanese government has established clinical services, mobile medical services, free medical interpretation services for hospitals, and health information services by telephone, Ruenkaew (2001) found that Thai workers were not able to access the facilities. This study found four key reasons why.

**Personal ability and knowledge**

These workers hardly know the Japanese language despite a long stay in Japan. One Thai worker said, “Language seems to be a problem, leading to a lack of knowledge about rights, law and procedures that is necessary for living in Japan.” Most Thai workers need a companion when visiting doctors. When friends are not available, they cannot get treatment. Dependence on friends or relatives for translation is problematic because patients need confidentiality in cases of HIV/AIDS.

As a result of poor language ability, many workers do not know their labor rights. Many Thai workers do not know that they can have access to social security, even if their status is illegal. A 40-year-old woman injured by falling metal at work received only medical expenses for three weeks in the ICU and had no medical check-up in the next five years even though she had the right according to Japanese law. The labor law states that companies must pay treatment fees for injuries occurring at work, compensate
60 percent of lost salary, compensate for resulting disability through labor accident insurance, and pay insurance premiums according to the number of employees.

Self harm

Many workers said that they faced high stress from work so they turned to heavy drinking and smoking and had insufficient rest. According to sources in Thai communities, many young workers died because of liver, lung, and breast cancer. Many workers had psychological problems though they were not aware of this.

Several use drugs. Some workers refuse to attend medical checks for fear that urine checks would expose their substance abuse. Because drugs are hard to come by in Japan, Brontex, a cough syrup with codeine, is most sought after among Thai addicts who call it bon, which is the Thai pronunciation of “ball.” They use the phrase tae bon, “play football,” to mean taking Brontex. The syrup can be bought at any pharmacy, snack shop, or Thai liquor store. Drinkers warm it with a lighter under the bottle to stimulate the opium radicals before drinking.

Low wages and low living standards

Most Thai migrant workers complain about bad working conditions. They claim that wages do not cover their living expenses, forcing them to take on more than one job, or do overtime work during their time off. Hard work means they cannot take care of their health. They dare not visit doctors for fear of being arrested. They do not seek medical treatment due to the high cost of uninsured medical treatment in Japan. Although they are sick, they avoid seeing doctors in fear that they will be sent home and will have failed to make money for their families. Some workers go to hospital for treatment of chronic diseases such as diabetes but cannot do so regularly because of economic constraints.

High cost of treatment and insurance

Some migrant workers incurred high debts because they needed medical care but had no health insurance because of their illegal status. As an example, one worker owed a hospital 900,000 yen
(350,000 baht) for a stomach operation and had to repay 50,000 yen (20,000 baht) every month. Later, his son became ill from thalassemia and needed treatment which cost 2,300,000 yen (900,000 baht). He had to take a loan from his employer and pay back over two years.

Many Thai workers, especially those working in the sex industry, enter Japan on fake passports. Some use other workers’ health insurance documents to access treatment. This causes confusion in patient records and creates risk in diagnosis and cure. Pregnant women often do not go to a hospital until the time of delivery and then cannot find a hospital which will admit them. In some cases, they have to travel a long distance to gain admittance. For example, one Thai woman traveled from Ibaraki prefecture to give birth at a hospital in Nagano, because this hospital is reputed not to demand money from patients who cannot afford it.

Due to the high costs of medical care, many Thai workers, especially those without visas and health insurance, choose to purchase medicines on their own. They do not have medical checks, or see doctors, often because they are denied services by hospitals. A Thai woman in Ibaraki prefecture, for example, was asked *Hyaku man en kakaru?* (Can you afford one million yen for the treatment?) when she was suffering from severe anemia and recurrent high fever.

Thai shops and video rental stores always have over-the-counter medicines from Thailand on sale along with prescription drugs for inflammation, obesity, diabetes, and high blood pressure, also mainly from Thailand. This leads to incorrect and inappropriate use of medicines, especially those requiring specific dosages. Many Thai workers are addicted to medicines for inflammation, and their easy availability and incorrect use are likely to result in ineffective medication. For example, one man believed that he had gout and took a certain medicine for over a year until he decided to visit a doctor and found that he did not have that illness. Another woman took medicine for obesity for years until she developed an irregularity with her heart beat. The doctor had difficulty identifying her problem because she had taken too many medicines.
Access to HIV/AIDS treatment

Migrant workers (including Thai) and commercial sex workers (CSWs) are vulnerable to HIV/AIDS. According to Itoh (2006), non-Japanese nationals, mostly migrant workers, have accounted for approximately 15 percent of all newly reported HIV/AIDS cases. Workers from Southeast Asia are the most numerous. He found the language barrier and high treatment cost are major factors making migrants vulnerable. The language barrier results in a lack of information on prevention and limited access to proper testing, treatment, and care. In many cases, migrant workers do not seek treatment until they are in the advanced stages of AIDS or need to be admitted to the emergency room. Many migrant workers either do not have valid legal status or possess visas that make them ineligible for public health insurance. They are reluctant to undergo testing or receive treatment because they cannot afford the costly medical bills. Some hospitals refuse such patients.

Trimayuni (2001) also found that migrant workers have little knowledge about HIV/AIDS, other than that it is a fatal disease; have no knowledge about safe sex or condom use; lack knowledge about medical care; face language problems; incur unaffordable medical expenses in the receiving country; and often self-medicate with herbal medicines.

In particular, female migrant workers are very vulnerable to the HIV/AIDS virus because of personal problem (feeling lonely, bored, stressed, and homesick) and external factors (sexual abuse and contaminated blood transfusions).

Interventions of government and Japanese civil society

Migrants’ access to treatment has not improved, and the Japanese government’s policy has not changed significantly. Since 1993, nine prefecture governments, including the Tokyo Metropolitan Government in the Kanto block, have allocated budget to compensate unpaid medical fees for the emergency care of undocumented workers. Partial compensation is paid to a hospital after it is confirmed that a patient proves unable to pay despite repeated requests for one year. Since the introduction of this unpaid fee compensation system, the number of migrant workers...
being refused treatment has dramatically decreased. However, to date only nine out of the forty-six prefectures have adopted this system.

At present, there are only three prefectures, Tokyo, Kanagawa, and Gumma, which allocate sufficient budget for the subsidy system. Five other prefectures of Nagano, Chiba, Ibaraki, Hyogo, and Tochigi allocate insufficient budget and do limited public relations on the scheme so only a few hospitals apply it. The remaining thirty-eight prefectures have no such subsidy at all.

The Japanese Immigration Bureau runs a campaign to arrest illegal labor “to revive the title Japan—the Safest Country in the World.” Yet illegal labor and trainees are in high demand. Employers tell illegal workers to flee when police or immigration officers came to make inspections or arrests. Strong law enforcement is not the solution to the illegal labor problem.

Lack of access to treatment is a major cause of severe HIV infection among migrant workers than among Japanese, and for their poorer health as measured by CD4 counts (a kind of lymphocyte indicating the human immunity level). CD4 counts for uninsured HIV-positive undocumented migrants are around 50 cell/mm$^3$, significantly lower than for the insured (around 290 cell/mm$^3$). This is the main reason why many infected Thai pass away soon after visiting medical facilities.

The Japanese government has been criticized for taking a comprehensive approach to fight all infectious diseases rather than focusing solely on HIV/AIDS. Only 8 percent of total health expenditure was earmarked for HIV/AIDS (JCIE, 2004). According to the 2002 Annual Report of the National AIDS Surveillance Committee (2002), 57 percent of all the newly reported cases are clustered in Tokyo and the nearby areas of Kanagawa, Chiba, and Saitama.

Japanese civil society and Thai expatriates have helped to improve access to treatment through campaigns that encourage workers to have blood tests, that support medical staff in hospitals in overcoming language barriers, and that link the treatment standards of Japan to those of Thailand. They have also established a transfer system so that repatriated patients can continue to receive medical care in the hope of reducing the rates of HIV/AIDS
infection and death among Thai migrant workers.

JCIE (2004) reported that there were approximately 100 NGOs involved in HIV/AIDS issues in Japan with voluntary medical experts and people living with HIV/AIDS. Private financial resources for NGOs involved in HIV/AIDS issues are severely limited. Minatomachi Clinic and Kobayashi Clinic in Kanagawa prefectures are among the few affordable clinical services provided by health personnel. Some volunteer doctors and nurses including volunteer medical and nursing students have run mobile medical services for migrant communities in Tokyo and Kanagawa twice a month. These provide medical check-ups and some also offer legal consultation.

To overcome the language barrier, some NGOs like MIC Kanagawa provide medical interpretation services for hospitals without charge. Some provide health information services by telephone in many languages.

Thai residents in Japan have also joined together to help fellow Thais. TAWAN (the Thai word for sun) is a group of Thai women including nurses, Thai consultant staff of several Japanese agencies, professional interpreters, and housewives running outreach activities to provide information on health care and HIV prevention. TAWAN and NGOs like SHARE (Service for the Health in Asian and African Region), including some hospitals, have tried to contact Thai NGOs to transfer patients’ medical histories to ensure uninterrupted treatment on return to Thailand.

While the national policy on migrant worker’s access to treatment has not yet improved, some academics and NGOs have started a campaign with health personnel and social workers at the prefecture level, running workshops to help them understand how to help migrant workers who cannot afford medical fees, through legal means and existing governmental assistance programs

Case studies

These three case studies portray different treatment histories.

Case 1: Mr. X, 42

Entering Japan in the 1990s as an undocumented worker, X was sent to Saku Central Hospital in November 2005, ill and
unable to walk. He was found to be HIV positive with a CD4 below 50. He was hospitalized for two months, and sent to Thailand.

Believing that AIDS is an incurable and fatal disease, his family stopped sending him to hospital. He later died.

Case 2: Ms. Y, 30

Also an overstayed migrant, Y came to Saku Central Hospital with symptoms of anemia, but no other opportunistic diseases. She was HIV positive.

She refused medical interpretation to maintain confidentiality. Doctors tried to assure her that the disease was not fatal, and she would receive free treatment when she returned to Thailand. She was well informed by SHARE about medical treatment in Thailand.

Now she is in good health in her hometown in Thailand.

Case 3: Ms. Z, 28

Z decided to return to Thailand after she had been denied treatment by a hospital that claimed it was not proficient in dealing with HIV/AIDS, but it was a long New Year weekend when the Thai embassy closed.

The symptom of brain abscesses as a result of AIDS worsened, she fell unconscious, and was sent to Saku Central Hospital. The brain abscesses were already too advanced, making it very difficult for doctors to improve her general condition enough to start antiretroviral drug treatment.

She died soon after arriving in Thailand.

Some observations on treatment

Delayed treatment lowers the patients’ chances of survival because of terminally deteriorating conditions as in the cases of Mr. X and Ms. Z, and also increases medical expenses. On the other hand, early detection of HIV is highly likely to save the patient’s life.

Providing information about free medical treatment in Thailand, particularly life-long antiretroviral treatment, is a core factor in giving patients more confidence to go back home as in the
case of Ms. Y. Family understanding is also very important. In the case or Mr. X, the family stopped him getting treatment, while Ms. Y received very good support from her family.

While doctors in Kanagawa do not have to worry whether to accept patients because there is a government subsidy program, doctors at Saku Central Hospital in Nagano have to be concerned with the increased expenses and have to find a solution, instead of just concentrating on treatment. In these three cases, doctors were repeatedly asked by the hospital administration how to deal with the possibility of unpaid medical fees.

Saku Hospital's treatment for migrant workers with no visas and health insurance is a very special case, because this hospital was founded with money from farmer organizations, and because the founding doctors have a strong will to save lives.

However, it is a question how long this can continue, because of unpaid expenses such as the 3,420,250 yen in the case of Mr. X and one million yen in the case of Ms. Y. (This was in fact paid off by her Japanese boyfriend through her relatives). Can other hospitals bear this burden? The answer is no, as can be seen from the refusal to accept migrant workers and the insistence on guarantors prior to treatment, as Ms. Z was told by the first hospital. So without government support, hospitals and doctors who wish to help patients and solve health problems will exhaust their resources.

The model of Dr. Takayama Yoshihiro of Saku Central Hospital and that of SHARE in solving the problem of access to treatment among migrant workers are similar, but, like the Human Right Watch Report seven years ago, they have not made any difference. Everything remains the same, with kind-hearted doctors and NGOs offering help in isolated spots as best they can. Problems remain. Basic human rights are being violated in an economic superpower like Japan, and will cause problems in Japan's public health. The problems will persist as long as the central and local governments do nothing.

Despite doctors' best efforts in helping patients, there are still cultural and language barriers. Professional medical care interpretation would be of great help. Doctors at Saku Hospital have found that some of the volunteer interpreters in Nagano are
not reliable in maintaining confidentiality, do not strictly adhere to their job, sometimes doing more than they should, and lack adequate medical knowledge, unlike professionally trained volunteer interpreters in Kanagawa. However, to train professional medical interpreters requires expertise, and is not possible without government support at the national and local levels. MIC Kanagawa, an NGO working in this field, is facing difficulties because the Kanagawa government has reduced its financial support. If the situation is allowed to go on, the interpretation support system will probably fail.

The campaign for blood testing does not encourage workers who are at risk to take the test, because treatment is not guaranteed. The three case studies gave exactly the same reason why they delayed the test. So in order to achieve effective prevention measures, the government should consider a program providing basic treatment and referring patients when they need to take antiretroviral medicine.

In order to advance prevention among foreign communities in Japan and encourage early diagnosis at hospitals for those identified as HIV-positive, it is important that access to treatment is ensured to non-Japanese HIV-positive residents before they are able to return to their home country and that such information is made known widely to the foreign communities at large.

**Policy recommendations**

Some people who could not ignore what was happening to vulnerable migrant workers and foreign residents started to provide them with counseling services. In the late 1980s many NGOs or civic groups were formed all over Japan. They cooperated with each other to extend helping hands to foreign nationals who are deprived of their rights as human beings. In addition, labor unions became involved in the early 1990s. Shelters were also established to protect women who were trafficked, forced into prostitution, or victims of domestic violence.

The Solidarity Network with Migrants Japan was founded to advocate the human rights of migrant people, network these groups, and promote mutual cooperation among them (JCA, 2010).
The Japanese government is supposedly a major donor to the Global Fund yet has been criticized for contributing only US$ 560 million over 2008–2011, a small amount compared to the estimated global need for US$ 15 to 18 billion over 2008–2010 to meet internationally agreed-upon targets, including the goal of achieving universal access to HIV/AIDS services by 2010.

The Japanese government should set up an emergency fund for local governments to support hospital treatment for migrant workers who cannot pay. Patients should receive initial treatment for opportunistic infections until they are ready to return to their own country to receive antiretroviral medicines for free. This will help reduce the fatality rate considerably. The government should also provide information for hospitals and health workers on how to take care of migrants. At present, patients can be repatriated for further treatment, as has been done by SHARE, Saku Hospital, and a few other hospitals. In addition, central and local governments must recognize the need to establish medical interpretation services in every prefecture.

The work of Thai volunteers in providing assistance and information on health issues is of utmost importance. These activities should be enhanced with the support of the Thai government through the Thai embassy which should give high priority to the healthcare of Thai expatriates, no less than trade, tourism, and culture. Embassy staff should have sufficient knowledge of this issue to provide correct medical information upon request.

Thailand's Ministries of Labor and of Foreign Affairs should cooperate with the Ministry of Public Health in providing information about healthcare, prevention, and the rights of workers and trainees before they leave the country. Embassy volunteers should also be trained on health issues. In addition, financial assistance for Thais abroad should be grants, not loans, because no one wants to deplete their savings unnecessarily. Everyone wants to return home a victor.

The media reports in Thailand and Japan should present the reality that Thai workers in Japan have to face, in order to lower the pressure they receive from their families back home and to make newcomers aware of the true circumstances. They should provide
useful information on health issues.

Finally, collaboration among Thai and Japanese governments, as well as many key stakeholders including health workers, NGOs, and the Thai communities in each country are necessary for better living conditions in both countries in the long term.

Epilogue

At the end of July 2008, the Thai Network of People Living with HIV/AIDS, in cooperation with the AIDS Access Foundation, the Foundation for AIDS Rights, and the Thai NGO Coalition on AIDS, sent a letter to the prime minister of Japan and the governors of Nagano and Ibaraki Prefectures, urging them to improve urgently the immediate treatment of migrants. The letter cited two cases of Thai migrants who had suffered comas due to brain abscesses. They fell victim to neglect; subsequently one became disabled, and the other lost her life (Ms. Z). On the same day, with good coordination, the Japanese Network of People Living with HIV/AIDS (JaNP+), in cooperation with Japanese NGOs and doctors, held a press conference in Tokyo in support of the submission of the letter.

Responding to this advocacy, on 29 September 2008, the Division of Disease Control, Health Service Bureau of the Japanese Ministry of Health, Labor and Welfare sent a letter to all core AIDS centers in Japan asking them to accept migrants.

The Division of Disease Control, Health Service Bureau stated that... cases have recently been reported in which some HIV/AIDS Specialized Hospitals have been criticized for neglecting to provide AIDS medical care to non-Japanese patients. We have been asking each prefecture to instruct the management of HIV/AIDS Specialized Hospitals and Prefectural HIV/AIDS Specialized Hospitals about the official policy objectives referenced above. We would like for you to once more instruct both HIV/AIDS Specialized Hospitals and Prefectural HIV/AIDS Specialized Hospitals to provide adequate treatment for non-Japanese patients.
Notes

1 During my Asian Public Intellectuals fellowship, I was involved with these three case studies. The referral of Mr. X back to Thailand was my inspiration to do the research. To ensure that Ms. Y would not suffer the same sad fate as Mr. X, I had to secretly follow up her confidential health condition. I followed the condition of Ms. Z since she was hospitalized in Saku hospital until her last day.

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