STIGMA AND DISCRIMINATION AMONG HEALTH CARE PROVIDERS, PEOPLE LIVING WITH HIV IN HEALTH CARE SETTINGS IN THAILAND: FINDINGS FROM 2014-2015 AND 2017

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Department of Disease Control, Ministry of Public Health
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KEY POINT

- Stigmatizing and discriminatory attitudes and practices towards people living with HIV (PLHIV) and key populations, such as men who have sex with men (MSM), female sex workers (FSW), people who inject drugs (PWID), Transgender Women (TGW) and migrants, in health care settings impede reaching the 90–90–90 treatment targets.
- Thailand is committed to the “AIDS Zero” goal (i.e., zero new HIV infections, zero AIDS-related deaths, and zero stigma and discrimination against people living with or affected by HIV [PLHIV]).
- Thailand National AIDS strategy sets an ambitious goal of reducing discrimination by 50% in health care facilities; from 23% measured in 2014 to 10% by 2021.
- These surveys provide the foundation for tailoring health facility stigma and discrimination-reduction activities and can easily be adopted for other countries to use.
What are stigma and discrimination?

HIV-related stigma refers to the negative beliefs, feelings and attitudes towards PLHIV and other key populations at higher risk of HIV infection, such as PWID, FSW, MSM and TGW. HIV-related discrimination refers to the unfair and unjust treatment of someone based on his or her real or perceived HIV status.

Discrimination may be directed towards more vulnerable groups such as PWID, FSW, MSM, and TGW. HIV-related discrimination is often based on stigmatizing attitudes and beliefs about populations, behaviours, practices, sex, illness and death. Discrimination can be institutionalized through existing laws, policies and practices that negatively focus on these populations.¹

Why should we avoid stigma and discrimination in health care settings?

Stigma and discrimination are globally recognized as key barriers to an effective HIV response. Stigma and discrimination towards PLHIV, as well as populations at higher risk of HIV exposure, in health care settings can impact whether people feel comfortable accessing services for HIV related testing, care and treatment.

Why is it important to measure stigma and discrimination in health care settings?

Surveys conducted biannually over several rounds can provide useful information about successes and challenges in reducing stigma and discrimination. When specific indicators of stigma and discrimination do not improve over time, additional training and efforts can focus on the specific areas that need improvement.

What topics were covered in the surveys?

Health care providers competed a questionnaire that consisted of six parts and 14 questions and PLHIV completed a questionnaire that consisted of five parts and 17 questions. These core indicators asked health care providers whether they:

A. Were unwilling to care or were providing poorer quality of care to PLHIV OR thought to be living with HIV in past 12 months;

B. Were worried when touching the clothing, bedding or belongings of OR dressed the wounds of OR drew blood from a patient living with HIV/AIDS in the past 12 months;

C. Wore double gloves OR used any special infection control/prevention measure that do not use with other patients in the past 12 months;

D. Agreed that: most PLHIV do not care that they could infect other people OR PLHIV should be ashamed about their HIV status OR people become infected with HIV because they engage in irresponsible/immoral behavior OR women living with HIV should not be allowed to have babies if they wish;

E. Were unwilling to care or were providing poorer quality of care to a migrant, MSM, PWID, FSW or TG OR thought to be a migrant, MSM, PWID, FSW or Transgender person in past 12 months.

For PLHIV, the core indicators were the following:

A. The following happened to PLHIV in a health care facility because of his/her HIV status: Health care providers refused or denied services or treatment OR health care providers told him/her to return, put him/her in the last queue or made him/her wait longer than other patients OR health care providers were rude, or scolded or blamed him/her OR health care providers asked him/her to place their hospital robe in an area/basket specifically designated for HIV patients;

B. Health care providers disclosed his/her HIV status to other people without consent OR his/her medical record was marked as being HIV positive in a way that let people around know his/her status;

C. PLHIV decided not to go to a health facility because of: feeling ashamed of HIV status OR feeling guilty about having HIV.
Where were these surveys conducted?

The surveys were conducted in 18 provinces in 2014-2015 and 20 provinces in 2017 (Figure 1).

Who were included in the surveys?

Health care providers were randomly selected from lists of the following groups:

- **Staff providing direct services to PLHIV** (e.g., antiretroviral treatment, voluntary counseling and testing, Tuberculosis services, etc.)

- **Clinical staff providing indirect services to PLHIV** (e.g., in-patient ward, surgery, dentistry, obstetrics/gynecology, intensive care, pharmacy, etc.)

- **Non-clinical staff providing general health services** (i.e., cashiers, receptionists, cleaning staff, and ward attendants). Excluded staff were those without direct patient contact, such as those from administrative, accounting and book keeping, and engineering/maintenance sectors. On the day of data collection, health care providers were asked by supervisors to complete self-administered questionnaires. PLHIV were 18 years and older and currently receiving HIV related services at a health care facility.
Findings

High percentages of health care providers ever had stigmatizing attitudes towards PLHIV (approximately 84%). However roughly one quarter observed discriminatory practices towards PLHIV in the past 12 months (Table 1). Between 50 and 60% of health care providers experience fear of exposure to HIV and using unnecessary control precautions with clients living with HIV.

Observed stigma towards, reported personal use of unnecessary infection control with and ever having stigmatizing attitudes towards PLHIV increased slightly and personal fear of infection while caring for PLHIV decreased between 2014-2015 and 2017.

Table 1. National estimates for stigma and discrimination among health care providers in 2014-2015 and 2017: Core Composite Indicators

<table>
<thead>
<tr>
<th>INDICATOR (past 12 months)</th>
<th>2014-2015 % (90% CI) (range), SD</th>
<th>2017 % (90% CI) (Range), SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observed stigma (discriminatory practices) towards PLHIV in the past 12 months</td>
<td>23.7 (9.7, 34.9), 3.9</td>
<td>27.0 (19.3, 37.2), 3.2</td>
</tr>
<tr>
<td>Reported personal worry or fear of infection while caring for a client living with HIV in the past 12 months</td>
<td>60.9 (31.9, 90.7), 11.4</td>
<td>50.7 (44.9, 59.7), 4.3</td>
</tr>
<tr>
<td>Reported personal use of unnecessary infection control precautions to avoid being infected with HIV from a client living with HIV in the past 12 months</td>
<td>53.1 (43.2, 65.7), 3.9</td>
<td>60.8 (37.8, 78.0), 5.8</td>
</tr>
<tr>
<td>Ever had stigmatizing attitude towards PLHIV</td>
<td>84.5 (71.3, 92.8), 3.8</td>
<td>83.5 (73.7, 94.1), 6.2</td>
</tr>
</tbody>
</table>

Data from 2017 only, indicate that the highest percentage of health care providers observed other health care providers being unwilling to care for PWID, followed by migrants, MSM, FSW and TG (Figure 2).

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

<table>
<thead>
<tr>
<th>Key populations</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>a migrant</td>
<td>13.6</td>
</tr>
<tr>
<td>a person who injects drugs</td>
<td>15.6</td>
</tr>
<tr>
<td>a female sex worker</td>
<td>10.6</td>
</tr>
<tr>
<td>a transgender women</td>
<td>8.7</td>
</tr>
<tr>
<td>a man who has sex with men</td>
<td>11.5</td>
</tr>
<tr>
<td><strong>Percentage</strong></td>
<td><strong>0.0</strong></td>
</tr>
</tbody>
</table>
PLHIV showed decreases in avoiding or delaying health care because of fear of stigma or discrimination (absolute percentage decrease of 60%); experiencing stigma or discrimination or HIV disclosure (8%) and non-confidentiality in a health care facility (58%); or being advised or coerced to terminate a pregnancy (56%) (Table 2). There was an absolute percentage increase of 44% for experiencing internalized stigma. Under 1% of PLHIV in 2017 reported ever avoiding or delaying health care because of fear of stigma or discrimination among ever pregnant females PLHIV.

Table 1. National estimates for stigma and discrimination among health care providers in 2014-2015 and 2017: Core Composite Indicators

<table>
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<th>INDICATOR</th>
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<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoided or delayed health care because of fear of stigma or discrimination in past 12 months</td>
<td>13.0 (5.2, 26.1), 7.9</td>
<td>5.2 (1.2, 14.9), 2.6</td>
</tr>
<tr>
<td>Experienced stigma or discrimination in a health care setting in the past 12 months</td>
<td>12.1 (4.4, 23.8), 8.1</td>
<td>11.1 (1.9, 20.6), 3.8</td>
</tr>
<tr>
<td>Experienced HIV disclosure and non-confidentiality in a health care facility in the past 12 months</td>
<td>24.5 (3.9, 39.4), 11.8</td>
<td>10.3 (1.7, 18.9), 4.1</td>
</tr>
<tr>
<td>Was advised/coerced to terminate pregnancy in the past 12 months among ever pregnant women living with HIV</td>
<td>5.0 (0.1, 9.1), 3.9</td>
<td>2.2 (0.0, 7.6), 1.4</td>
</tr>
<tr>
<td>Decided not to go health facility because of internalized stigma in the past 12 months</td>
<td>24.2 (10.8, 42.1), 7.2</td>
<td>34.9 (4.9, 54.4), 7.4</td>
</tr>
<tr>
<td>Ever avoided or delayed health care because of fear of stigma or discrimination among ever pregnant women living with HIV</td>
<td>Not Available</td>
<td>0.4 (0.0, 3.0), 0.1</td>
</tr>
</tbody>
</table>
Lessons learned

- Routine monitoring of stigma and discrimination among health care providers and PLHIV is feasible and an essential tool for providing actionable evidence for decision making at the national, provincial and local health care facility levels.

- Changes between rounds 2014-2015 and 2017 show some successes in the effort to decrease stigma and discrimination in Thailand. In particular, there were reductions:

  - Health care providers expressing fear of infection while caring for a client living with HIV in the past 12 months;
  - PLHIV avoiding or delaying health care because of fear of stigma or discrimination in past 12 months; and
  - PLHIV experiencing HIV disclosure and non-confidentiality in a health care facility in past 12 months.

- Given that there are only two data points it is impossible to determine trends. Additional rounds are planned every two years to measure trends in stigma and discrimination over time.

- Collecting data on stigma and discrimination can build evidence for the need to address stigma and discrimination and to design health care facility stigma and training programs. In Thailand, these data are being used to develop stigma and discrimination-reduction interventions for all levels of health care providers. Efforts focus on identifying the key drivers of stigma and discrimination, including unwarranted fear of workplace HIV infection and unnecessary use of infection control and attitudes towards and awareness of stigma and discrimination in health care facilities.

- This research is an example of best practices for understanding important sources of stigma discrimination. Findings are essential for build evidence to eliminate discrimination in health-care settings and for strengthening mechanisms and frameworks for monitoring, evaluating and ensuring accountability for discrimination-free health care as recommended by UNAIDS.

- To achieve national targets, political commitment and national leadership to fast-track implementation of an HIV-related stigma and discrimination interventions package is essential. This package should be rolled out at health care facilities in all provinces throughout Thailand.
Final points

Thailand continues to lead the way forward in addressing stigma and discrimination in health care facilities and serves as a model for other countries. Routine monitoring of stigma and discrimination among health care providers and PLHIV is feasible and an essential tool for providing actionable evidence for decision making at the national, provincial and local health care facility levels. Collecting routine monitoring data in health care facilities is essential for developing effective responses and programs within health care facilities in an effort to decrease stigma and discrimination by health care workers.

Thailand is currently utilizing these data to shape stigma and discrimination reduction interventions in health care facilities for all levels of staff. These interventions will include education for health care staff to reduce unwarranted fear of workplace HIV infection, unnecessary use of infection controls and to eliminate stigma and discrimination attitudes and practices towards PLHIV and key populations. Overall, these are important findings for building and sharing evidence and best practices to eliminate discrimination in health-care settings and for strengthening mechanisms and frameworks for monitoring, evaluating and ensuring accountability for discrimination-free health care as recommended by UNAIDS.2

Acknowledgement

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