BUILDING A COMPREHENSIVE NATIONAL PROGRAM TO REDUCE STIGMA AND DISCRIMINATION:

BEST PRACTICES FROM THAILAND

OCTOBER 2016

Department of Disease Control,
Ministry of Public Health

BUILDING A COMPREHENSIVE NATIONAL PROGRAM TO REDUCE STIGMA AND DISCRIMINATION IN HEALTH CARE SETTINGS:

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KEY POINTS

- Thailand is a global leader in formulating the national program to measure situation and reduce HIV related stigma and discrimination (S&D).
- Since 2012, Thailand has prioritized S&D reduction as one of the primary goals in its National AIDS Strategy. In addition, Thailand has reinforced its commitment to reduce S&D under the National Operational Plan for Ending AIDS 2015–2019 and the current national strategy to ending AIDS 2017-2030.
- Thailand has developed a national framework to measure status and progress in reducing HIV related S&D.
- Thailand has developed the comprehensive SD reduction strategies particularly the interventions for SD reduction in health care settings.

How did Thailand start national efforts for reducing HIV related S&D?

- The first step was to develop measurable S&D targets using standardized indicators and establish effective strategies as part of the Thailand's National HIV Strategic Plan;
- The second step was to develop high quality tools to measure S&D situation and to monitor progress over time in target populations or settings;
- The third step was to use data to develop S&D reduction interventions that are cost effective, practical to implement and of high quality.

How has Thailand measured status and progress?

Thailand has developed a national framework to measure HIV related S&D to monitor in several populations. To reduce costs in monitoring progress, S&D related questions were added to the existing national surveys of the general population and the integrated HIV biological and behavioral surveillance surveys (IBBS) of key populations, including people who inject drugs (PWID), men who have sex with men (MSM), transgender women (TGW), female sex workers (FSW), male sex workers (MSW) and migrant workers.

Independent surveys have been conducted in health facilities among health care providers and people living with HIV (PLHIV). The stigma index will be conducted as the part of national monitoring system. This survey is the research methodology that put PLHIV at the center of throughout its process as well as empowering all those involved and strengthening their networks for study design, data collection, analysis and use data advocating on the key barriers and issues perpetuating stigma -a key obstacle to access key health services. Below is the framework for measuring HIV related S&D situation among the different population groups.

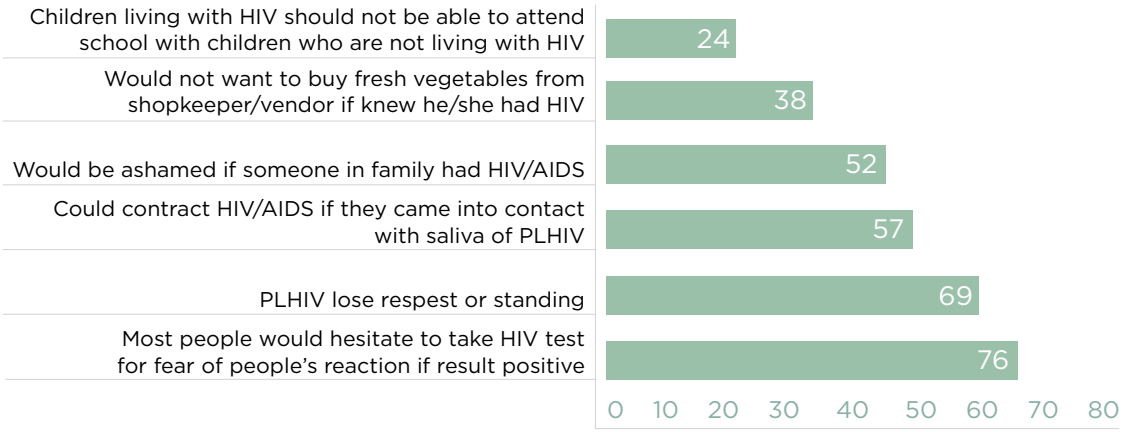
Table 1. Thailand's national frame work to measure HIV related stigma and discrimination.

POPULATION TO SURVEY	FREQUENCY	WHAT TO MEASURE?	HOW TO MEASURE?
GENERAL POPULATION	Every 3-5 years	Attitudes towards PLHIV	Through existing household surveys eg. National Health Examination Survey, Multiple Indicators Cluster Survey (MICS)
KEY POPULATIONS	Every 2 years	Stigma manifestation and experienced stigma	Through existing HIV integrated biological and behavioral surveillance surveys
HEALTH CARE PROVIDERS	Every 2 years	Concerns about contracting HIV, attitude and judgments about PLHIV, HIV+ mothers and KP, stigma avoidance behaviors, observed and experienced S&D toward PLHIV and key populations	Survey in health care settings of sentinel provinces with randomly selected samples
PLHIV	Every 2 years Ad hoc	Stigma manifestation and experienced stigma Stigma manifestation and experienced stigma and discrimination across sectors	The PLHIV Survey in health care settings The stigma index survey
REPORTING SYSTEM ON HIV RELATED HUMAN RIGHTS VIOLATION	Ongoing	Events or complaints related to violence, abuse, and human rights violations towards KP and PLHIV	Mobile and web -based tool for event-based monitoring system

What are the attitudes and opinions towards PLHIV among the general population?

UNAIDS recommends countries to report on the following Global AIDS Monitoring (GAM) indicator: percentage of the general population having discriminatory attitudes towards PLHIV. In Thailand, 59% of women and men, 20–59 years old, reported discriminatory attitudes towards PLHIV based on agreement on either question of "You think that children living with HIV or AIDS should not attend the same classroom with other children" or "You feel too disgusted to buy fresh food or ready-to-eat food from a shopkeeper or vendor whom you know has HIV or AIDS" from the fifth national health examination survey conducted in 2013-2014. Females had higher discriminatory attitudes compared to males (60% vs 56%) and urban dwellers had slightly higher discriminatory attitudes compared to rural dwellers (59% vs 57%). High percentages of the general population were found to demonstrate different types of stigma manifestation (Figure 1).

Figure 1. Stigmatizing and discriminatory attitudes and opinions about HIV and PLHIV by the general population in Thailand



What are the S&D experiences of key populations?

FSW, MSM, MSW and TGW were asked about S&D during the 2016 HIV integrated biological behavioral surveillance surveys. UNAIDS recommends countries to report on the GAM indicator: Avoidance of health care among key populations because of S&D. Only 1.8% of FSW reported avoiding health care because of S&D. Except for internalized stigma, most FSW reported low levels (< 7%) of having experienced S&D in the previous year (Table 2).

Table 2. National estimates for stigma and discrimination for female sex workers, Thailand, 2016

INDICATOR	% ESTIMATE
EXPERIENCED S&D FROM FAMILY IN PAST 12 MONTHS	1.7
DECIDED NOT TO GO FOR HEALTH SERVICES BECAUSE OF S&D IN THE PAST 12 MONTHS	1.8
EXPERIENCED S&D IN HEALTH CARE SETTING IN THE PAST 12 MONTHS	6.2
REPORTED INTERNALIZED STIGMA	52.2
EXPERIENCED SEXUAL VIOLENCE IN THE PAST 12 MONTHS	5.6

Less than five percent of men who have sex with men (MSM), male sex workers (MSW) and transgender women (TGW) reported avoiding health care because of S&D. Similar to FSW, MSM, MSW and TG reported higher percentages of internalized stigma compared to experiencing S&D.

Table 3. National estimates for stigma and discrimination for men who have sex with men, male sex workers and Transgender women, Thailand, 2018

INDICATOR	MSM	MSW	TGW
	% ESTIMATE		
EXPERIENCED S&D IN FAMILY IN THE PAST 12 MONTHS	1.4	0.36	0.31
EXPERIENCED S&D AT WORKPLACE OR EDUCATION INSTITUTES IN THE PAST 12 MONTHS	5.0	N/A	12.1
DECIDED NOT TO GO FOR HEALTH SERVICES BECAUSE OF S&D IN THE PAST 12 MONTHS	3.3	4.7	4.4
EXPERIENCED STIGMA AND DISCRIMINATION IN HEALTH CARE SETTING IN THE PAST 12 MONTHS	5.6	7.7	6.2
REPORTED INTERNALIZED STIGMA	14.2	17.1	9.0
EXPERIENCED SEXUAL VIOLENCE IN THE PAST 12 MONTHS	7.4	7.1	9.0

What are the levels of S&D among health care providers?

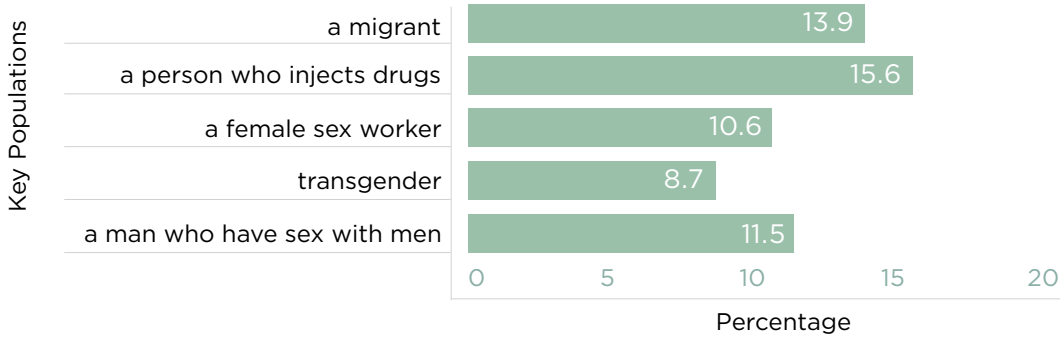
Although just over one quarter of health care providers reported observed S&D towards PLHIV, much higher percentages of health care providers reported worry of fear of infection while caring for a client living with HIV and personal use of unnecessary infection control precautions with clients living with HIV. Eighty three percent of health care providers reported ever having stigmatizing attitudes towards PLHIV.

Table 4. National estimates for stigma and discrimination in 2017: Core Composite Indicators

INDICATOR (PAST 12 MONTHS)	% ESTIMATE
OBSERVED STIGMA (DISCRIMINATORY PRACTICES) TOWARDS PLHIV	27.0
REPORTED PERSONAL WORRY OR FEAR OF INFECTION WHILE CARING FOR A CLIENT LIVING WITH HIV	50.7
REPORTED PERSONAL USE OF UNNECESSARY INFECTION CONTROL PRECAUTIONS TO AVOID BEING INFECTED WITH HIV FROM A CLIENT LIVING WITH HIV	60.8
EVER HAD STIGMATIZING ATTITUDE TOWARDS PLHIV	83.5

Relatively low percentages of health care providers reported observing other providers unwilling to care for a patient who was or was thought to be a member of a key population in the past 12 months (Figure 2). PWID had the highest percentage (16%) of health care providers who were observed being unwilling to care for them and TG had the lowest percentage (9%) of health care providers who were observed being unwilling to care for them.

Figure 2. Observed health care providers unwilling to care for a patient who is or thought to be a member of a key population in the previous 12 months, 2017



What are the experiences of S&D among PLHIV

Five percent of PLHIV reported avoiding or delaying health care because of fear of S&D in the previous year. (Table 5). Among females living with HIV, 2.2% reported being advised or coerced to terminate their pregnancy.

Table 5. National estimates for stigma and discrimination among people living with HIV in 2017: Core composite Indicators

INDICATOR (IN THE PAST 12 MONTHS)	% ESTIMATE
EXPERIENCED STIGMA OR DISCRIMINATION IN A HEALTH CARE SETTING IN THE PAST 12 MONTHS	11.1
EXPERIENCED HIV DISCLOSURE AND NON-CONFIDENTIALITY IN A HEALTH CARE FACILITY IN PAST 12 MONTHS	10.3
WAS ADVISED/COERCED TO TERMINATION OF PREGNANCY AND STERLIZATION AMONG EVER PREGNANT WOMEN LIVING WITH HIV	2.2
AVOIDED AND DELAYED HEALTH CARE BECAUSE OF FEAR OF STIGMA AND DISCRIMINATION	5.2
DECIDED NOT TO GO TO HEALTH FACILITY BECAUSE OF INTERNALIZED STIGMA	34.9

Reporting S&D and human rights complaints

The website and smartphone application for real-time reporting of gender inequality and human rights violations by individuals, with capacity for linking individuals to a response team and database has been developed in Thailand. This innovation tool generates information to inform planning for protecting human rights related to S&D. The system aims to bring the reporting closer to affected populations and to response teams. In particular, community-led crisis response teams that can immediately provide assistance to those experiencing S&D.

Lessons learned

Including S&D reduction as one of the primary goals in Thailand's National HIV and AIDS Strategy is a critical first step calling for political commitment and leadership to accelerate the implementation of national S&D reduction efforts.

Using a comprehensive national framework to measure progress in reducing HIV related S&D serves as an important roadmap for countries to handle subjective and complex subjects related to S&D and provides actionable evidence for actions.

Thailand has developed an effective national framework to measure progress in reducing HIV related S&D.

Building S&D questions into existing surveys is most efficient in terms of cost and effort.

Tools should be practical and easy to use, especially for those who are not researchers, to be conducted by health care workers themselves at hospitals and at the provincial level.

Use questions that have been developed and piloted by experts in the field of stigma and discrimination, including PLHIV.

Ensure that surveys are repeated over time so that progress and challenges can be measured.

Use findings to direct educational programs to reduce S&D in specific population groups or locations.

Conclusion

A comprehensive and sustainable framework to measure S&D is evidence to generate commitment and interventions to reduce S&D in Thailand. Measuring S&D in the general population, key populations, health care providers and PLHIV provides a meaningful picture of what to target interventions in health care settings. The core indicators described in this briefing have been developed based on global tools and experiences with inputs from PLHIV, key population members and local context from the field and are useful for measuring progress and challenges in S&D reduction in any country. Innovations in on-line reporting of complaint and violations to human rights is currently underway in Thailand and can also be used in other countries as a prototype for effective response of human rights protection.

Acknowledgement

This effort was possible with the strong leadership from the Thailand Department of Disease Control, Ministry of Public Health, and partnership from Foundation for AIDS Rights, Thailand NGO Coalition on AIDS, Thai Network of People Living with HIV, the Research Institute for Health Sciences (RIHES) of Chiang Mai University, International Health Policy and Program of the Ministry of Public Health, technical support from RTI International, the United States Agency for International Department (USAID), UNAIDS and UN Joint Team on AIDS Thailand. Preparation of this document supported by UNAIDS.

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