Stigma related to HIV and AIDS as a barrier to accessing health care in Thailand: a review of recent literature

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ABSTRACT

Background: Thailand has been recognized as a regional leader in its response to the human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) epidemic. However, low rates of voluntary testing, late entry into healthcare and delayed treatment continue to be major challenges. Stigma associated with HIV has been cited as a significant barrier preventing a successful and co-ordinated response. HIV-related stigma is known to exist among Thai communities. However, less is known about the attitudes of healthcare workers towards people living with HIV, and how this impacts health-seeking behaviours. This paper considers recent literature from Thailand (2007-2012), which discusses how HIV-related stigma affects health-seeking behaviour, as well as experiences of HIV-related stigma in healthcare settings.

Materials and Methods: Information was collected from electronic databases and websites using the search terms 'HIV stigma healthcare'. Literature published in English, from 2007 onwards, discussing the relationship between HIV-related stigma and health-seeking behaviour, or HIV-related stigma in healthcare settings in Thailand was included in this review.

Results: There is scarcity of information assessing the forms of stigmatizing attitudes known to exist within the Thai healthcare sector. Literature highlights that key affected populations feel most stigmatized against. Interactions and negative experiences in government healthcare settings have contributed to a reduced engagement around seeking healthcare.

Discussion and Conclusions: More research is needed on HIV-related stigma in healthcare settings in Thailand. Evidence suggests that interventions at the policy, environmental and individual levels are required to address stigma and protect the health and rights of people living with HIV/AIDS.

Key words: AIDS, discrimination, HIV, health-seeking behaviour, healthcare settings, stigma, Thailand

BACKGROUND

HIV-related stigma

It is widely accepted that the social and health inequities resulting from human immunodeficiency virus (HIV)-related stigma, continue to be a significant barrier in an effective global response to the HIV/acquired immunodeficiency syndrome (HIV/AIDS) epidemic. The Joint United Nations Programme on HIV/AIDS (UNAIDS) defines HIV-related stigma as: ‘...a “process of devaluation of people either living with, or associated with HIV and AIDS”. Discrimination follows stigma, and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.'
The socio-cognitive approach to understanding stigma, recognizes the interaction of an individual's perceptions, within the broader social processes enabling and reinforcing continuums of acceptability for stigmatizing behaviours.[9‑19] A brief outline of key socio-cognitive approaches to understanding stigma is shown in Figure 1. Although this is not exhaustive, it does provide a snapshot of conceptualizations of stigma as described in other works.[9‑19]

At the macro-social level, factors influencing stigma such as cultural and religious values, social class and community understanding of the HIV virus is presented in the outer circle of Figure 1. At the inter-personal and intra-personal level, the inner circle presents manifestations of stigma, conceptually grouped as ‘enacted stigma’, ‘perceived stigma’, ‘internalized stigma’ and ‘vicarious stigma’. [9‑19]

Literature describes ‘enacted stigma’ as experienced acts of discrimination, ‘perceived stigma’ as expectations that stigma is in the community or will occur during social interactions and ‘internalized stigma’ as the stigmatizing attitudes and beliefs of an individual.[9‑19] Steward et al., build on these categories, by defining ‘vicarious stigma’ as heard stories or witnessed events that provide evidence of how HIV has been treated.[10]

These conceptualizations of stigma are mutually inclusive, with complex interrelationships, and relevance to those with stigmatizing behaviours and also those who feel stigmatized against.[9‑19]

HIV-related stigma, health-seeking behaviour and healthcare settings

Research has found that ramifications of HIV-related stigma on health-seeking behaviour may result in individuals fearing to get tested, and for people living with HIV/AIDS (PLWHA), responses include delaying or adhering to treatment and potentially not adopting preventative behaviours.[8,20,21] Worldwide, there are a number of studies indicating the existence of HIV-related stigma in healthcare settings.[22‑32] Stigmatizing behaviours belonging to healthcare staff often stem from judgements associating HIV infection with immoral behaviours, fears related to contagion or an insufficient awareness of what stigma looks like and what the consequences of stigma are.[33,34]

To develop a better understanding of how HIV-related stigma manifests in Thai healthcare settings, and the affect of stigma on health-seeking behaviour, this review looked at recent studies from Thailand to identify common themes and priority areas for future research.

Epidemiological overview of HIV/AIDS in Thailand

UNAIDS estimates that there are around 490 000 [450 000-550 000] people living with HIV in Thailand.[35] More than 1 in 100 adults are infected with HIV, and AIDS is a leading cause of death and disability in the country.[36]
Modelling exercises predict that 43,040 new HIV infections will occur during 2012-2016, with around 9473 new infections in 2012 alone.[37] On average, that is approximately one infection every hour. In 2011, there were an estimated 27,650 AIDS-related deaths in Thailand, with similar projections at 26,829 for 2012.[38] Around one in three new HIV infections during 2012 will occur in intimate partnerships, while 6% of new infections will be among casual sex partners.[37,38]

HIV in Thailand is concentrated among sex workers (SWs) and their clients, people who inject drugs (PWID), men who have sex with men (MSM) and migrants.[37,38] During 2012-2016, 62% of new HIV infections are expected to occur among these key affected populations (KAPs), with 11% among SW and their clients; 10% among PWID and 41% among MSM.[37,38]

**Testing and anti-retroviral treatment in Thailand**

Voluntary HIV counselling and testing (VCT) rates are low. There is a limited availability across the country of quality sexually transmitted infection (STI) clinics and VCT services,[38,39] with most testing services still centralized within hospitals. Data of VCT rates among the general population from ‘The National Household Survey’ in 2006, found that 19% of people aged 15-49 knew their results from a HIV test in the past 12 months.[38] In 2010, around 51% of SW; 40.8% of PWID and 29.2% of MSM were tested for HIV in the past 12 months and knew the results.[37]

National treatment guidelines recommend the initiation of anti-retroviral therapy (ART) at CD4 levels of ≤350 cells/mm³.[38] However, late entry into care is the norm, with 60% of PLWHA initiating ART with CD4 levels of less than 100 cells/mm³, presenting challenges for immune system recovery and leading to poorer health outcomes.[38,40] In 2010, there was an estimated 430,000 PLWHA requiring treatment.[41] Data from 2011 shows that 225,272 people were reported to be receiving ART, representing 65% of the estimated total number of PLWHA in the country.[38] Provider initiated testing at antenatal clinics saw higher ART coverage among females at 82%, compared with males at 54%.[38] Furthermore, almost one-third of PLWHA in Thailand face the dual burden of HIV and tuberculosis (TB), as seen during 2011 when around 27.7% of PLWHA received treatment for TB.[38]

**Policy approaches towards HIV-related stigma**

The protection of the rights of PLWHA was a strategic objective of The National AIDS Plan for 2007-2011.[42] This plan supported the Thai Government’s provision to protect the rights, including anti-discriminatory measures, of the population under the Thai Constitution of 2007.[42]

Currently, the National AIDS Management Centre (NAMc) is responsible for ‘increasing awareness of adverse effects of stigma, discrimination and human rights violations on HIV prevention and care among communities and service providers’. [37] Acts of discrimination and rights violations regarding PLWHA are dealt with by the NAMc and the Department for the Protection of Rights and Liberties, in conjunction with civil society.[37,42] Future plans of the NAMc, as outlined in the ‘Thailand National AIDS Strategy 2012-2016’, are to conduct a ‘training and sensitization programme’, followed by a survey on HIV-related stigma and discrimination for all HIV programmes and health services.[37] This strategy commits Thailand’s future response to improving the quality of life of PLWHA by identifying barriers to accessing healthcare caused by stigma, discrimination and human rights violations.[37,38]

**MATERIALS AND METHODS**

This review looked at original research published in English on HIV and AIDS stigma and discrimination with reference to Thailand. During May 2012, electronic databases namely, Medline, PubMed, the Social Sciences Citation Index, Social Sciences Index and Abstracts and the International Bibliography of the Social Sciences were searched. Initial searches were non-country specific, using the search terms ‘HIV stigma healthcare’, before narrowing down to literature based on Thailand, using the search terms ‘HIV stigma healthcare Thailand’. Only original qualitative research or descriptive analyses were included.

Experts working within Thailand on HIV/AIDS were consulted for recommendations on publicly available studies on HIV-related stigma. Websites belonging to several bilateral agencies and organizations such as World Health Organization (WHO), UNAIDS, Raks Thai Foundation, the Global Network of People Living with HIV (GNP+) and APN+ and the Global Fund to fight AIDS, TB and malaria (Global Fund) were also searched.

The criteria for inclusion in the review were articles containing information regarding HIV-related stigma affecting health-seeking behaviour, or HIV-related stigma in healthcare settings; published in 2007 or afterwards. This timeframe for inclusion was to take into account the national policy changes made in 2007, in relation to the Thai Constitution (2007), to include rights protection and anti-discrimination measures.

As this is a review, no ethical approval was sought. However, all personal communication was kept confidential.

**RESULTS**

Initially, 34 articles on HIV and AIDS stigma and discrimination with relevance to Thailand were identified. Studies prior to 2007, or those not containing a reference to HIV-related stigma affecting health-seeking behaviour or
stigma in healthcare settings were discarded. This resulted in a total of 15 articles to be reviewed [Figure 2]. In seven of the studies, HIV-related stigma was not a primary focus, however, was reported in healthcare settings or found to affect health-seeking behaviours. Two studies were publicly available from agencies working within Thailand, and 13 were published on the aforementioned electronic databases. Literature included in the review was based on case studies, surveys and descriptive analyses produced or translated to English.

Only one core study, examined the attitudes of Thai healthcare professionals. This study, by Chan et al., was a qualitative investigation using a sample of 20 nurses with results published in three different journals.[43-45] Other recent studies or reviews with a focus on examining attitudes of Thai healthcare staff could not be found, indicating a paucity of available information in this area.

The majority of studies were from the perspectives of PLWHA, with others based on, or including perspectives from the community or the perspectives of healthcare workers. All of these viewpoints touched on interpersonal and intrapersonal forms of HIV-related stigma – internalized; perceived; enacted and vicarious stigma. Stigmatizing attitudes towards PLWHA were commonly based on perceptions of immoral behaviours, or a lack of knowledge regarding disease transmission and progression. Across all of the studies, structural barriers in Thailand were discussed as having an effect on health-seeking behaviour. So, using these conceptualizations, an illustrating example from each study has been linked to these theories. In the same way, negative attitudes towards KAP and a lack of knowledge or fear of transmission were common themes within the studies regarding HIV-related stigma in healthcare settings. Thus, an illustrating example from each study has been given as it corresponds to each theme. The intrinsic complexity and crossover of these ideas is also shown in Tables 1-4, with some examples applicable to several stigma concepts. The tables have been divided by the populations that were studied: PLWHA; sub-populations of PLWHA; Thai communities and healthcare workers. Organizing the tables in this way provides an overview of how HIV-related stigma manifests at the individual, community and healthcare levels. As previously mentioned, structural or policy issues have also been added to recognize the confluence of wider systemic factors.
Fear of stigma, experiences of stigma in healthcare settings and acts of discrimination were recurring issues affecting the health-seeking behaviours of PLWHA, especially for those who also use drugs. For mobile populations, structural barriers relating to health insurance restrictions further compounded the effect of stigma on health-seeking behaviours. Ethnicity or nationality, co-infection with TB, sexual orientation, drug use and mental health issues were additional ‘layers’ of stigma on top of being HIV positive.\footnote{\textsuperscript{15,60}}

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<thead>
<tr>
<th>Study participants</th>
<th>Health-seeking behaviour</th>
<th>Healthcare settings</th>
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<td></td>
<td>Internalized stigma</td>
<td>Perceived stigma</td>
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<tr>
<td>Thanawuth et al.\textsuperscript{[44]}</td>
<td>402 PLWHA</td>
<td>After diagnosis, 79% of asymptomatic patients were disconnected from the healthcare sector due to reasons including manifestations of stigma and insufficient knowledge of HIV-disease progression</td>
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<tr>
<td>Le Coeur et al.\textsuperscript{[47]}</td>
<td>513 PLWHA</td>
<td>HIV testing was perceived as an individual ‘weakness’, with fears also associated with confidentiality breaches</td>
</tr>
<tr>
<td>Li et al.\textsuperscript{[48]}</td>
<td>408 PLWHA</td>
<td>Depression was correlated with manifestations of stigma among PLWHA, creating social isolation and decreasing chances of social support</td>
</tr>
<tr>
<td>Rithpho et al.\textsuperscript{[49]}</td>
<td>22 PLWHA</td>
<td>PWID feared negative treatment from healthcare staff, and concerns regarding patient confidentiality resulted in 18% of participants purchasing ART privately</td>
</tr>
<tr>
<td>TNP+\textsuperscript{[50]}</td>
<td>233 PLWHA</td>
<td>Around 27% of participants avoided going to healthcare centres, even when needed</td>
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PLWHA - People living with HIV/AIDS; KAP - Key affected population; ART - Anti-retroviral therapy

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<tr>
<td>Burapat et al.\textsuperscript{[51]}</td>
<td>756 PLWHA co-infected with tuberculosis (TB)</td>
<td>Co-infection with TB increased fear of stigma</td>
</tr>
<tr>
<td>Jittimanee et al.\textsuperscript{[52]}</td>
<td>769 PLWHA co-infected with TB</td>
<td>Low HIV knowledge and fear of stigma resulted in patients’ self-medicating or seeking care in the private sector</td>
</tr>
<tr>
<td>Liamputtong et al.\textsuperscript{[53]}</td>
<td>26 HIV+ Thai women</td>
<td>Women felt more stigmatized than men</td>
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<tr>
<td>Rongkavilit et al.\textsuperscript{[54]}</td>
<td>70 Thai youth (16-25 years) living with HIV</td>
<td>High prevalence of mental health issues</td>
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PLWHA - People living with HIV/AIDS; KAP - Key affected population

Key crosscutting findings

**Stigma exists in Thai healthcare settings**

The study of 20 students, graduates and professional Thai Nurses found stigmatizing beliefs affected perceptions and hypothetical treatment scenarios for PLWHA.\textsuperscript{[59]} Chan et al. reported that participants considered PLWHA with co-characteristics of drug use and/or links to sex work, as less deserving of their sympathy and (professional/private)
support.[59] These co-characteristics or co-stigmas indicated a form of social or moral ordering. This ordering was expressed when discussing the utilization of commercial sex services, which was seen as ‘wrong’ but a ‘private matter within the realm of normal male behaviour’ and ‘generally better than drug use’. [59] Attitudes towards HIV infection were associated with ‘immoral’ behaviours’, with PWID seen as the lowest ‘immoral’ group. The physical scarring of opportunistic diseases such as Kaposi’s Sarcoma, was also viewed as being more ‘offensive’ and a reason for fear and avoidance of patients with AIDS.[57,59] A key finding in the study of Thai nurses, was that most participants did not view themselves as having stigmatizing beliefs, despite expressing negative towards PLWHA. This finding suggests that some participants in the study had an insufficient awareness of what stigma looks like. While these findings are limited to a small sample of healthcare workers, they provide some correlation to findings from studies based on the experiences of PLWHA. For instance, The Index of Stigma and Discrimination by TNP+,[59] reported cases of discrimination where PLWHA were refused health, dental or family planning services.[59]

### Fear of stigma and criminalization affects the health behaviours of PWID

Fear of disclosure, mistrust in healthcare staff and concerns regarding patient confidentiality were frequently cited concerns of PWID. [46,49,51] These issues resulted in cases of HIV-positive PWID fearing to seek healthcare or delaying treatment.[49] The influence of perceived stigma on preventative behaviours was raised in the TNP + stigma index, which reported around 10% of HIV-positive PWID not disclosing their serostatus to friends sharing the same needle.[49] A fear of disclosure to public health facilities, based on fear of criminalization or discrimination, also affected the ability of PWID to seek healthcare in several studies.[46,49,51] Chan et al. suggest that the recent ‘zero tolerance’ and ‘war on drugs’ message run by the Thai

### Illustrating examples

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<thead>
<tr>
<th>Study participants</th>
<th>Health-seeking behaviour</th>
<th>Structural issues</th>
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<tbody>
<tr>
<td><strong>Saether et al.</strong>[56]</td>
<td>Migrants feared workplace discrimination or arrest by police</td>
<td>ART prescribing guidelines do not consider the realities faced by mobile populations</td>
</tr>
<tr>
<td><strong>Ford et al.</strong>[56]</td>
<td>Seafarers felt vulnerable to HIV infection</td>
<td>Concentration of brothels in dock areas perpetuate the culture of ‘risk taking’</td>
</tr>
<tr>
<td><strong>Maman et al.</strong>[57]</td>
<td>Condoms are a sign of mistrust in relationships</td>
<td>Little evidence on the evaluation of HIV-related stigma interventions</td>
</tr>
<tr>
<td><strong>Ti et al.</strong>[58]</td>
<td>Seafarers have been pressured by police to go for HIV testing</td>
<td>Enrolment in voluntary drug treatment programmes increased the likelihood of HIV testing</td>
</tr>
<tr>
<td><strong>UNESCO</strong>[49]</td>
<td>Interviews revealed stigmatizing attitudes towards PLWHA</td>
<td>Insufficient scope of sexual health services for men and TG</td>
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**Table 3: Studies based on or including the perspectives of the community**

<table>
<thead>
<tr>
<th>Study participants</th>
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<th>Structural issues</th>
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<tbody>
<tr>
<td><strong>Chan et al.</strong>[59]</td>
<td>Nurses believed they did not hold stigmatizing attitudes</td>
<td>Whether HIV stigma and discrimination is covered adequately within nursing curriculum</td>
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**Table 4: Studies based on the perspectives of the health care workers**

<table>
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<th>Study participants</th>
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<th>Health care settings</th>
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<tr>
<td><strong>Chan et al.</strong>[59]</td>
<td>‘Zero tolerance’ discourse run by the Thai Government may have affected nurses’ attitudes towards PWID</td>
<td>Whether HIV stigma and discrimination is covered adequately within nursing curriculum</td>
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</table>
Government was a contributing factor to stigma associated with PWID.\cite{59}

**Stigma and discrimination are significant barriers preventing migrant’s accessing healthcare in Thailand**

Unregistered migrants often had to pay out-of-pocket expenses for the cost of medication and health services, and in some provinces, ART was only provided to migrants who could pay for it, with some being denied access to treatment.\cite{55} Cases were reported where collaboration between healthcare facilities and police, resulted in forced HIV testing or arrest when healthcare was sought.\cite{55,56} Instances like these have contributed to the reluctance by some migrants to visit health services. Other issues complicating decisions to seek healthcare included a fear of arrest for not having proper documentation, loss of work to attend appointments, transportation issues and the inability to pay fees.\cite{55} Experiences with lower standards in healthcare compared with Thai nationals, and language barriers with healthcare staff, led to incidences of migrants self-medicating or having problems adhering to ART regimens.\cite{55}

**Co-infection with TB increases the effect of stigma on health-seeking behaviours**

The layering of stigma, or co-stigmas, was also discussed in studies of PLWHA co-infected with TB. Manifestations of stigma experienced by PLWHA influenced whether care for TB infections were sought at a public or private providers.\cite{51} Stigma related to TB was also associated with PLWHA self-medicating or taking antibiotics before they sought treatment for disease progression.\cite{52} This indicates that experiences with stigma have the potential to change the way PLWHA seek healthcare for infections like TB. Experiences with, or fear of stigma could result in those individuals not on treatment, and with CD4 counts of \( \leq 350 \text{ cells/mm}^3 \), delaying the opportunity to begin ART. The issue of PLWHA preferring to seek healthcare at a private facility, due to distrust or dissatisfaction with the government healthcare system was discussed in several studies.\cite{33,34,49}

**Stigma, discrimination and poor quality health services are affecting MSM and TG populations**

Clinics, hospitals and drop in centres were lacking in scope and quality of services for MSM and TG communities.\cite{39} Healthcare staff tended to be inadequately trained to support and respond to the gender and sexuality issues specific to MSM and TG patients, resulting in a decreased motivation to seek STI and HIV prevention services.\cite{39} Stigmatizing behaviours from healthcare staff, and practices such as ‘gossiping’ about previous clients in front of other patients, were reported as negative experiences, in turn creating perceptions of mistrust and unwillingness among MSM and TG to return to health providers.\cite{39}

**Stigma and mental health affects the health-seeking behaviours of PLWHA**

The interaction between perceived and internalized forms of stigma, with the issue of mental health, was raised across several studies.\cite{48,50,54} Mental health issues, such as depression in PLWHA, had a flow on effect, resulting in issues such as changes in social support, social isolation, health-seeking behaviour and ART adherence.\cite{48,50,54} Li et al. call attention to the view that mental illness in Thailand is an issue, which is already stigmatized, resulting in PLWHA having to cope with a ‘double stigma’.\cite{48}

**DISCUSSION**

Across the spectrum of interventions to manage HIV in Thailand, there are indications that HIV-related stigma is affecting the health-seeking behaviours of PLWHA. With HIV prevalence highest among MSM in Thailand, actions to scale-up coverage of STI and HIV prevention services for this group, are being thwarted by stigmatizing experiences at healthcare centres.\cite{39} Even among populations where Thailand has made significant progress, experiences with stigma in healthcare settings threatens to affect these results. This has been seen with interventions to prevent mother-to-child transmission of HIV. Vertical transmission rates of HIV from mother-to-child in Thailand have been reduced to approximately 3.5%.\cite{37} Yet, there have been recent cases of HIV-positive mothers not returning to antenatal clinics for care in subsequent pregnancies, or occasionaly adopting mixed feeding practices, despite access to free formula milk.\cite{38} Across the country, recent figures suggest an 81% retention rate of HIV-positive patients known to be on ART 12 months after initiation; however, many are starting treatment too late.\cite{37,38} With a government supported healthcare scheme that is ART inclusive, the underlying question is – why are PLWHA, who know their serostatus, disconnecting from the healthcare system? There is no silver bullet answer to this question, as a number of possible factors underwrite this problem. Nevertheless, as studies have demonstrated in this review, HIV-related stigma and early impressions of health services has affected the health-seeking behaviours of PLWHA. A strategic approach to ameliorate the causes of HIV-related stigma in healthcare settings, would direct attention across three priority areas, with interventions focusing on policy reform, the healthcare environment and the individual.\cite{33}

Current policies that enable stigma and discrimination towards drug users and SWs in Thailand should undergo reform for current and future HIV interventions to be successful. A notable policy in this context has been the Thai Government’s recent ‘Harm Reduction Policy’, which has been part of the national ‘war on drugs’ discourse. Provisions in this policy included service categories for risk minimization, HIV, STI, TB diagnosis and treatment,
mental health support and drug rehabilitation.\[^{38}\] During 2012, the United Nations called for a closure of compulsory drug detention and rehabilitation centres enabled by this policy, based on issues such as human rights abuses, denial of healthcare and a vulnerability to HIV and TB infection.\[^{61,62}\] There is evidence to indicate that policies based on law-enforcement, and criminalization of drug use, prevent PWID from seeking care and getting tested, often due to fear of, or negative experiences within healthcare settings. The existence of such policies targeting drug users and also SWs, normalize the stigmatizing attitudes belonging to healthcare staff and the public generally. They also perpetuate a cycle of negatively stereotyping PLWHA, encumbering an effective response to the HIV/AIDS epidemic.

The Universal Coverage Scheme (UC) is another example of a policy shaping the way PLWHA are received by healthcare staff. While this antiretroviral (ARV) inclusive healthcare system has changed the country’s treatment landscape, current regulations for utilizing services covered by the scheme require patients to access health services at the local health facility where they registered.\[^{38}\] For mobile populations such as SWs and migrants, obtaining a referral can be difficult, especially under the Compulsory Migrant Health Insurance (CMHI) or the Social Security System (SSS).\[^{63}\] These regulatory barriers make it problematic for mobile populations to access treatment and care at their current location, if it is not where they initially registered. This inadvertently creates stigmatizing conditions, where PLWHA are refused treatment when they seek care for the management of their HIV infection.

Additionally, at the programme level, ART prescribing guidelines that are dependent on healthcare accessibility, and provider decisions regarding adherence, are affecting HIV-positive mobile populations.\[^{55}\] There is an absence of information regarding whether ART prescribing guidelines, and provider decision-making in Thailand is also impacting other KAPs. A recent study from North America found a significant proportion of providers were reluctant, or would not prescribe ART for PWID, based on opinions of drug use rather than CD4 counts.\[^{21}\] This often implicit, overriding process of provider-based decisions in the provision of ART could be an ethical consideration in Thailand. Particularly regarding mobile populations, where current policy decisions regarding rationing of ART are questionable,\[^{38,63}\] and reminiscent of the early days of rapid ART scale up witnessed with the WHO ‘3 by 5’ Initiative (2003).\[^{164}\] The interplay between economic rationale and internalized forms of stigma belonging to healthcare providers in Thailand, requires further investigation to establish whether or not provider-based decisions have had an impact on ART provision for SWs, MSM, PWID and migrants.

At the healthcare level in Thailand, current provisions for health service delivery also present a number of challenges.\[^{65}\] Issues include, prolonged gaps in CD4 testing from an initial HIV test, and healthcare providers who are not adequately trained to identify the clinical symptoms of HIV.\[^{46}\] Adding to these systemic issues are experiences with stigma and discrimination in the public system, resulting in multiple cases of PLWHA seeking healthcare in the private sector.\[^{49,52}\] Jittimanee et al. note that cases diagnosed by private health providers are often not reported,\[^{52}\] highlighting the need to improve linkages between the government and private healthcare sector. Fears relating to patient confidentiality are other reasons PLWHA, especially PWID, seek care in the private sector, and although the privacy of patient records is protected under Thailand’s National Health Act (2007), informing the community on patient privacy rights could go a long way in reducing some of the mistrust in the public health system.\[^{51}\] Addressing some of these systemic issues and policy implications, would create a more enabling environment at the healthcare level for focussed HIV-related stigma interventions.

Involving PLWHA in the planning, implementing and evaluating of programmes targeting HIV-related stigma in healthcare settings, is one way to improve service delivery.\[^{66,67}\] In their review of HIV-related stigma in healthcare settings, Nyblade et al. point out that it is important for healthcare workers to disassociate PLWHA from behaviours that are considered improper or immoral.\[^{33}\] They suggest that the involvement of PLWHA in training programmes provides a ‘human face’ and the opportunity to develop a better understanding of HIV as a disease that people live with.\[^{33}\] Involving PLWHA in care and stigma programmes has been attempted in Thailand, through previous initiatives such as the ‘Comprehensive and Continuous Care (CCC) Centres’, initially run under the supervision of Médecins Sans Frontières in 2001.\[^{68}\] Under this model, training was provided to PLWHA to work within the government hospital system to be co-providers of care.\[^{68}\] Yet despite the merits this model set out to achieve, over dependence on volunteerism and the stress of logistic demands in service provision, were expressed as key issues by participating PLWHA in the CCC centres.\[^{69}\] Future initiatives seeking to involve PLWHA need to consider the mutual benefit to those individuals, beyond the guise of inclusivity to reduce service delivery costs.

Providing a healthcare environment, which is accommodating and supportive of PLWHA, can provide a necessary form of respite from the wider community challenges of stigma and discrimination.\[^{33}\] A supportive health care setting can also assist PLWHA with coping strategies to manage their physical and mental health. Ensuring this environment exists, starts within training colleges and universities for health practitioners. Curricula
should cover an in-depth understanding of what stigma is, and what the consequences of stigma are. Studies from India[20] and China[32] have examined attitudes of healthcare workers across the sector, ranging from doctors through to laboratory technicians and cleaners. These studies have emphasized the importance of understanding social norms and personal attitudes to better understand the rationale behind stigmatizing behaviours. The concentration of the epidemic among KAP in Thailand, and indications from studies that PWID and mobile populations are among the most stigmatized, should inform the design of future interventions. Health-based training or workplace programmes need to provide health workers with fundamental information about stigma, discrimination and rights of PLWHA, along with basic information about how HIV is transmitted, appropriate precautions and the occupational risk of HIV infection as compared with other common highly transmissible diseases.[33]

Interventions targeting HIV-related stigma within healthcare settings should also be reinforced by approaches at the community level. Communication messages to the public should be clear and unambiguous,[4] targeting basic health literacy on HIV, dismissing HIV myths and emphasizing that HIV can be treated. An undercurrent in the literature in this review was the low level of HIV knowledge, regarding modes of transmission and disease progression, both among PLWHA and within the community.[38,46,52,55,57,59] Fear of contracting HIV is a common reason driving the stigmatizing and discriminating behaviours of individuals, which can be abrogated through understanding the modes of transmission. Early prevention campaigns on HIV and AIDS in Thailand, along with localized community structures such as AIDS committees, have diminished as funding has focused towards increasing ARV provision.[69] Complacency in improving community knowledge on HIV through education campaigns, not only stifles progress in reducing stigma, but could also result in younger generations lacking awareness on prevention strategies and the importance of HIV testing.

While this review has attempted to capture the key issues relating to HIV-related stigma in Thai healthcare settings, there have been several limitations. The most noteworthy was the availability of information regarding evaluations of stigma prevention approaches, and assessments of stigma in Thai health facilities. Secondly, several Thai studies within this review were limited in scope in terms of sampling and number of participants, particularly the study on Thai nurses and graduates. In addition, studies with a focus on measuring levels of HIV-related stigma employed varying methods of qualitative analysis and differing ‘stigma scales’. A ‘gold standard’ in stigma measurement, which is culturally and contextually appropriate, is needed if programmes are serious about evaluating their effectiveness in approaches to HIV-related stigma reduction. Efforts by international agencies such as USAID, to measure stigma in health facilities through their ‘Health Facility and Provider Stigma Measurement Tool’,[70] is an example of a possible reference for future stigma assessment work in Thailand. Experiences from the TNP + report, should also inform future work, as well as prevent inconsistencies. A lack of timelines for experiences and participants’ understanding of survey questions was an issue in the TNP + index. For example, 24 of 233 participants wanted a cure for HIV, with the majority being concerned about issues associated with drug regimens and body image.[50] Obscurity in questions or terminology producing such responses underlines the importance of participant understanding during research. Nevertheless, this review has highlighted that HIV-related stigma, especially within healthcare settings, has affected the health-seeking behaviours of PLWHA in Thailand.

If the programme targets in the ‘Thailand National AIDS Strategy 2012-2016’ are to be achieved, addressing the stigma directed at PLWHA should be a priority. Thailand has made substantial progress in the past, demonstrated by the in-country production of anti-retroviral generic medicines, and steps towards providing these through state healthcare, despite regional and country challenges. A strategic and committed approach is now needed, to address the pervasive and repudiating issue of HIV-related stigma, especially when perpetrated by healthcare staff.

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