HEALTHCARE ACROSS THE BORDER: STIGMATIZATION EXPERIENCES AND HEALTHCARE-SEEKING BEHAVIOUR OF MALE EXPATRIATES WITH HIV/AIDS IN THAILAND

BY

MR. DENNIS CONTRADOR CASING

A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS (ASEAN STUDIES) PRIDI BANOMYONG INTERNATIONAL COLLEGE THAMMASAT UNIVERSITY ACADEMIC YEAR 2017 COPYRIGHT OF THAMMASAT UNIVERSITY
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THESIS

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ENTITLED

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was approved as partial fulfillment of the requirements for the degree of Master of Arts (ASEAN Studies) on August 7, 2018

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ABSTRACT

In ASEAN (Association of Southeast Asian Nations), Thailand is considered as the region’s leader with regards to its effective response to the HIV/AIDS epidemic. In order to understand the epidemic, it is essential to investigate one of its significant drivers: HIV-related stigma. Hence, this research study assessed the experiences of stigma as well as the healthcare-seeking behaviour of male expatriates with HIV/AIDS in Thailand.

A PLHIV (People Living with HIV) questionnaire was used as the survey tool in this study. The questionnaire focused on three main domains: sociodemographic characteristics, health-related stigma, and disclosure and confidentiality. Health-related
stigma targeted three specific forms: anticipated stigma, experienced stigma, and internalized stigma. Together with the questionnaire is a semi-structured interview which probed further the answers provided by the respondents as they were guided during data collection. The methodology of this study is descriptive qualitative and explanatory in describing the stigmatization experiences of the respondents and their healthcare-seeking behaviour.

Finding suggest that health-related stigma is still persistent, which made the respondents avoid or delay going to a healthcare facility. Specifically, the response categories that were prominent in anticipated stigma include the feeling of not being sick enough, high cost of healthcare services, and the location of healthcare facilities being near their workplace that induces fear that they might be seen by their colleagues. Internalized stigma was also prominent as majority of the respondents felt guilty and ashamed of their HIV status resulting to their avoidance or delay in going to a healthcare facility.

The result of this study can be used in policy-making and planning especially with regards to public health goals related to HIV/AIDS prevention and management among migrants, and the development of programs and interventions that will help reduce the three forms of health-related stigma. Moreover, there is a need for expatriates in Thailand to be oriented with the details of their health insurance in order for them to determine if HIV-related laboratory tests and procedures are included in their health insurance program. This research study also suggests the recognition of expatriates as an HIV-affected group that is in need of intervention in order that national policies can focus on their development. This study provides an opportunity for knowledge exchange and networking in the ASEAN community with regards to their respective health programs and services for expatriates.

**Keywords:** Health, Migration, HIV, AIDS, Stigma, Psychology, ASEAN
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Mr. Dennis C. Casing
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<tr>
<td>AEC</td>
<td>ASEAN Economic Community</td>
</tr>
<tr>
<td>AHRN</td>
<td>Asian Harm Reduction Network</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>APCASO</td>
<td>Asia Pacific Council of AIDS Service Organizations</td>
</tr>
<tr>
<td>APCOM</td>
<td>Asia Pacific Coalition of Male Sexual Health</td>
</tr>
<tr>
<td>APN+</td>
<td>Asia Pacific Network of People Living with HIV/AIDS</td>
</tr>
<tr>
<td>APNSW</td>
<td>Asia Pacific Network of Sex Workers</td>
</tr>
<tr>
<td>ASAP</td>
<td>AIDS Society of Asia Pacific</td>
</tr>
<tr>
<td>ASCC</td>
<td>ASEAN Socio-Cultural Community</td>
</tr>
<tr>
<td>ASEAN</td>
<td>Association of Southeast Asian Nations</td>
</tr>
<tr>
<td>ATFOA</td>
<td>ASEAN Task Force on AIDS</td>
</tr>
<tr>
<td>AWP</td>
<td>ASEAN Work Program</td>
</tr>
<tr>
<td>CARAM-Asia</td>
<td>Coordination of Action Research on AIDS Mobility</td>
</tr>
<tr>
<td>CBD</td>
<td>Central Business District</td>
</tr>
<tr>
<td>GNP+</td>
<td>Global Network of People Living with HIV</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HIV-NAT</td>
<td>The HIV-Netherlands Australia Thailand Research Collaboration International</td>
</tr>
<tr>
<td>ICW</td>
<td>Community of Women Living with HIV</td>
</tr>
<tr>
<td>IPPF</td>
<td>International Planned Parenthood Federation</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, Gay, Bisexual, and Transgender</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have Sex with Men</td>
</tr>
<tr>
<td>NAMC</td>
<td>National AIDS Management Center</td>
</tr>
<tr>
<td>NHSO</td>
<td>National Health Security Office</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>PWID</td>
<td>People Who Inject Drugs</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infections</td>
</tr>
<tr>
<td>TBCA</td>
<td>Thailand Business Coalition on AIDS</td>
</tr>
<tr>
<td>TNAF</td>
<td>Thai National AIDS Foundation</td>
</tr>
<tr>
<td>TNCA</td>
<td>Thai NGO Coalition on AIDS</td>
</tr>
<tr>
<td>TNP+Thai</td>
<td>Thai Network of People Living with HIV/AIDS</td>
</tr>
<tr>
<td>TP</td>
<td>Transgender People</td>
</tr>
<tr>
<td>TRC-AC</td>
<td>Thai Red Cross Anonymous Clinic</td>
</tr>
<tr>
<td>TRC-ARC</td>
<td>Thai Red Cross AIDS Research Centre</td>
</tr>
<tr>
<td>TREAT-Asia</td>
<td>Therapeutics, Research, Education, AIDS Training in Asia</td>
</tr>
<tr>
<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV and AIDS</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Form</td>
</tr>
<tr>
<td>-----------</td>
<td>---------------------------------------------------------------------------</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific, and Cultural Organization</td>
</tr>
<tr>
<td>UP-PGH SAGIP</td>
<td>University of the Philippines-Philippine General Hospital STI-AIDS</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

1.1 Background of the Study

HIV and AIDS is a health problem that has been greatly discussed and researched because of its immense impact on the world. It does not only have physiological effects on the infected person, but also major psychological effects. Moreover, the rapid spread of the disease has economic and social implications which are causes of concern globally. The response to the HIV/AIDS epidemic should be holistic in such a way that it covers prevention, care, treatment, and support.

UNAIDS (2017) released its 2016 estimate with regards to global HIV statistics as well as regional HIV statistics (Table 1.1). In 2016, there were 36.7 million people living with HIV. Among them, 34.8 million were adults, and 2.1 million were children. 19.5 million people or 53% of all people living with HIV had access to antiretroviral therapy. There were 1.7 million new HIV infection among adults during that same year. Moreover, about 1 million people died from AIDS-related diseases worldwide.

Table 1.1 2016 Global and Regional HIV Statistics

<table>
<thead>
<tr>
<th></th>
<th>People living with HIV</th>
<th>New HIV infections</th>
<th>AIDS-related deaths</th>
<th>People accessing Antiretroviral Therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Worldwide</td>
<td>36.7 million</td>
<td>1.8 million</td>
<td>1.0 million</td>
<td>19.5 million</td>
</tr>
<tr>
<td>Asia and the Pacific</td>
<td>5.1 million</td>
<td>270,000</td>
<td>170,000</td>
<td>2.4 million</td>
</tr>
</tbody>
</table>

*Source: Joint United Nations Programme on HIV and AIDS (2017)*

Asia and the Pacific region recorded the second highest number of people living with HIV in the world with 5.1 million people. Of the given estimate, 1.8 million are from ASEAN-member countries, which accounts to 36% of all people living with HIV in Asia and the Pacific region. An estimate of 270,000 new HIV infections was recorded, 40% of whom are from ASEAN. 170,000 people died of AIDS-related illnesses in the same year. An estimate of 2.4 million people of 47% among people living with HIV in the region receive treatment coverage through antiretroviral therapy.
The key affected populations include men who have sex with men, sex workers, people who inject drugs, and transgender people (Figure 1.1).

**Figure 1.1 Key-affected populations in Asia and the Pacific**

![Image: Distribution of new HIV infections among population groups by region in Asia and Pacific]

*Source: Joint United Nations Programme on HIV and AIDS (2016)*

In the report from Avert (2017), the key affected population of the HIV/AIDS epidemic include men who have sex with men (MSM), people who inject drugs (PWID), and the transgender people (TP). HIV prevalence among MSM is particularly high in cities such as Bangkok in Thailand, Yangon in Myanmar, and Yogyakarta in Indonesia. The HIV prevalence rates in these cities are between 20% and 29%. One-third of the global estimate of PWID live in Asia and the Pacific. The HIV prevalence among this key affected population varies greatly across different countries in the Asia and the Pacific. With regards to the transgender population, the HIV prevalence rate is particularly high in Delhi and Mumbai in India, and Phnom Penh in Cambodia.

Reduction of the overall impact of HIV/AIDS epidemic is one of the priorities of ASEAN, as stated in its ASEAN Socio-Cultural Community (ASCC) Blueprint. The *ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, Zero AIDS-Related Deaths*, which was adopted in the 2011 ASEAN Summit in Bali, Indonesia, declared and renewed the association’s commitment to the following:
a) Reducing sexual transmission of HIV by 50 percent by 2015;
b) Reducing transmission of HIV among people who inject drugs by 50 percent by 2015;
c) Scaling up antiretroviral treatment, care, and support to achieve 80 percent coverage for people living with HIV who are eligible for treatment, based on World Health Organization HIV treatment guidelines;
d) Eliminating new HIV infections among children and substantially reducing HIV-related maternal deaths by 2015; and
e) Reducing by 50 percent tuberculosis deaths among people living with HIV.

In the ASEAN Declaration of Commitment on HIV and AIDS: Fast-Tracking and Sustaining HIV and AIDS Responses to End the AIDS Epidemic by 2030, which was adopted in the 2016 ASEAN Summit in Vientiane, Lao PDR, the association pledged to ensure the achievement within the region the 90-90-90 treatment targets. The program was drawn from the United Nations Political Declaration on HIV and AIDS: On the Fast-Track to Accelerate the Fight against HIV and to End the AIDS Epidemic by 2030. The aim is that, by 2020, 90% of people living with HIV know their status, 90% of people living with HIV who know their status are receiving treatment, and 90% of people on treatment have suppressed viral load. Moreover, another aim of the program is to reduce new HIV infections to fewer than 500,000 by 2020; to reduce AIDS-related deaths to fewer than 500,000 by 2020; and to eliminate HIV-related stigma and discrimination by 2020. The declaration has the following specific goals that are set by 2020:

a) Ensure that 30 million people living with HIV have access to treatment through meeting 90-90-90 targets by 2020;
b) Eliminate new HIV infections among children by 2020 while ensuring that 1.6 million children have access to HIV treatment by 2018;
c) Ensure access to combination prevention options, including pre-exposure prophylaxis, voluntary medical male circumcision, harm
reduction and condoms, to at least 90% of people, especially young women and adolescent girls in high-prevalence countries and key populations – gay men and other men who have sex with men, transgender people, sex workers and their clients, people who inject drugs, and prisoners.
d) Eliminate gender inequalities and end all forms of violence and discrimination against women and girls, people living with HIV, and key populations by 2020;
e) Ensure that 90% of young people have the skills, knowledge, and capacity to protect themselves from HIV and have access to sexual and reproductive health services by 2020, in order to reduce the number of new HIV infections among adolescent girls and young women to below 100,000 per year;
f) Ensure that 75% of people living with, at risk of and affected by HIV, benefit from HIV-sensitive protection by 2020;
g) Ensure that at least 30% of all service delivery is community-led by 2020;
h) Ensure that HIV investments increase to US$ 26 billion by 2020, including a quarter for HIV prevention and 6% for social enablers.
i) Empower people living with, at risk of, and affected by HIV to know their rights and to access justice and legal services to prevent and challenge violations of human rights; and
j) Commit to taking AIDS out of isolation through people-centered systems to improve universal health coverage, including treatment for tuberculosis, cervical cancer, and hepatitis B and C.

ASEAN is characterized by apparent diversity in numerous aspects. There is immense diversity among member countries in terms of geography, economic development, religion, culture, and beliefs that ultimately affect their health systems, health structure, and health provisions. In terms of religion, Brunei, Malaysia, and Indonesia have Islamic views, while Philippines has its Catholic perspective. Moreover,
each member country also has its own laws and policies, which determines how HIV-related issues are dealt with. The question remains as to how the regional strategies are going to be implemented on a national level despite the diversity of the member states.

1.1.1 Overview of the HIV/AIDS Epidemic in ASEAN-member Countries

In the 2016 report of UNAIDS, the organization outlined the profiles of each ASEAN-member states with regards to their respective HIV/AIDS conditions (Table 1.2).

On June 2011 in New York, during the United Nations General Assembly High Level Meeting on AIDS, the member states adopted a new Political Declaration on HIV/AIDS, which mandates UNAIDS to support countries in the submission of their progress reports towards achieving and realizing their new commitments.

Table 1.2 2016 HIV/AIDS Snapshot in ASEAN

<table>
<thead>
<tr>
<th>ASEAN Countries</th>
<th>people living with HIV</th>
<th>new HIV infections</th>
<th>AIDS-related deaths</th>
<th>people on antiretroviral treatment</th>
<th>percentage of antiretroviral coverage</th>
<th>prevalence rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brunei Darussalam</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
<td>no data</td>
</tr>
<tr>
<td>Cambodia</td>
<td>71,000</td>
<td>&lt;1,000</td>
<td>1,800</td>
<td>57,000</td>
<td>80%</td>
<td>0.7% (2013)</td>
</tr>
<tr>
<td>Indonesia</td>
<td>620,000</td>
<td>48,000</td>
<td>38,000</td>
<td>78,000</td>
<td>13%</td>
<td>0.4% (2013)</td>
</tr>
<tr>
<td>Lao PDR</td>
<td>11,000</td>
<td>&lt;1,000</td>
<td>&lt;500</td>
<td>4,600</td>
<td>41%</td>
<td>0.3% (2016)</td>
</tr>
<tr>
<td>Malaysia</td>
<td>97,000</td>
<td>5,700</td>
<td>7,000</td>
<td>36,000</td>
<td>37%</td>
<td>0.4% (2016)</td>
</tr>
<tr>
<td>Myanmar</td>
<td>230,000</td>
<td>11,000</td>
<td>7,800</td>
<td>130,000</td>
<td>55%</td>
<td>0.8% (2016)</td>
</tr>
<tr>
<td>Philippines</td>
<td>56,000</td>
<td>10,000</td>
<td>&lt;1,000</td>
<td>18,000</td>
<td>32%</td>
<td>0.1% (2015)</td>
</tr>
<tr>
<td>Singapore</td>
<td>2,300</td>
<td>no data</td>
<td>no data</td>
<td>2,292</td>
<td>&gt;95</td>
<td>0.15% (2014)</td>
</tr>
<tr>
<td>Thailand</td>
<td>450,000</td>
<td>6,400</td>
<td>16,000</td>
<td>310,000</td>
<td>69%</td>
<td>1.1% (2014)</td>
</tr>
<tr>
<td>Vietnam</td>
<td>250,000</td>
<td>11,000</td>
<td>8,000</td>
<td>120,000</td>
<td>47%</td>
<td>0.40% (2014)</td>
</tr>
</tbody>
</table>

Source: Joint United Nations Programme on HIV and AIDS (2016)
(1) Brunei Darussalam

The Global AIDS Progress Reporting in Brunei Darussalam (2014) indicate that the first local case of HIV in the country was recorded in August 1986. Ninety-three cases in citizens and permanent residents were recorded ever since up until the end of 2013. The highest annual increase of HIV cases was in 2013 with 12 new cases. All the 12 cases were transmitted through sexual means.

(2) Cambodia

The National AIDS Authority (2015) in Cambodia stated that there is an estimated 71,000 people living with HIV in Cambodia. The prevalence rate shows a steady decline from 2.0% in 1998 and 0.9% in 2006 to 0.7% in 2013. The HIV epidemic in the country is concentrated on entertainment workers, men who have sex with men, people who inject drugs, and transgender people.

(3) Indonesia

In the projection and estimation that was made by the Indonesian National AIDS Commission in 2013, the overall HIV prevalence is at 0.4%. The key populations most affected by the HIV in Indonesia are sex workers (estimated population size of 226,791, and HIV prevalence of 5.3%), gay men and other men who have sex with men (estimated population size of 754,310, and HIV prevalence of 25.8%), people who inject drugs (estimated population size of 33,492, and HIV prevalence of 28.76%), transgender people (estimated population size of 38,928, and HIV prevalence of 24.8%), and prisoners with an HIV prevalence rate of 2.6%.

(4) Lao PDR

The National Committee for the Control of AIDS (2016) reported that the country’s national HIV prevalence in the general population is 0.3%. According to the country’s AIDS registry, there is a significant increase in new HIV cases from 679 in 2013, 834 in 2014, to 1,096 in 2015. There is also an increase in AIDS-related deaths from 107 in 2014 to 133 in 2015. The key affected population in the country are female sex workers, men who have sex with men, people who inject drugs, and clients of sex workers.
(5) Malaysia

Ministry of Health Malaysia (2016) recorded the national HIV prevalence in the country at 0.4%. The five states in Malaysia that account for almost two-thirds or 62% of all people living with HIV in the country are Johor, Selangor, Kelantan, Pahang, and Terengganu. Moreover, while people living with HIV are predominantly males (89%), over time, the pattern gradually shifted towards an increased infection rates among females. The male:female ratio declined from 9:6 in 2000 to 5:5 in 2015. The population which are most affected by the epidemic are people who inject drugs, female sex workers, transgender people, and men who have sex with men.

(6) Myanmar

In the 2016 data of UNAIDS, Myanmar has a 230,000 people living with HIV, and the prevalence rate of the country is 0.8%. The National AIDS Programme of the Ministry of Health (2015) stated that the key affected population in the country are sex workers (estimated population size of 66,000 and HIV prevalence of 5.4%), people who inject drugs (estimated population size of 83,000, and HIV prevalence of 26.3%), and gay men and other men who have sex with men (estimated population size of 252,000, and HIV prevalence of 6.4%.

(7) Philippines

In the January 2018 HIV/AIDS and ART Registry of the Epidemiology Bureau, Department of Health (2018), the estimated number of people living with HIV in the country is 51,409. In that month, there were 1,021 newly-infected persons. 976 were males and 45 were females/ The median age was 28 years old. The key affected population are men who have sex with men, commercial sex workers, people who inject drugs, and overseas foreign workers.

(8) Singapore

The National AIDS Programme of the Ministry of Health, Singapore (2014) reported that the prevalence rate of known people living with HIV among the resident population was 0.15% The epidemic in the country is predominantly male, with a ratio of almost ten males to one female. The key affected population include men
who have sex with men, men who buy sex from commercial sex workers, commercial sex workers, and male and female migrant workers.

(9) Vietnam

In the estimate of the Vietnam Authority of HIV/AIDS Control, Ministry of Health (2014), the HIV prevalence in the country is 0.40%. People who inject drugs remains the main key affected population with an estimated population size of 271,506 (HIV prevalence of 11%), according to the country’s Ministry of Public Security. The HIV epidemic in Vietnam is also concentrated on gay men and other men who have sex with men, and female sex workers and their sexual partners. The antiretroviral therapy coverage of people living with HIV reached 47% in the 2016 data.

(10) Thailand

The National AIDS Committee (2014) in Thailand reported that the HIV prevalence rate in the country is 1.1%. The prevalence rate in 2000 is 1.8% and in 2010, the prevalence rate is 1.3% (Figure 1.2). A decline in the number of newly infected persons is observed based on the data from 2000 to 2010. The reduction rate is 65%, from around 35,000 to around 13,000. There are 6,400 new HIV infections in the 2016 data (Figure 1.3). Within the same time frame, the estimated number of AIDS-related deaths sharply decreased by 63%, from 51,000 to 23,000. In the 2016 data, there were 16,000 reported AIDS-related deaths (Figure 1.4). This is an indication of the success of the antiretroviral treatment program of the country, which health authorities expanded and rapidly scaled up. The key affected population are female sex workers, male sex workers, men who have sex with men, and transgender people.
Figure 1.2 Trend in HIV prevalence rate in Thailand

Source: Joint United Nations Programme on HIV and AIDS (2017)

Figure 1.3 Trend in new HIV infections in Thailand

Source: Joint United Nations Programme on HIV and AIDS (2017)
1.1.2 HIV-Related Stigma

HIV-related stigma prohibits effective HIV/STD identification, prevention, and care (Guan, et al., 20016). HIV-related stigma is defined by the Joint United Nations Programme on HIV/AIDS (2003) as a process of devaluation of people either living with, or associated with HIV and AIDS. Stigma is followed by discrimination, and it is defined as the unfair and unjust treatment of an individual based on his or her real or perceived HIV status.

HIV stigma and discrimination is manifested in various forms:

1) Self-stigma or internalized stigma refers to the negative self-judgment, which results in shame, worthlessness, and blame. It has a damaging effect on the mental well-being of people living with HIV. The constant fear of discrimination breaks down the confidence of the person to seek help and medical care. Moreover, it affects the ability of the infected person to live in a positive way, limits his meaningful self-agency, his quality of life, and his adherence to treatment and access to healthcare services (People Living with HIV Stigma Index, 2015).
2) Governmental stigma is a form of HIV-related stigma that exists in countries that have discriminatory laws, rules, and policies regarding HIV. Such stigma that can alienate and exclude people living with HIV. Consecutively, it reinforces the stigma surrounding the diseases (UNAIDS, 2015).

The ten-member countries of ASEAN have varied laws with regards to HIV-related issues, as shown in Table 1.3 (ASEAN Secretariat, 2015). There are no punitive laws with regards to male to male sex in Cambodia, Indonesia, Lao PDR, Philippines, Thailand, and Vietnam. There are laws with regards to that in Brunei, Malaysia, Myanmar, and Singapore. As for sex work, sex workers are imprisoned in Myanmar and Vietnam. There are punitive laws for private sex work in ASEAN-member countries except Cambodia and Singapore. Brothels are prohibited in all ten countries. With regards to people who inject drugs, death penalty is enforced except in Cambodia and the Philippines. In terms of restriction on entry, travel, and stay, there are punitive laws only in Brunei, Malaysia, and Singapore among the countries in ASEAN.

3) Healthcare stigma does not only equate to denial of healthcare services. It can come in many forms, which includes mandatory HIV testing without consent or appropriate counselling. Health providers may minimize contact with, or care of, patients living with HIV, delay or deny treatment, demand additional payment for services, and isolate people living with HIV from other patients (UNAIDS, 2017).

4) Employment stigma refers to the kind of stigma that people living with HIV suffer in the workplace, wherein they experience discriminatory practices such as termination or refusal of employment. In many countries, HIV-related stigma and discrimination is a cause of unemployment or denial of work opportunity (GNP+, 2012).
Table 1.3 *HIV-relevant punitive laws in ASEAN*

<table>
<thead>
<tr>
<th>Country</th>
<th>MSM</th>
<th>Sex workers</th>
<th>PUD</th>
<th>HIV transmission or exposure</th>
<th>Travel restrictions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Detention for SW</td>
<td>Private sex work</td>
<td>Brothels</td>
<td>Detention for PUD</td>
</tr>
<tr>
<td>Brunei</td>
<td></td>
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<td>Cambodia</td>
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<td>Indonesia</td>
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<td>Lao PDR</td>
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<td>Malaysia</td>
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<tr>
<td>Myanmar</td>
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<td>Philippines</td>
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<td>Singapore</td>
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<tr>
<td>Thailand</td>
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<tr>
<td>Viet Nam</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

= country has punitive laws
= country does not have punitive laws
= information not available

*Source: Joint United Nations Programme on HIV and AIDS (2016)*

1.1.3 Migrant Workers in Thailand

In the Thailand Migration Report (2014), there is an estimated 3.5 to 4.5 million foreigners living in Thailand. In this estimate, around 2.7 million come from neighboring countries of Cambodia, Lao PDR, and Myanmar. The first phase of the Prevention of HIV/AIDS among Migrant Workers in Thailand (PHAMIT) project was implemented with the support of Global Fund from 2003 to 2008. Moreover, Thailand has had specific national government plan to address HIV among migrant since 2007. The main target of the Ministry of the Public Health as well as other government ministries, international organizations, and non-governmental organizations is prevention services. There is community-based condom distribution, health education, voluntary counselling and testing, and STI screening primarily in the border and central provinces.
Limited access to HIV-related services among migrants is a problem due to legal, financial, and language constraints. There is presence of fear of job loss, and interactions with the Ministry of Labour, as well as the police and immigration authorities are not supportive in promoting health-seeking behaviour among undocumented migrants.

1.2 Statement of the Problem

The objective of the study is to assess the stigmatization experiences and healthcare-seeking behaviour of male expatriates with HIV/AIDS in Thailand. Specifically, other aims of this study are to acquire the general profile of the respondents, assess their stigmatization experiences, and determine the forms of stigma that they experience.

1.3 Aims and Objectives of the Study

The overall aim of the study is to understand the stigmatization experiences and healthcare-seeking behaviour of male expatriates with HIV/AIDS living in Thailand. Within this broad theme, the study delves to attain the following objectives:

1. To acquire a general profile of male expatriates living with HIV/AIDS who seek HIV-related services in Thailand.
2. To describe the stigmatization experiences of the respondents, and how these affect their healthcare-seeking behaviour.

1.4 Research Questions

In addition to obtaining the general profile of male expatriates with HIV/AIDS who seek HIV-related services in Thailand. This study aims to give light to the following specific questions,

1. What stigmatization experiences are encountered by expatriates with HIV/AIDS in Thailand?
1.5 Significance of the Study

In general, the study will make us understand the stigmatization experiences and the healthcare-seeking behaviour of male expatriates with HIV/AIDS in Thailand.

The result of this study can help in policy-making and planning especially with regards to public health goals related to HIV/AIDS prevention and management among expatriates. Moreover, it can help provide direction for HIV-related programs in other ASEAN-member countries. Through this study, there will be knowledge exchange and networking in the ASEAN community with regards to their respective health programs and services for expatriates.
CHAPTER 2
REVIEW OF LITERATURE

This research study pursues related literature review based on information obtained from books, academic journals, research papers, newspapers, and magazines, either in print or in online editions. This part of the study aims to seek for data from the regional level (ASEAN) to the national level (Thailand) up to the specific variables of the research with regards to the target participants.

2.1 Background of ASEAN’s HIV/AIDS Involvement

The first reported case of HIV in the ASEAN region was in the early 1980s, and it has continued to spread at varying rates. In the 2016 data (UNAIDS, 2017), an estimate of 1.8 million people from the region are living with HIV/AIDS.

2.1.1 ASEAN Work Program I (AWP I)

The spread of HIV in the region was first identified as a threat at the 4th ASEAN Summit in 1992. The ASEAN-member countries agreed to make a coordinated effort to curb the spread of HIV/AIDS. As a result of the agreement, the ASEAN Task Force on AIDS (ATFOA) was established, and a regional program to combat HIV/AIDS was developed. The main goal of ATFOA is to prevent further transmission of HIV and to mitigate the impacts of HIV and AIDS in ASEAN by improving regional responses and enhancing member countries’ development of people-oriented initiatives. Its strategic objectives are to promote regional cooperation and partnership in combating HIV and AIDS, to strengthen capability and capacity in responding to HIV and AIDS, and to strengthen ASEAN partnership with regional and international partner organizations, civil society organizations, and the private sector.

The first meeting of the task force was in 1993, which led to the development of the first ASEAN Regional Program in HIV/AIDS Prevention and Control (1995-2000). This was under the assistance of the ASEAN Secretariat and the World Health Organization. Through the assistance of UNAIDS, a Medium-Term Work Program (AWP I) was later developed. The purpose of this is to implement the ASEAN Regional Program. AWP I identifies priorities for regional cooperation as well...
as a range of programs and activities aimed at strengthening collaboration among ASEAN-member countries in combating HIV/AIDS. These include collaborating with multi-sectoral collaboration on youth interventions, assessing family and community support systems, improving HIV surveillance, and involving Islamic religious leaders. Consequently, the ASEAN AIDS Information and Research Reference Network was also established to share information and experiences.

Several issues arose during the implementation of AWP I. Such issues include mobilising resources more proactively, ensuring that regional activities would focus on matters such as transboundary issues, for which a regional approach would have comparative advantage, greater involvement of nongovernmental organizations and the civil society, and evaluation of results and promoting awareness of the activities of ATFOA to more effectively mobilise support and resources. These issues were later addressed or rectified in the second work program.

2.1.2 ASEAN Work Program II (AWP II)

The Second ASEAN Regional Work Programme on HIV/AIDS, 2002-2005 (AWP II), continued some activities from AWP I. It has also implemented new ones relating to emerging issues such as injecting drug use. The common country priorities identified in AWP II are broadly grouped as:

a) HIV surveillance;

b) Prevention programs;

c) Access to drugs, reagents, and condoms;

d) Treatment, care, support, and counselling;

e) Creation of a positive environment, including laws and regulations; and

f) Gender and capacity building to cross cut themes and strategies.

The main objective of AWP II is to prevent the spread of HIV/AIDS, and thereby reduce the social and economic impact on ASEAN-member countries. Its specific objectives are:

a) Reducing the rate of HIV transmission in ASEAN-member countries;
b) Creating a positive and enabling environment for HIV/AIDS prevention activities, and providing treatment, care, and support for people living with HIV/AIDS’

c) Strengthening national responses to HIV/AIDS prevention, treatment, care, and support programs in ASEAN-member countries through inter-country activities; and

d) Strengthening multi-sectoral collaboration and coordination among governments and regional partners to facilitate national and regional programs. These include international agencies and nongovernmental organizations, regional networks of people living with HIV/AIDS, international donors, and the private sector.

2.1.3 7th ASEAN Summit Declaration on HIV/AIDS

In addition to the ASEAN Work Programs, the fight against HIV and AIDS was further discussed in the 7th ASEAN Summit Declaration on HIV/AIDS, which was adopted in Brunei Darussalam in 2001. The summit identified multi-sector collaboration at the national, regional, and international level as a vital requirement in combating the transmission of HIV/AIDS. There was involvement of various individuals and organizations from the government, NGOs, business sector, the United Nations, and other international agencies. The consultation led to the creation of the Coalition of Asia Pacific Regional Networks on HIV/AIDS, which is comprised of seven regional community networks: Asia Pacific Network of People Living with HIV/AIDS (APN+), AIDS Society of Asia Pacific (ASAP), Asian Harm Reduction Network (AHRN), Asia Pacific Network of Sex Workers (APNSW), Coordination of Action Research on AIDS Mobility (CARAM-Asia), and the Asia Pacific Council of AIDS Service Organizations (APCASO).

2.1.4 ASEAN Declaration of Commitment (19th ASEAN Summit)

The ASEAN region strives to achieve its goal of eradicating new HIV infection, and stopping and reversing the HIV/AIDS epidemic through various programs in the past. This commitment was further strengthened with the establishment of the ASEAN Socio-Cultural Community blueprint, which mentions the region’s aim of reducing HIV transmission, and the impact of HIV epidemic on individuals,
community. And society. In the 2011 ASEAN Summit in Bali, Indonesia, the ASEAN Declaration of Commitment: Getting to Zero New HIV Infections, Zero Discrimination, and Zero AIDS-Related Deaths, was conceived.

Additionally, the ten ASEAN-member countries declared and renewed their commitment to:

a) work towards zero new HIV infections in ASEAN through various means, such as ensuring that adequate financial resources are provided for scaling up evidence-based and targeted prevention programs for key affected populations; ensuring that national prevention strategies target populations at higher risk, such as people who use drugs, sex workers, and men having sex with men; and implementing and expanding risk and harm reduction programs for people who use drugs.

b) work towards zero AIDS-related deaths through accelerating efforts to achieve the goal of universal access to antiretroviral treatment, and expanding efforts to combat HIV co-morbidities such as tuberculosis and hepatitis.

c) work towards zero HIV-related discrimination through the promotion of legal, political, and social environments that enable HIV responses, including the establishment of multi-stakeholder partnerships among the health sector, law enforcement and public security, academia, faith-based leaders, and local government leaders, among others. A review of national laws, policies, and practices to enable full achievement of universal access targets was also included in the plan; and

d) ensure financial sustainability, national ownership and leadership for improved regional and national responses to HIV.

2.1.5 ASEAN Declaration of Commitment (28th ASEAN Summit)

In the 2016 ASEAN Summit in Vientiane, Lao PDR, the region reaffirmed previous ASEAN Declarations on HIV and AIDS. Furthermore, they declared their commitment to Fast-Track and Sustain the ASEAN Response to
HIV/AIDS by focusing and targeting HIV/AIDS programs for key affected populations. They also declared their commitment to focus and target HIV and AIDS programs to key affected populations, scale up and strengthen the coverage, reach, and quality of continuum of comprehensive integrated packages of prevention, testing, treatment, care, and support services. The region also ensured that they will work towards a response where there is equal access to high-quality services, prevention, treatment, care, and support, and no one is denied such services because of HIV-related stigma and discrimination.

2.2 HIV and AIDS in Thailand

UNAIDS (2017) provided country fact sheets enumerating HIV and AIDS estimates, as well as essential data related to the HIV pandemic in different countries. In 2016, it was estimated that 450,000 people were living with HIV out of Thailand’s more than 60 million population (Figure 2.1). The adult HIV prevalence in the country is 1.1%, which is one of the largest HIV prevalences in Asia and the Pacific. It accounts for 9% of the region’s total population of people living with HIV/AIDS.

Figure 2.1 HIV/AIDS data in Thailand (2000 to 2016)

![HIV/AIDS data in Thailand (2000 to 2016)](image)

Source: Joint United Nations Programme on HIV and AIDS (2017)

Although there is a decline in the HIV epidemic in the country, there are certain groups that have much higher rates of HIV compared to the general population (Table 2.1). The key affected population are men who have sex with men, transgender people,
male and female sex workers, and people who inject drugs. Other groups who are also vulnerable to HIV include the spouses of the mentioned populations, migrant workers, and prisoners.

**Table 2.1** *Key affected population size estimates in Thailand*

<table>
<thead>
<tr>
<th>Populations</th>
<th>Estimate</th>
<th>Year of estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female sex workers</td>
<td>129,000</td>
<td>2016</td>
</tr>
<tr>
<td>Male sex workers</td>
<td>26,000</td>
<td>2016</td>
</tr>
<tr>
<td>Men who have sex with men</td>
<td>528,000</td>
<td>2016</td>
</tr>
<tr>
<td>Transgender</td>
<td>63,000</td>
<td>2016</td>
</tr>
<tr>
<td>People who inject drugs</td>
<td>42,000</td>
<td>2014</td>
</tr>
</tbody>
</table>

*Source: Joint United Nations Programme on HIV and AIDS (2016)*

In the estimated 6,400 new HIV infections in 2016, 50% were from men who have sex with men, male sex workers, and transgender people. In the country, 9.15% of the mentioned group are living with HIV. In this particular key affected group, it can be inferred that prevention programs have not reached to as many young men who have sex with men. According to UNESCO Bangkok (2013), young men are less likely to know where to obtain an HIV test. They have also less understanding with regards to risky sex behaviours. Other factors which placed younger men at high risk of contracting HIV is their perception of themselves as a low-risk group, and sex with multiple partners. This behaviour is further fuelled by performance-enhancing drugs, which result in low condom usage.

In a study by van Griensven, f., et al. (2013) among a cohort of men who have sex with men in Thailand, it was found out that HIV incidence among young men who have sex with men who are between 18 to 21 years of age, is 8.8 per 100 person-years. On the other hand, the HIV incidence for those men over 30 years old is 3.7 per 100 person-years. In the same study, risk factors for HIV incidence include drug use for
sexual pleasure, receptive anal intercourse, inconsistent condom use, and group sex, among others.

In 2014, the Thai Red Cross Anonymous Clinic (TRCAC) in Bangkok started its pre-exposure prophylaxis (PrEP) project. This antiretroviral treatment in the form of a pill is taken by HIV-negative people before potential exposure to HIV in order to prevent them from acquiring the disease. People who participate in this project are charged $1 a day for their supply of pills, together with counselling and health evaluations. Since consistent condom use remains low in Asia, PrEP is considered an additional prevention choice for people at risk for HIV exposure (UNAIDS, 2016).

PrEP should be considered for administration to high risk groups, particularly young men who have sex with men, who have consistently high HIV incidence in the abovementioned study. The demographic characteristics and behavioural risk factors for acquiring HIV among young men who have sex with men have been described, and HIV prevention programs such as PrEP, supplemented with recommended counselling and health evaluations, should be considered not only in Thailand, but in other countries who share the same HIV patterns with the country.

2.2.1 Migrants and HIV

As Thailand is considered a hub for investment and tourism, it also serves as a regional hub for migrants, either as a destination or a transit point to another country. As one of the countries with the largest economies in Southeast Asia, it becomes a chain of migration among unskilled workers from its lower-income neighbors such as Cambodia, Myanmar, and Laos. Thailand also attracted professionals and skilled labor in other countries to assist in large projects and programs.

Based on the BBC report of Nash (2017), Dr. Yvonne McNulty, who is an expat researcher and senior lecturer at the school of human development and social science at SIM University in Singapore, defines a business expatriate as a legally working individual who resides temporarily in a country of which they are not a citizen, in order to accomplish a career-related goal. Expatriates are people who have relocated abroad either by themselves, by an organization, or a direct employer by their host country. In the same article, Mr. Zeeck, founder and CEO of InterNations, one of the world’s largest expat network, defined the words, expatriate and migrant, and
differentiated them from the word, immigrant. Just like the definition of migrant, an expatriate moves abroad for a limited amount of time or have not yet decided upon the length of their stay. They still have the citizenship of their country of origin. This is in contrast with the definition of immigrant, which is defined as a person who have come to a different country to live there permanently.

With the establishment of the ASEAN Economic Community (AEC) in 2015, the goal and vision of the region is the integration and cooperation among the ten-member countries on having a single market and production base. One of the most important topics in AEC is the free flow of skilled labour. Mutual Recognition Arrangements (MRAs) are framework arrangements, which facilitates trade in services for professionals who are authorized, licensed, and certified by authorities in their home countries. Currently, the professions with MRAs are: engineering services (2005); nursing services (2006); architectural services and framework arrangement for the mutual recognition of surveying qualifications (2007); medical practitioners and dental practitioners (2009); accountancy services (2014); and tourism professionals (2012) (Invest in ASEAN, 2018).

According to the Thailand Migration Report (2014), an estimate of up to four million migrants are living in Thailand. A vast majority of them are from neighbouring ASEAN countries like Myanmar, Cambodia, and Lao PDR. Based from the given estimate, 3.25 million have come to Thailand for employment purposes, 127,000 are considered displaced persons, and the rest are composed of students and retirees from other countries.

The National Health Security Office (NHSO) in Thailand tend to classify migrants into 1) circular migrants and tourists; and 2) foreign migrant workers in Thailand. The first classification are the target respondents in this research study, and these migrants are those non-Thailand nationals who enter and leave the country legally. This group can be subdivided into a) tourists; b) migrants with temporary work permits; c) transit visitors to another country; and d) people granted with temporary permission to stay in Thailand for a variety of reason, such as for academic studies, diplomatic services, living with family members, retirees, etc. (Kantayaporn T., and Mallik, S., 2013).
With the exclusion of transit visitors, the number of migrant entries to Thailand totaled between 20 to 23 million per year in 2011 and 2013 (Table 2.2). Majority of them are tourists. The data on 2013 is up to August of that year, according to the source. However, it can be inferred from the table that the balance of visitors in the country in 2011 was 443,069, and in 2012 was 485,732. The data translates to governing authorities the need to consider appropriate health coverage for these migrants, whether their stay in the country is short-term or long-term.

Table 2.2 Number of entries and exits to Thailand and balance remaining

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Entries and Annual Balance</th>
<th>Tourists</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Entry</td>
<td>Exit</td>
</tr>
<tr>
<td>2011</td>
<td>20,396,852</td>
<td>19,953,783</td>
</tr>
<tr>
<td>2012</td>
<td>23,820,906</td>
<td>23,335,174</td>
</tr>
<tr>
<td>2013</td>
<td>18,920,662</td>
<td>18,856,415</td>
</tr>
</tbody>
</table>


Little has been written about the migrant and mobile population in Thailand, particularly those who are living with HIV/AIDS. A person of migrant status can place him in heightened vulnerability to HIV due to factors such as social exclusion and lack of access to healthcare services or social protection. In the case of Thailand, a registered migrant has access to the Thai healthcare insurance system through the social security scheme (SSS) for those employed in the formal sector, or the migrant health insurance scheme for the others. According to the Thailand AIDS Response Progress Report (2015), the Ministry of Public Health enacted in 2013 a policy that provides health insurance, including antiretroviral therapy coverage for cross-border migrants, whether classified as registered or unregistered migrants, who are not covered by social security.

The challenge, perhaps, on the part of the Thailand government, is to encourage more migrants to subscribe to health insurance. Migrants still have limited access to HIV-related healthcare services for diagnosis and treatment due to legal, financial, and language constraints. Stigma is still present among people living with HIV that makes
them fear of loss of employment, interactions with government offices such as the Ministry of Labour, and immigration and police authorities.

2.3 Stigma and Discrimination

HIV/AIDS-related stigma and discrimination is an important issue faced by people living with HIV because it has many serious consequences, both medical and psychological. Parker and Aggleton (2003) stated that the stigma attached to the disease reflects structural inequalities related to gender, social class, and races. In Thailand, it is estimated that 450,000 people are living with HIV/AIDS. With the influx of expatriates in the country, whether as short-staying or long-staying tourists or professionals, and the presence of government agencies and private hospitals with HIV-related services accommodating both locals and foreigners, there is a need to explore the HIV-related stigmatization experiences of this specific demographic.

Numerous studies have documented the prevalence of HIV/AIDS-related stigma and discrimination on various countries, and across many groups of people living with HIV/AIDS, including young men who have sex with men, older adults, women, the LGBT, and ethnic minorities.

The People Living with HIV Stigma Index is a community research and community initiative that was developed by and for people living with HIV. The collaborating parties include in this project are the International Planned Parenthood Federation (IPPF), UNAIDS, the Global Network of People Living with HIV (GNP+), and the International Community of Women Living with HIV (ICW). In Thailand, The People Living with HIV Stigma Index Report (2010), which interviewed 233 people living with HIV/AIDS, outlined the experiences of stigma and discrimination of the infected people. Such experiences include restriction from participation in community and religious activities, job loss, rejection from employment opportunities, and denied access to medical services. The study was commissioned between February 2009 and January 2010. Moreover, the respondents of the said research study also expressed their concern about migrant workers with HIV/AIDS. They stated that migrant workers face numerous problems when accessing care, such as language difficulties, cultural misunderstandings, and the fear of arrest, deportation, and the need to pay bribes to be able to reach hospitals.
Various studies have also been conducted with regards to the effect of such stigma and discrimination to the infected person. In a study by Panetier, J., et al. (2015), for instance, stigma and discrimination hampered effective HIV response in Thailand by damaging a person’s willingness to HIV testing, and eventually, treatment, and retention. A survey conducted by Li, M.J., et al. (2014), among people living with HIV linked HIV-related stigma to low adherence to antiretroviral treatment.

The International Centre for Research on Women (2005) outlined the possible consequences of such stigma, and it included: loss of income and livelihood, loss of marriage and childbearing options, poor care within the health sector, withdrawal of caregiving in the home, loss of hope, feelings of worthlessness, and loss of reputation.

2.3.1 Forms of Stigma, and Healthcare-seeking Behaviour

Stangl, A., et al. (2012) outlined the key domains of HIV-related stigma and discrimination, and proposed specific questions to three groups: people living with HIV, the general population, and healthcare providers. Among the manifestations of stigma, the domains that were proposed for measurement include: 1) anticipated stigma, which is the fear of negative implications should one’s HIV status become known, should one associate with a person living with HIV, or should one becomes positive to HIV; 2) perceived stigma, or the general population’s perception of stigma toward people living with HIV by community members; 3) internalized stigma, or the acceptance among people living with HIV of the negative beliefs and feelings associated with HIV about themselves; 4) experienced stigma, which refers to the experiences of discrimination towards people living with HIV, or association with a person living with HIV; 5) discrimination; and 6) resilience, which means overcoming and resisting the experienced stigma and discrimination.

In a research study by Chi, P., et al. (2014), they outlined manifestations of stigma in the interpersonal and intrapersonal level, and they are conceptually grouped as: 1) enacted stigma, or acts of discrimination experienced by a person living with HIV; 2) perceived stigma, or the expectations that stigmatization in the community will occur during social interactions; 3) internalized stigma, or the stigmatizing attitudes and beliefs of a person living with HIV, which is a form of judgment and stigmatization;
and 4) vicarious stigma, or heard stories or events that were witnessed indicating evidence of how HIV has been treated.

The research study of Churcher, S. (2013) indicates that as a result of HIV-related stigma, the healthcare-seeking behaviour of people living with HIV is affected. Such responses include delaying of adherence to the antiretroviral therapy, and not adopting preventative sexual behaviours. In Thailand, issues with regards to healthcare service delivery include, prolonged gaps in CD4 testing from an initial HIV test, and inadequately trained healthcare providers in the identification of HIV symptoms. As a result of these experiences of stigma and discrimination in the public healthcare system, there are also reports that people living with HIV prefer to seek healthcare services in the private sector. Although the privacy of patient records is protected under Thailand’s National Health Act of 2007, people living with HIV still experience fear of breach of patient confidentiality, especially patients who are categorized in the key affected group, people who inject drugs. They still prefer to seek the services of the private sector instead of availing the services of the public health system.

2.4 Theoretical and Conceptual Frameworks of the Study

2.4.1 Socio-cognitive Theory of Health-related Stigma

In the research study of Churcher, S. (2013), he utilized the socio-cognitive approach to understanding stigma, which is based on the theorization of health-related stigma by Erving Goffman, an influential sociologist of the twentieth century. Goffman defined stigma as the phenomenon whereby an individual with an attribute which is deeply discredited by his or her society is rejected as a result of the attribute. Stigma is a process by which the reaction of others spoils normal identity.

The theory of stigma by Goffman was adapted and extended by social psychologists, and when applied to HIV/AIDS, the theory covers the concept of how PLHIV are labeled by the public, among many other concepts. Churcher outlined the key socio-cognitive approaches to understanding stigma in Figure 2.2.
Presented in the outer circle of Figure 2.2 are the factors influencing stigma at the macro-social level. Such factors disease-related stigma, stereotype-related stigma, power dynamics, and social, religious, and cultural values. On the other hand, the inner circle is the interpersonal and intrapersonal level, which presents manifestations of stigma. They are grouped as 1) vicarious stigma; 2) perceived stigma; 3) enacted stigma; and 4) internalized stigma.

This research study will utilize one of the two questionnaires that was created by Srithanaviboonchai, K., et al. (2017) in their research study on healthcare stigma and discrimination. They used and refined a standardized global health facility staff stigma and discrimination questionnaire to adapt to the Thailand healthcare facility
This questionnaire intended for health facility staff was created by Nyblade, L., et al. (2013). The second questionnaire, from which this research study will use, was developed by the researchers in order to measure the experience of health facility-related stigma and discrimination among people living with HIV in Thailand. The researchers followed five key steps in the development of their questionnaires, as depicted in Figure 2.3.

**Figure 2.3 Process and timeline for questionnaire development**

- **Consultative meeting to draft the questionnaires using global tools as primers**
  - June 2013
- **Pre-test the 1st draft questionnaires in 2 hospitals (20 health staff and 12 PLHIV)**
  - July 2013
- **Study team meeting to consider the pre-test results and came up with the 2nd draft questionnaires**
  - July 2013
- **Field-test the 2nd draft questionnaires in Bangkok and Chiang Mai (738 health staff and 714 PLHIV)**
  - January and March 2014
- **Data management and analysis to finalize the questionnaires**
  - April 2014

*Source: Srithanaviboonchai, K., et al. (2017)*

The researchers first held a three-day consultative meeting, wherein the participants included stakeholders from the civil society, donors, and other international
organizations. They added and adapted content from the original questionnaire to suit the Thai context. They also adapted questions from the 2009 Thai PLHIV Stigma Index Survey. The first draft of the questionnaire for Thai health facility staff contained 59 questions and six sections. On the other hand, the first draft of the questionnaire for PLHIV contained 31 questions and five sections. Both questionnaires on their first draft were pre-tested in two government hospitals in Nonthaburi and Lampoon provinces. After which, the respondents were asked to give feedback regarding the content and language of the questionnaires.

Based from the feedback from the pre-test, the questionnaires were revised, notably in terms of format, language, wording, flow of questions, and content of some questions. The questionnaires on their second draft were then field tested in some hospitals in Bangkok and Chiang Mai. The researchers held a five-day data analysis, and gathered key feedback from the field implementation of the questionnaires. As a result, the health facility staff questionnaire now consists of 14 questions containing 26 items. On the other hand, the PLHIV questionnaire now includes 17 questions with 33 items covering five domains, as presented in Table 2.3.

<table>
<thead>
<tr>
<th>Section</th>
<th>Issues questioned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Demographics</td>
</tr>
<tr>
<td></td>
<td>Usage of health services</td>
</tr>
<tr>
<td></td>
<td>Gender and KP</td>
</tr>
<tr>
<td>Health-related stigma</td>
<td>Anticipated stigma</td>
</tr>
<tr>
<td></td>
<td>Experienced stigma</td>
</tr>
<tr>
<td></td>
<td>Internalized stigma</td>
</tr>
<tr>
<td>Disclosure and confidentiality</td>
<td>Disclosure of HIV status</td>
</tr>
<tr>
<td></td>
<td>Confidentiality</td>
</tr>
<tr>
<td>Stigma and discrimination in relation to reproductive health</td>
<td>Sex and marriage</td>
</tr>
<tr>
<td></td>
<td>Having children</td>
</tr>
<tr>
<td>Experience of stigma among pregnant women</td>
<td>Screening question</td>
</tr>
<tr>
<td></td>
<td>Termination of pregnancy</td>
</tr>
<tr>
<td></td>
<td>Prevention of mother to child HIV transmission</td>
</tr>
<tr>
<td></td>
<td>Disclosure of HIV status</td>
</tr>
</tbody>
</table>

Source: Srithanaviboonchai, K., et al. (2017)
2.4.2 Adaptation of Previous Questionnaire

The researcher has chosen to utilize the PLHIV questionnaire of the aforementioned researchers because of the common aim of understanding HIV-related stigma. However, since the focus of this study are male expatriates with HIV/AIDS, additional content was added, and the test items that to be used are only those that are relevant to the target participants.

Revision was also done to the questionnaire with regards to its format. In almost all the items in the questionnaire, the respondents only need to put a check mark on their chosen answer. Blank spaces are also provided on some questions should their answer is not among the listed choices. This makes the questionnaire easier to answer, and it makes the engagement time between the researcher and the respondent minimal as the research will be conducted in a casual manner. Although the target respondents will be informed that answering the questionnaire is voluntary, utmost consideration will also be given to them in terms of privacy. Moreover, the field study will solely be conducted by the researcher, and that no cash reward will be given to the respondent as compensation for their time. Hence, time spent by the respondent will be kept to a minimum but without sacrificing the integrity of test taking.

2.4.3 Research Conceptual Framework

This research study aims to assess the stigmatization experiences and the healthcare-seeking behaviour of male expatriates with HIV/AIDS in Thailand; and to acquire a general profile of the target respondents. In order to achieve these objectives, this research study will use three main variables to analyze the respondents’ healthcare-seeking behaviour.

The main variables chosen to be analyzed are: 1) sociodemographic characteristics; 2) health-related stigma; and 3) disclosure and confidentiality.
This research study will follow the conceptual framework presented in Figure 2.4. It enumerates the items under sociodemographic characteristics in order to acquire a general profile of the target respondents. From six questions in the original questionnaire, the new questionnaire now contains seven questions. The questions are about the respondent’s age, length of stay in Thailand, type of visa they are holding,
type of health insurance they have, duration of using healthcare services in Thailand, length of time knowing their HIV status, and their status of antiretroviral treatment.

Conceptually, health-related stigma is further divided into three domains: anticipated stigma, experienced stigma, and internalized stigma. The number of questions of the original questionnaire and the new questionnaire are both four. The first question asked whether anticipated stigma caused delay in accessing care and treatment among PLHIV. Three response categories are to be chosen by the respondents, and they are: 1) stigma-related reasons regarding fear; 2) stigma-related questions regarding quality of service; and 3) non-stigma related reasons. There are eleven items in the questionnaire that aims to assess experienced stigma. One question on self-stigma is also included in the questionnaire with three response categories.

The third main variable is disclosure and confidentiality. There is one question with three response categories regarding this matter in the final questionnaire. The questions about the stigma in relation to reproductive health in the original questionnaire was dropped since it is for female respondents, whereas in this study, the target respondents are male expatriates.
CHAPTER 3
RESEARCH METHODOLOGY

Data collection in this study was done in both quantitative and qualitative research methodologies using primary and secondary data. The primary data that was collected included sociodemographic characteristics, stigmatization experiences, and healthcare-seeking behaviour of male expatriates with HIV/AIDS in Thailand using a guided questionnaire or a monitoring tool which was created in a previous research study, and a semi-structured interview to probe further the answers provided by the respondents in the aforementioned data collection tool. The secondary data of this research study included books, academic journals, research papers, newspapers, and magazines, in both print and online editions, that discuss the thesis topic area.

The research methodology of this study is descriptive qualitative and explanatory in order to discuss the stigmatization experiences of male expatriates with HIV/AIDS in Thailand. Moreover, the study aimed in assessing the stigmatization experiences and the healthcare-seeking behaviour of the target participants.

3.1 Research Setting and Participants

Medical facilities and civil society organizations in Bangkok that offer HIV-related services were purposely selected to identify the participants of the study. Through these groups, snowball sampling technique was also used to identify more prospective participants. Initially, a list of such groups was drawn up, and it includes:

a) AIDS Society of Asia and the Pacific (ASAP)

b) Asia Pacific Coalition of Male Sexual Health (APCOM)

c) Asian Harm Reduction Network (AHRN)

d) Asia Pacific Network for People Living with HIV/AIDS (APN+)

e) The HIV Netherlands Australia Thailand Research Collaboration (HIV-NAT)

f) National AIDS Management Center (NAMC)

g) Rainbow Sky Association of Thailand, Thai National AIDS Foundation (TNAF)
h) Thai Network of People Living with HIV/AIDS (TNP+)
i) Thai NGO Coalition on AIDS (TNCA)
j) Thailand Business Coalition on AIDS (TBCA)
k) Therapeutics, Research, Education, AIDS Training in Asia (TREAT Asia)
l) Thai Red Cross AIDS Research Centre (TRC-ARC)
m) Silom Pulse Clinic

Upon contacting the abovementioned organizations, the researcher was told that they could not directly contact the set target participants because of the confidentiality and sensitivity of the research topic. However, after a visit to Thai Red Cross Anonymous Clinic (TRC-AC), the researcher was able to converse with a staff from an affiliated foundation, who assists foreigners in the said clinic. He is currently commissioned by the foundation to provide assistance to foreigners going to TRC-AC who might have a hard time in explaining the services they want to avail, as well as in answering HIV-related inquiries. Moreover, the researcher was told that a weekly counselling session for HIV-positive individuals is being held at a certain hospital in Bangkok. This also became a venue for the researcher to conduct his research study, upon the consent of the participants.

The researcher also contacted several organizations from the Philippines who might have contact with target participants. From there, point persons based in Thailand were identified, and were also able to refer people to participate in the research study. Some referred participants were contacted through e-mail, wherein scanned copies of the questionnaire were sent, and the researcher received answered questionnaires in either scanned or jpeg format.

The researcher also used several social media platforms: Facebook, Twitter, and Blogspot. There are Facebook groups for HIV-positive individuals and supporters, where the researcher posted the research questionnaire in Google Form format for prospective respondents. Based from the sociodemographic part of the questionnaire, the researcher filtered those that are eligible and fit as target respondents of the research study. In Twitter, the researcher posted the link of the Google Form format of the questionnaire daily. Various administrators and managers of HIV-related blogs were
also contacted, and help was sought with regards to generation of more respondents of the study.

A written informed consent was obtained from the male expatriates with HIV/AIDS who agreed in participating in the research study. Due to the nature and sensitivity of the research study, as well as the limited time availability of the participants, the questionnaire and interview were administered with utmost confidentiality, and time duration spent was minimal except in instances wherein the interviewee agreed to be interviewed further. With regards to participants who responded to the online version of the questionnaire, the researcher left an email address and phone number where he can be contacted in case the interviewee has questions. Moreover, blank spaces in the online version of the questionnaire were also provided where the respondents can freely write additional data that they want to share.

In the case of face-to-face interviews, they were done casually and discreetly because of the manner of operation of the clinic. Almost all interviews were done through the assistance of the staff from the foundation, and the time spent was kept to a minimal to avoid disturbance to the clinic operations. The respondents were given the option to read and complete the questionnaire by themselves, or with the guidance of the researcher in consideration of the sensitive nature of the research topic. Guiding the interviewee was preferred though because it allowed the researcher to probe further based on the answers of the respondents in the questionnaire.

In essence, all the participants were fully informed of the nature of the research study, and were assured of confidentiality during the entire study process. There was shared participation between the researcher and the participant during the individual interview, especially during the process of filling in the questionnaire. For online respondents, the researcher provided means where he can easily be reached. The participants were thanked for their participation in the research study, and were told that should they need a copy of the result of the research study, the researcher can email it to them.
3.2 Data Collection

Since the number of male expatriates with HIV/AIDS in Thailand are based on estimates, and that the exact number is not determined, a target sample size of 100 was set based on the resources available and time constraints, and such determination is not based on statistical calculations. After exploring various platforms and methods of obtaining data, the researcher was able to collect data from 108 male expatriates with HIV/AIDS in Thailand. Seventy-one of the respondents were interviewed face-to-face, while 37 respondents filled up the online questionnaires which were gathered from various social media platforms that were accessed by the researcher. The number of participants already allowed for meaningful exploratory insights and conclusions. However, some limitations of the study, including data collection, sampling technique, among others, will be discussed further.

This research study utilized the PLHIV questionnaire created by Chariyalertsak, C., et. al., (2017). The original questionnaire included 17 questions with 33 items covering five domains. However, since the focus of this study are male expatriates, the questionnaire was revised, and the items that were utilized are only those that are relevant to the target participants. Twelve questions were retained which focused on the following domains: background information or sociodemographic characteristics, health-related stigma, and disclosure and confidentiality.

a) Background Information/Sociodemographic Characteristics

Seven questions in the questionnaire are related to the sociodemographic characteristics of the respondents (Figure 3.1). The questions gathered information about the participant’s age, length of stay in Thailand, type of visa, health insurance coverage, duration of using health care services in Thailand, length of time knowing HIV status, and status of antiretroviral therapy. The participants were advised that they have the option of not answering questions that they feel uncomfortable answering because of the sensitivity of the matter. However, it was emphasized repeatedly by the researcher that all information that the participants provide will be dealt with utmost confidentiality. The questionnaires were coded chronologically, and a small blank space was provided for the participants to sign their initials. No personal information was demanded that will reveal or pose risk in revealing the identity of the respondents.
b) Health-related Stigma

This section included questions about anticipated stigma, experienced stigma, and internalized stigma in relation to the utilization of health services. The first question asked whether anticipated stigma hampered access to care and treatment (Figure 3.2). If the participant replies positively to the question, a follow up question is asked, and the participants need to tick the reasons that applied to them as to why they avoided or delayed going to a healthcare facility. The responses are categorized as: fear as the stigma-related reason, quality of service as the stigma-related reason, and non-
stigma related reasons such as inconvenient location of the healthcare facility, no health insurance coverage, and poor quality of medical care, among others.

**Figure 3.2 Anticipated stigma part of the questionnaire**

<table>
<thead>
<tr>
<th>9. In the last 12 months, have you avoided going to or delayed going to a healthcare facility (HIV or non-HIV related issues)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes, I have avoided.</td>
</tr>
<tr>
<td>☐ No, I never avoided.</td>
</tr>
</tbody>
</table>

If YES, what was the reason why you avoided going to the healthcare facility? (check all that applies)

- ☐ Fear of disclosure of HIV status.
- ☐ I know someone at the facility.
- ☐ Near my work so my colleagues might see me.
- ☐ Unfriendly services.
- ☐ Staff talk badly to me because of my HIV status.
- ☐ Made me wait longer than non-HIV patients.
- ☐ Staff avoid touching me.
- ☐ Staff using double gloves.
- ☐ Staff stare at me or gossip about me.
- ☐ Inconvenient; too far; no transportation.
- ☐ No health insurance; high cost.
- ☐ Poor quality medical care and treatment; don’t trust staff’s medical knowledge.
- ☐ I was not sick enough; don’t want treatment; can treat myself.

Initials: ____________________

*Source: Srithanaviboonchai, K., et al. (2017)*

There are eight main questions about experienced stigma (Figure 3.3) at health care facilities: denial of care, treatment given on a conditional basis, delay of care, patient’s medical record visibly marked as HIV positive, talked with rudely, poor quality of care, health service providers’ avoidance of touching them, admission as an in-patient in a healthcare facility. Moreover, three additional questions were asked should the respondent was admitted as an in-patient in the last 12 months. These three questions probe stigmatization and discrimination experiences in an in-patient ward.
Figure 3.3 Experienced stigma part of the questionnaire

The section on internalized stigma has one self-stigma question with three sub-items (Figure 3.4). It asked about feeling ashamed or guilty of being of being an HIV-positive individual, and fear of being stared at or gossiped by health facility staff.

Source: Srithanaviboonchai, K., et al. (2017)
c) Disclosure and Confidentiality

There are two questions about disclosure and confidentiality of HIV status in the questionnaire (Figure 3.5). It includes: 1) involuntary disclosure of HIV status by health facility staff to other people without the patient’s consent; and 2) respondents’ level of confidence that health facility staff will keep their HIV status confidential.

3.3 Data Analysis

Quantitative data for this research study was collected from 108 male expatriates with HIV/AIDS in Thailand. A cross-sectional descriptive study with a semi-structured interview was conducted. Information was obtained on sociodemographic characteristics, stigmatization experiences, and healthcare-seeking behaviour of the respondents. Emphasis was given on stigmatization experiences as it includes three forms of stigma: anticipated stigma, experienced stigma, and internalized stigma.

Source: Srithanaviboonchai, K., et al. (2017)
Descriptive statistics and frequencies were used to describe the sociodemographic characteristics of the respondents. The same method was also used to describe the stigmatization experiences of the respondents: anticipated stigma, experienced stigma, and internalized stigma, including the sub-items within these three forms of stigma. The section on disclosure and confidentiality were also described using the same method. Notes on the semi-structured interviews were also reviewed to explore corroborating evidence to further explain the descriptive results presented in this research study.

The methodology of this study is descriptive qualitative and explanatory in order to describe and assess the stigmatization experiences of the respondents, and their healthcare-seeking behaviour.
CHAPTER 4
RESULTS AND DISCUSSION

In this chapter, results of the questionnaire and brief semi-structured interview are divided in three main parts: 1) sociodemographic characteristics; 2) stigmatization experiences; and 3) healthcare-seeking behaviour. Moreover, the second section on stigmatization experiences will be further subdivided into three categories: anticipated stigma, experienced stigma, and internalized stigma. Healthcare-seeking behaviour, on the other hand, is incorporated in the results and discussion on stigmatization experiences and the three domains of health-related stigma.

A total of 108 respondents took part in this research study, and they are classified as circular migrants and tourists, according to the definition of the National Health Security Office (NHSO) in Thailand. They are non-Thai nationals who enter and leave Thailand legally, and they are subdivided into tourists, migrants with work permits, transit visitors to another country, and people who are granted with temporary permission to stay in the country for reasons such as academic studies, diplomatic services, living with family members, and retirees, among others.

4.1 Sociodemographic Characteristics

Information on the sociodemographic characteristics of male expatriates with HIV/AIDS in Thailand are provided in Table 4.1. Majority of the respondents (67 people or 62.04%) are between the ages of 31 to 50 years old. Thirty-three (30.56%) of the respondents are between 18 to 30 years old, while eight (7.41%) of the respondents are 51 years old or above.

Majority (68 people or 62.96%) of the respondents are holders of non-immigrant visas, while 14 respondents (12.96%) are holders of tourist visas. Six (5.56%) have retirement visas, while the rest (20 people or 18.52%) did not indicate the type of visa they are currently holding.
Table 4.1 Sociodemographic characteristics of male expatriates with HIV/AIDS in Thailand

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Total (N=108)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-30 years old</td>
<td>33</td>
<td>30.56%</td>
</tr>
<tr>
<td>31-50 years old</td>
<td>67</td>
<td>62.04%</td>
</tr>
<tr>
<td>51 years old and above</td>
<td>8</td>
<td>7.41%</td>
</tr>
<tr>
<td><strong>Type of visa:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tourist visa</td>
<td>14</td>
<td>12.96%</td>
</tr>
<tr>
<td>Non-Immigrant visa</td>
<td>68</td>
<td>62.96%</td>
</tr>
<tr>
<td>Retirement visa</td>
<td>6</td>
<td>5.66%</td>
</tr>
<tr>
<td>No visa</td>
<td>20</td>
<td>18.52%</td>
</tr>
<tr>
<td><strong>Insurance:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private health insurance (self-paying clients)</td>
<td>12</td>
<td>11.11%</td>
</tr>
<tr>
<td>Health insurance for migrant workers (company-issued)</td>
<td>77</td>
<td>71.30%</td>
</tr>
<tr>
<td>Insurance from home countries</td>
<td>19</td>
<td>17.59%</td>
</tr>
<tr>
<td>Do not have insurance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Length of time receiving healthcare services at any healthcare facility in Thailand:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than one year</td>
<td>73</td>
<td>67.59%</td>
</tr>
<tr>
<td>Less than one year</td>
<td>23</td>
<td>21.30%</td>
</tr>
<tr>
<td>Less than one month</td>
<td>12</td>
<td>11.11%</td>
</tr>
<tr>
<td><strong>Length of time that you know your HIV status:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than one year</td>
<td>62</td>
<td>57.41%</td>
</tr>
<tr>
<td>Less than one year</td>
<td>39</td>
<td>36.11%</td>
</tr>
<tr>
<td>Less than one month</td>
<td>7</td>
<td>6.48%</td>
</tr>
<tr>
<td><strong>Are you receiving ARV medications?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes, currently receiving.</td>
<td>104</td>
<td>96.30%</td>
</tr>
<tr>
<td>Used to receive but now stopped.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No, never received.</td>
<td>4</td>
<td>3.70%</td>
</tr>
</tbody>
</table>

All the respondents have health insurance. Out of 108 of them, 77 (71.30%) have company-issued insurance, and 12 respondents (11.11%) have private health insurance, which they do pay on their own. Nineteen (17.59%) stated that they have insurance in their home countries.

With regards to the length of time that the respondents are receiving healthcare services in any healthcare facility in Thailand, 73 respondents (67.59%) of them have availed of healthcare services for more than one year; twenty-three respondents (21.30%), less than one year; and 12 respondents (11.11%), less than one month.

More than half (62 people or 57.41%) of the respondents have known their HIV status for more than one year. Thirty-nine (36.11%) have known about their HIV status...
for less than one year. Lastly, seven respondents (6.48%) are newly-diagnosed HIV patients. They have known their status for less than one month.

Almost all (104 people or 96.30%) of the respondents are receiving ARV medications. Four (3.70%) have not started with their medication regimen yet.

### 4.2 Stigmatization Experiences/Health-related Stigma

In this research study, stigmatization experiences of the respondents are discussed under health-related stigma, which is further divided into three domains: anticipated stigma, experienced stigma, and internalized stigma. The division was based on the monitoring tool that was utilized for this study, as well as the categories that were created in previous research studies regarding HIV-related stigma, which the author deemed suitable for this research study.

#### 4.2.1 Anticipated Stigma

Table 4.2 provides information on anticipated stigma experienced by the respondents. Anticipated stigma is defined by Earnshaw, V., et al. (2013) as a form of HIV health-related stigma that involves expectations of discrimination, stereotyping, and/or prejudice from others in the past or because of one’s HIV status.

Out of 108 respondents, 46 respondents (42.59%) avoided or intentionally delayed going to a healthcare facility, either for HIV or non-HIV related issues. On the other hand, 62 respondents (57.41%) did not avoid or delay going to a healthcare facility. Out of the 46 respondents who avoided or intentionally delayed going to a healthcare facility, 38 (82.61%) of them stated that they feel that they are not sick enough, they do not want treatment, or that whatever symptoms or sickness they feel can be self-treated by resting or through over-the-counter medications. Furthermore, the respondents stated that they experience minor illnesses such as cough, flu, or fever, which they feel do not need treatment at a healthcare facility. Dr. Daniel Murrell (2017) of healthline.com stressed that a person with HIV can have symptoms such as rash, fever, chills, headache, fatigue, sore throat, diarrhea, among others, which can last for a few days to weeks, then disappear without treatment.
Table 4.2 Information on anticipated stigma experienced by the respondents

<table>
<thead>
<tr>
<th>Question: In the last 12 months, have you avoided going to or delayed going to a healthcare facility?</th>
<th>Total (N=108)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>46</td>
<td>42.59%</td>
</tr>
<tr>
<td>No</td>
<td>62</td>
<td>57.41%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If YES, what was the reason why you avoided going to the healthcare facility?</th>
<th>Total (N=46)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of disclosure of HIV status</td>
<td>9</td>
<td>19.57%</td>
</tr>
<tr>
<td>Know someone at the facility</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Near workplace so colleagues might see me</td>
<td>20</td>
<td>43.48%</td>
</tr>
<tr>
<td>Unfriendly services</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staff talk badly to me because of my HIV status</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Made me wait longer than non-HIV patients</td>
<td>14</td>
<td>30.43%</td>
</tr>
<tr>
<td>Staff avoid touching me</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staff using double gloves</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Staff stare at me or gossip about me</td>
<td>6</td>
<td>13.04%</td>
</tr>
<tr>
<td>Inconvenient; too far; no transportation</td>
<td>12</td>
<td>26.09%</td>
</tr>
<tr>
<td>No health insurance; high cost</td>
<td>22</td>
<td>47.83%</td>
</tr>
<tr>
<td>Poor quality medical care and treatment; don’t trust staff’s medical knowledge</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not sick enough; Do not want treatment; Can treat myself</td>
<td>38</td>
<td>82.61%</td>
</tr>
</tbody>
</table>

Twenty-two respondents (47.83%) are confused about the coverage of their health insurance, and they feel that the cost of treatment is high. Through further probe with the respondents, several respondents stated that they pay for HIV-related services which might be free of charge if only they know what their insurance covers. Furthermore, they stated that since HIV/AIDS is not a common sickness that they can freely talk to their company-assigned hospitals, they are left with no choice but to pay for HIV-related services by themselves. Other respondents said that their health insurances are from their home countries and do not cover healthcare services that they are availing in Thailand. Unlike Thai citizens, the respondents are self-paying clients of hospitals and clinics offering HIV-related services. The most common clinic that both Thai nationals and foreigners go to for HIV-related services is the Thai Red Cross Anonymous Clinic (TRC-AC). In comparison to laboratory fees between TRC-AC and HIV hubs in the Philippines, another ASEAN-member state, the prices are almost within the same range on some laboratory tests. However, the prices between TRC-AC...
and Silom Pulse Clinic, which are both located near BTS Saladaeng station and Silom MRT station in Bangkok, vary greatly. Viral and CD4, which are two of the most important laboratory tests for HIV/AIDS patients, the price in the Philippines are way higher than in TRC-AC in Thailand.

According to AIDS InfoNet (2014), CD4 cells or T-cells are a type of white blood cell that plays an important role in a person’s immune system. The CD4 cell count is a key measure of the health of the immune system. When a person is infected with HIV but has not started treatment, the number of CD4 cells go down, and the immune system is being weakened. Hence, the lower the CD4 cell count, the more likely it is that the infected person will get sick. In conjunction with CD4 cell count, viral load test is also recommended by HIV specialists. Viral load, on the other hand, is a test which measures the amount of HIV in a person’s blood, and it is also used as a basis to determine if an infected person’s HIV treatment is working. For prognosis, viral load can predict how fast HIV disease progresses without treatment, For prevention, it predicts how easy it is to transmit HIV to someone else.

Table 4.3 shows a comparison of prices of some laboratory fees between TRC-AC, Silom Pulse Clinic in Bangkok, and an HIV hub in the Philippines called the UP-PGH SAGIP or the STI/AIDS Guidance Intervention Prevention unit of the University of the Philippines-Philippine General Hospital.

Table 4.3 Comparison of laboratory fees between Thai Red Cross Anonymous Clinic, Silom Pulse Clinic, and SAGIP unit of UP-PGH in the Philippines

<table>
<thead>
<tr>
<th>Laboratory Tests</th>
<th>Price in Thai Red Cross Anonymous Clinic</th>
<th>Price in Silom Pulse Clinic</th>
<th>Price in the SAGIP unit of UP-PGH</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) HIV screening test</td>
<td>200 Baht</td>
<td>500 Baht</td>
<td>313.16 Baht (free for MSM)</td>
</tr>
<tr>
<td>2) HBsAg Anti-HAV Anti-HBs Anti-HCV</td>
<td>200 Baht</td>
<td>600 Baht</td>
<td>673.30 Baht (Hepatitis Profile)</td>
</tr>
<tr>
<td>3) RPR (for syphilis)</td>
<td>100 Baht</td>
<td>600 Baht</td>
<td>40.71 Baht</td>
</tr>
<tr>
<td>4) Viral Load</td>
<td>1,500 Baht</td>
<td>3,200 Baht</td>
<td>3,757.95 Baht</td>
</tr>
<tr>
<td>5) Drug Resistance</td>
<td>5,000 Baht</td>
<td>N/A</td>
<td>3,131.62 Baht</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>6) CD4</td>
<td>300 Baht</td>
<td>800 Baht</td>
<td>1,252.65 Baht (referral to San Lazaro Hospital)</td>
</tr>
<tr>
<td>7) Anal Pap</td>
<td>250 Baht</td>
<td>3,600 Baht</td>
<td>N/A</td>
</tr>
<tr>
<td>8) Hepatitis B vaccination</td>
<td>145 Baht/dose</td>
<td>600 Baht/dose</td>
<td>Free for registered HIV patients but subject to availability</td>
</tr>
<tr>
<td>9) HPV vaccination</td>
<td>2,250 Baht/dose</td>
<td>3,000 Baht/dose</td>
<td>N/A</td>
</tr>
<tr>
<td>10) Chest X-Ray</td>
<td>N/A</td>
<td>N/A</td>
<td>68.90 Baht</td>
</tr>
</tbody>
</table>

*exchange rate is set at 1 Thai Baht to 1.60 Philippine Peso*

Twenty respondents (43.48%) avoided going to their healthcare facility of choice because it is near their workplace, and they fear that their colleagues might see them. In an online article in Fresh Property (2017), an online property agency specializing in rental, sales, and property management services, the central business district (CBD) in Thailand is categorized into two distinct sections: Core CBD, and Outer CBD. Silom area, which is the location of the Thai Red Cross Clinic, Silom Pulse Clinic, as well as King Chulalongkorn Memorial Hospital, Bangkok Christian Hospital, and BNH Hospital, is part of the Core CBD together with Wireless Road/Lumpini, and Early Sukhumvit (Nana-Phrom Phong). These neighborhoods host a multitude of office towers, residential options, embassies, and leisure and retail venues.

Other reasons of the respondents of avoiding or delaying going to a healthcare facility include: long waiting time compared to non-HIV patients (14 respondents or 30.43%), inconvenient location, lack of transportation, traffic jam (12 respondents or 26.09%), fear of disclosure of HIV status (9 respondents or 19.57%), and fear that staff might gossip about them (6 respondents or 13.04%).

None of the respondents who avoided or delayed going to a healthcare facility because of reasons such as: they know someone at the facility, unfriendly services in the facility, rude treatment of healthcare facility staff because of their HIV status, or the staff avoiding touching them or are using double gloves in handling them. Moreover, they do not think that their healthcare facility offers poor quality medical care and treatment, and have untrained staff.

In an online article of Vavrosky, K. (2016) in Dental Products Report, she stated that treating HIV/AIDS patients differently is considered unlawful, unethical, and an example of discrimination since these patients are covered under the Americans
with Disabilities Act of 1990. While standard precautions are employed to every patient, no change of protocol is warranted for HIV/AIDS patients. Thus, double gloving is not necessary in treating HIV/AIDS patients.

4.2.2 Experienced Stigma

Information on experienced stigma encountered by the respondents is provided in Table 4.4. All of the 108 respondents have been to a healthcare facility in the last 12 months. All of them did not experience being refused or denied treatment. However, 71 respondents (65.74%) reported that they were given a condition to change their behaviour prior to receiving treatment. Upon further probe with regards to this matter, the respondents further explained that a nurse or doctor talked to them about the laboratory exam that they are going to take, its purpose, and the reasons why they need to take such laboratory exam. This entails explanation with regards to the patient’s lifestyle, diet, and sexual behaviour, among others. The World Health Organization provides guiding principles for HIV testing and counselling for all healthcare facilities worldwide. First guideline is that HIV testing should be voluntary, and everyone tested should give informed consent. This guideline involves providing pre-test information with regards to the purpose of the laboratory test or treatment. Confidentiality must be protected, and that post-test support services should be offered.

Out of the 108 respondents, 52 (48.15%) stated that their medical record was not marked as being HIV positive in such a way that let other people know that they are living with HIV. Clients at TRC-AC are not necessarily people with HIV/AIDS. They can just be general clients who want to avail of laboratory tests related to HIV and other sexually transmitted infections. Regardless of the HIV status of the client, each one is given a clinic card with the client’s initials and, more importantly, a unique client serial number, in order to maintain anonymity and confidentiality. Aside from diagnostic procedures, TRC-AC also has its Men’s Health Clinic which provides sexual health services to men who have sex with men (MSM), including voluntary counseling and testing (VCT) services for them. The Men’s Health Clinic is located on the first floor of the building, and is separated from the general VCT service.

There were 102 respondents (94.44%) who reported that their health provider did not talk badly, scolded, or blamed them for having HIV. Eighty-eight
respondents (81.48%) said that they did not feel like they were given less attention compared to other patients. There were 98 respondents (90.74%) who stated that their health provider did not necessarily avoid touching them. Ten respondents (9.26%) were unsure of their experience with regards to this matter.

In the last 12 months, only 12 respondents (11.11%) were admitted as in-patient in a hospital. Out of those 12, all claimed that their beds were not marked as to indicate that they are HIV/AIDS patients. Ten (83.33%) of them stated that they did not necessarily stay in an area designated only for HIV-positive patients. From the Emergency Department to their respective private/shared hospital rooms, there were no markings or indications that they are designated to an area exclusive for people living with HIV. Furthermore, three respondents (25%) claimed that their health care provider asked them to place their hospital robe in an area specifically designated for HIV-positive patients, while eight respondents (66.67%) were unsure about the matter.

**Table 4.4 Information on experienced stigma encountered by the respondents**

<table>
<thead>
<tr>
<th>Question: In the last 12 months, have you been to a healthcare facility?</th>
<th>Total (N=108)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>108</td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Question: In the last 12 months, have any of the following happened to you in any healthcare facility because of your HIV status?</th>
<th>Yes</th>
<th>No</th>
<th>Not Sure/ Not Relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health provider refused to attend to you or you were denied treatment.</td>
<td>0</td>
<td>108</td>
<td>0</td>
</tr>
<tr>
<td>You were given a condition to change your behavior prior to receiving treatment.</td>
<td>71</td>
<td>15</td>
<td>22</td>
</tr>
<tr>
<td>Your record was marked as being HIV positive in a way that let people around you know you are living with HIV.</td>
<td>27</td>
<td>52</td>
<td>29</td>
</tr>
<tr>
<td>Health provider talked badly, scolded, or blamed you for having HIV.</td>
<td>0</td>
<td>102</td>
<td>6</td>
</tr>
<tr>
<td>You received less care or attention than other patients.</td>
<td>12</td>
<td>88</td>
<td>8</td>
</tr>
<tr>
<td>Health provider avoided touching your body.</td>
<td>0</td>
<td>98</td>
<td>10</td>
</tr>
</tbody>
</table>

Ref. code: 25605927040146IEO
<table>
<thead>
<tr>
<th><strong>Question:</strong> In the last 12 months, have you been admitted as an in-patient at a hospital?</th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(N=108)</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>12</td>
</tr>
<tr>
<td>No</td>
<td>96</td>
</tr>
<tr>
<td>Not Sure/Not Relevant</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If YES, your bed was marked as being HIV positive in a way that let people around you know that you are living with HIV.</strong></th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(N=12)</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
</tr>
<tr>
<td>Not Sure/Not Relevant</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If YES, you had to stay in an area designated only for HIV-positive patients of people living with HIV.</strong></th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(N=12)</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>10</td>
</tr>
<tr>
<td>Not Sure/Not Relevant</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>If YES, the healthcare provider asked you to place your hospital robe in an area or basket specifically designated for HIV-positive patients due to your HIV status.</strong></th>
<th><strong>Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(N=12)</strong></td>
<td><strong>%</strong></td>
</tr>
<tr>
<td>Yes</td>
<td>3</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
<tr>
<td>Not Sure/Not Relevant</td>
<td>8</td>
</tr>
</tbody>
</table>

### 4.2.3 Internalized Stigma

Information on internalized stigma experienced by the respondents is provided in Table 4.5. Scambler, G., and Paoli, F. (2008) defines internalized stigma as self-shaming or self-blaming narratives that are adopted by stigmatized individuals. It is also described as a felt, imagined, or self-stigma, and is a product of the internalization of shame, blame, hopelessness, guilt, and fear of discrimination associated with being HIV positive.

Only one question about internalized stigma is included in the monitoring tool, but three response categories are provided as reasons why they decided not to go to a healthcare facility. All the respondents feel guilty about their HIV status. Out of 108 respondents, 47 (43.52%) of them feels ashamed of their HIV status. Only 24 respondents (22.22%) feel afraid that healthcare facility staff stare or gossip about them.

One of the respondents further stated that he was supposed to work in another country but during the medical exam shortly before his deployment, he was diagnosed with HIV. HIV-positive individuals are strictly barred from entering in the...
country where he was supposed to work. He was regretful because he lost an opportunity for a better job, and to provide better for his family. He felt guilty because of his HIV status, and it took him some time to seek treatment. Eventually, he was able to find work in Thailand. He further narrated that while working in the country, he was able to find a better job with a better salary. Aware of the medical requirements of obtaining a work visa in Thailand, he was confident that he will be able to transfer to that company. He was surprised that included in the pre-employment requirements is an HIV test. He was made to sign an HIV consent form, together with consent forms for other laboratory exams. Eventually, he did not get the job despite his educational and professional qualifications as well as passing a series of interviews because of his HIV status. He further stated that he talked with the company’s medical doctor and HR personnel if a waiver is possible, deducting his medical benefits, since he is on antiretroviral medications with a CD4 count within normal range, and an undetectable Viral Load. Still, he was not employed by the company. He said that he feels remorseful that even in a country like Thailand which seems to be more relaxed with medical requirements, he is still haunted with the HIV that he acquired many years ago. The shame and guilt of being HIV-positive, as he stated, as well as the consequences it caused to his prospective employment, made him delay seeking help from doctors or hospitals specializing in HIV/AIDS.

According to Thailand Board of Investment (2015), one of the requirements of obtaining a work permit in Thailand is a medical certificate from a licensed physician in Thailand stating that the applicant is not of unsound mind, and not suffering from leprosy, acute tuberculosis, elephantiasis, narcotic addiction, habitual alcoholism, or syphilis stage 3.

According to the International Labour Organization (2009), their Code of Practice on HIV/AIDS and their World of Work has been translated in Thai language, and that Thailand’s Ministry of Labour developed in 2005 its own Code of Practice on Prevention and Management of HIV/AIDS in the Establishment. With regards to HIV testing, the country’s Code of Practice states that there must be no requirement for testing for HIV/AIDS or a request for a reference certifying whether a person is HIV-positive or negative as part of the screening of job applicants.
Table 4.5. Information on internalized stigma experienced by the respondents

<table>
<thead>
<tr>
<th>Question: Have you ever decided not to go to a healthcare facility because of the following:</th>
<th>Total (N=108)</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling ashamed of your HIV status</td>
<td>47</td>
<td>43.52%</td>
</tr>
<tr>
<td>Being afraid that health facility staff stare or gossip about you.</td>
<td>24</td>
<td>22.22%</td>
</tr>
<tr>
<td>Feeling guilty about your HIV status.</td>
<td>108</td>
<td>100%</td>
</tr>
</tbody>
</table>

4.3 Disclosure and Confidentiality

Table 4.6 provides information on disclosure and confidentiality that were experienced by the respondents. Out of the 108 respondents, 89 (82.41%) were not sure whether their healthcare provider ever disclosed their HIV status to other people without their consent. Seventeen respondents (15.74%) felt secure that their HIV medical records were not disclosed to other people, while two respondents (1.85%) felt that their HIV medical records were made known to other people even without their consent.

With regards to the confidentiality of their medical records, 67 (62.04%) of the 108 respondents were unsure as to whether their medical records are kept anonymously. Thirty-six respondents (33.33%) were sure that their medical records relating to HIV were kept confidential, while 5 (4.6%) do not think so.

Table 4.6 Information on disclosure and confidentiality experienced by the respondents

<table>
<thead>
<tr>
<th>(1) Has a healthcare provider ever disclosed your HIV status to other people without your consent? N=108</th>
<th>N=108</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>17</td>
</tr>
<tr>
<td>Not Sure/Not Relevant</td>
<td>89</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Do you feel that your medical records relating to your HIV status are being kept confidential? N=108</th>
<th>N=108</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>36</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>Not Sure/Not Relevant</td>
<td>67</td>
</tr>
</tbody>
</table>
4.4 Limitations of the Study

While this research study attempted to make known a specific demographic: male expatriates with HIV/AIDS in Thailand, there have been several limitations. The study population may not be representative of the wider population of male expatriates with HIV/AIDS in Thailand given that the data relating to their exact number is not available, and that inclusion in this research study is voluntary. The sensitivity of the topic of the research study as well as the fear of their identities being exposed despite the assurance of anonymity, made it difficult to gather more respondents.

With regards to the methods utilized in gathering data, the online respondents’ answers to the questionnaires were not probed further as there is no real-time interaction between the researcher and the online respondents despite that instructions and other pertinent information were provided in the online version of the questionnaire. However, it was ensured that contact details of the researcher are available to the online respondents should they need clarification about the questionnaire, or if they need a copy of the results of the research study. Moreover, the research study is also reliant to self-reported data in its data collection from the interviews, researcher-guided questionnaire, and online questionnaire.

The researcher utilized a monitoring tool from a previous research study but upon its utilization with the target respondents, it has been realized that other notable forms of stigma that should be looked into are government stigma and employment stigma, which are just as important since this study focused on migrants and expatriates.
CHAPTER 5
CONCLUSIONS AND RECOMMENDATIONS

This research study has attempted to understand the stigmatization experiences of one of the key affected population of the HIV epidemic, but not much has been written about them: male expatriates with HIV/AIDS living in Thailand. Although the data from Avert (2017) indicated that the key affected population of the HIV/AIDS epidemic in the Asia and the Pacific region are men who have sex with men, people who inject drugs, and the transgender people, and that the National AIDS Committee (2014) stated that the key affected population in Thailand are female sex workers, male sex workers, men who have sex with men, and the transgender people, the population of migrant workers in the country, male expatriates with HIV/AIDS in particular, should not be ignored. Moreover, according to the Thailand Migration Report (2014), there is an estimated four million migrants living in Thailand. Their latest available data also showed that in terms of number of entries and exits to Thailand, there remains a balance of 443,069 people in 2011, and 485,732 people in 2012.

In addition to obtaining the sociodemographic characteristics of male expatriates with HIV/AIDS living in Thailand, this research study was also conducted to answer the following questions: 1) What stigmatization experiences are encountered by male expatriates with HIV/AIDS in Thailand?; and 2) How do these stigmatization experiences influence their healthcare-seeking behaviour?

5.1 Answers to Research Questions

5.1.1 Sociodemographic Characteristics

Majority of the respondents are between 31 to 50 years old (62.04%), and they are currently holding non-immigrant visas (62.96%). The question of the respondent’s occupation in the questionnaire was intentionally omitted because basing from initial interactions with the target respondents, they verbalized that they feel uncomfortable disclosing about their jobs. Moreover, in the initial questionnaire, occupation is not included in the sociodemographic part. One form of stigma that was
Employment stigma is the kind of stigma that people living with HIV suffer in the workplace. According to Fit for Work (2015, July), a government-funded online blog, discrimination in the workplace can take various forms. These include: 1) direct discrimination, wherein an employer treats an employee who is HIV-positive less favourably than others who are not positive for HIV; 2) indirect discrimination, wherein conditions and rules in the workplace are disadvantageous to employees who are HIV positive; 3) associative discrimination, is when a person suffers discrimination because of their association with a person who has been diagnosed with HIV; 4) harassment is an offensive or intimidating behaviour intended to make a person’s experience in the workplace difficult; and 5) victimization or the unfair treatment of an HIV-positive employee who has made a complaint about harassment in the workplace. In an online article written by Laiyok, S. (2014, November) for Bangkok Post, she stated that Thailand lacks laws that prevent a job seeker with HIV/AIDS from being screened out by employers. Furthermore, the article stated that human rights advocates in the country agree that rejection from employers is a form of discrimination, and that a law should be in place to stop them from checking job applicants for HIV/AIDS.

In America, on the other hand, employees living with HIV/AIDS are protected from discrimination in employment by the Americans with Disabilities Act of 1990. The Center for Disease Control and Prevention further stated that the mentioned law prohibits private employers, state and local governments, employment agencies, joint labor management committees and labour unions from discrimination against qualified individuals with disabilities, including HIV-positive people.

The item in the questionnaire asking for the nationality of the respondents was also omitted as initial respondents verbalized that they prefer not disclosing their country of origin. When probed further, some respondents stated that they do not want their country to be identified as the country with citizens having HIV/AIDS and currently working in Thailand. Majority of the respondents (62.96%) are holders of non-immigrant visas. With regards to health insurance, a significant number of the respondents (62.96%) have company-issued health insurances. When
asked whether they have used their insurance for HIV-related services, some respondents stated that they have no idea what their insurance covers. Normally, they are registered at a specific hospital set by their employees, and although health checks are covered by the insurance, they are not sure whether HIV-related tests are covered by their health insurances. Some respondents go to infectious diseases specialists as paying clients, and they also pay on their own when they have their HIV-related laboratory tests done, and on purchasing their antiretroviral medications.

It is noted that majority of the respondents (67.59%) have been receiving healthcare services in Thailand for more than one year. 57.41% of the respondents have known about their HIV status for more than a year as well. 6.48% or 7 respondents have known about their HIV status for less than one month, implying that they were diagnosed with HIV in Thailand. Those who have known about their HIV status for more than a year are aware of their health condition before transferring to Thailand. Additionally, 96.30% of the respondents are currently receiving antiretroviral medications. There were 4 respondents who have never received ARV, and they indicated that this is because their CD4 level is still within normal range. According to Avert (2018, May), it is recommended that people living with HIV should start antiretroviral treatment right away. Previously, in countries such as the Philippines and Thailand, it is only when CD4 drops to 300 or below that ARV treatment is recommended. CD4 count is a test on how well a person’s immune system is functioning. The normal range for CD4 cells is about 500 to 1,500.

5.1.2 Stigmatization Experiences/Health-related Stigma

With regards to the questions relating to anticipated stigma, the responses are divided into three categories: fear as a stigma-related reason, quality of service as a stigma-related reason, various non-stigma related reasons. Twenty out of 46 respondents who avoided or delayed going to a healthcare facility stated that it is because the clinic or hospital is near their workplace, and that they fear that their colleagues might see them. Only 9 respondents stated that they fear of disclosure of their HIV status. This implies that people fear of being identified as HIV-positive by their peers and co-workers as their HIV status may affect not just their work but their relations with people in their workplace.
When it comes to the quality of service in the healthcare facilities, the only prominent problem observed is that 14 respondents feel that they were made to wait longer than non-HIV patients. None of the respondents said that the healthcare facilities have unfriendly services, or have staff talking badly about them because of their HIV status. Moreover, there have been no complaints of healthcare staff who avoid touching them, or are practicing double gloving technique when taking care of them.

Regarding non-stigma related reasons, 22 respondents feel that the cost of HIV-related services are high. It should be noted that although the respondents have company-issued insurance or private health insurance, they still go to private practitioners, purchase ARV medications, and do laboratory tests as self-paying clients. Consequently, in comparison to private clinics and hospitals, the cost of HIV-related services at Thai Red Cross Anonymous Clinic is significantly lower.

A significant number of respondents (82.61%) stated that they self-medicate or purchase over-the-counter medications if they do have minor illnesses such as flu, cough, or fever. ARVs are primarily taken for the purpose of preventing the replication and multiplication of the virus. They help in strengthening the immune system of an HIV-positive person. However, the minor illnesses mentioned should be checked by a doctor, and not necessarily an HIV specialist as these illnesses should be treated as separate from HIV.

5.1.3 Healthcare-seeking Behaviour

The form of healthcare stigma that pose as a major barrier to seeking healthcare services, which often results to delays or avoidance in obtaining HIV-related services is anticipated stigma, particularly the fear that their colleagues or co-employees might see them in specialty hospitals and clinics with HIV-related services. The cost of healthcare was also reported as barrier to seeking HIV-related services since they are paying clients when it comes to treatments for HIV. Moreover, for minor illnesses such as flu, fever, cough, or diarrhea, which can be symptoms of a failing immune system, they prefer to privately treat them rather than going to hospitals and clinics for treatment.

It should be noted that based from the information on experienced stigma that were encountered by the respondents, the responses are positive towards the quality
of HIV-related healthcare services in Thailand. Moreover, HIV specialists accept their patients’ laboratory results from other hospitals and specialty clinics. As earlier mentioned, the prices of HIV-related services in private hospitals are significantly higher compared to that of Thai Red Cross Anonymous Clinic, hence, the HIV specialists understand if their patients prefer to have their laboratory tests done at TRC-AC.

Findings in this study also indicate that feelings of shame (43.52%) and guilt (100%) caused HIV-positive individuals decide not to go or delay in seeking healthcare services in hospitals and clinics. In previous multiple studies, shame and guilt appears to be common in people living with HIV, and these are predictive of behaviours such as non-adherence to HIV medications, among others. This could have a dramatic impact on their treatment and quality of life.

5.2 Recommendations

This research study raises serious concerns about the burden of disease faced by male expatriates with HIV/AIDS in Thailand due to avoidance or delay in seeking healthcare services. Anticipated stigma and internalized stigma are the more prominent forms of healthcare stigma that are present in this specific demographic. In addition, the findings on these two forms of stigma become important determinants that may impact the burden of disease. There is also a need for them to be oriented with regards to the inclusions of their health insurance coverages so that they can be able to determine if there are HIV-related laboratory tests or procedures that they can avail for free. This is an area of intervention, and that generating awareness about public and private health insurance programs is necessary.

This research study also suggests policy recommendations, including the recognition of expatriates or migrants as an HIV-affected group that is in need of intervention in order that national policies can focus on their development. It is likewise recommended that health policies be designed that will empower this particular demographic to access HIV-related services. Providing a healthcare environment that is accommodating and supportive for people living with HIV can provide a necessary form of respite from the challenges of stigma and discrimination. As much as
antiretroviral medications are universally accessible to expatriates with HIV/AIDS, counselling services should also be made more accessible to them to minimize stigmatization experiences that may lead to delay or avoidance of treatment.

Despite its various limitations, the results of this research study have some important implications for addressing HIV-related stigma, and helping people living with HIV, particularly male expatriates with HIV/AIDS in Thailand. Having a greater understanding of what contributes to HIV-related stigma might have an essential role in the development of strategies to counter its adverse consequences, particularly on the healthcare-seeking behaviour of HIV-positive individuals.
REFERENCES


APPENDIX A
INFORMED CONSENT

Dear Respondent,

Good day! My name is Dennis C. Casing, and I am a graduate student taking up Master's Degree in ASEAN Studies at Pridi Banomyong International College-Thammasat University in Bangkok, I am presently doing a study entitled, Healthcare Across The Border: Stigmatization Experiences and Healthcare-seeking Behaviour of Male Expatriates Living with HIV/AIDS in Thailand.

The objective of the study is to understand the stigmatization experiences of male expatriates with HIV/AIDS living in Thailand, and how these affect their healthcare-seeking behaviour.

In line with this, I would like to ask for your participation in the study by answering the questionnaire. I will be guiding you as you answer the questions, and your participation will require about 10 to 15 minutes only. I understand that the information you will share are very private, and I assure you that the information obtained from this study shall be treated as confidential.

If you have further personal inquiry at the conclusion of the study, or wish to obtain a copy or summary of the result of the study, you may contact me through denniscasing@gmail.com or 0991654318.

Thank you very much.

Sincerely yours,

Dennis C. Casing
Researcher
Pridi Banomyong International College
Thammasat University
APPENDIX B

PLHIV QUESTIONNAIRE

Code: ____________

Interview Date: ____________

1. Age: ______ years

2. Nationality: ______________

3. Length of Stay in Thailand: ______________

4. Type of Visa: 
   - [ ] Tourist Visa
   - [ ] Non-immigrant Visa
   - [ ] Retirement Visa
   - [ ] Others, please specify

5. Currently, what type of insurance do you hold?
   - [ ] Private health insurance
   - [ ] Health insurance for migrant workers
   - [ ] Insurance from home countries
   - [ ] Don’t have any health insurance
   - [ ] Others, please specify

6. How long have you been receiving healthcare services at any healthcare facility in Thailand (HIV or non-HIV related)?
   - If one or more years, enter years: ______ year(s)
   - If less than one year, enter months: ______ month(s)
   - If less than one month, enter days: ______ day(s)

   Additional details on healthcare facility: __________________________

7. How long have you known that you are HIV positive?
   - If one or more years, enter years: ______ year(s)
   - If less than one year, enter months: ______ month(s)
   - If less than one month, enter days: ______ day(s)

8. Currently, are you receiving ARV drugs?
   - [ ] Yes, currently receiving.
   - [ ] Used to receive but now stopped.
   - [ ] No, never received because:

9. In the last 12 months, have you avoided going to or delayed going to a healthcare facility (HIV or non-HIV related issues)?
   - [ ] Yes, I have avoided.
   - [ ] No, I never avoided.

   If YES, what was the reason why you avoided going to the healthcare facility? (check all that applies)
   - [ ] Fear of disclosure of HIV status.
   - [ ] I know someone at the facility.
   - [ ] Near my work so my colleagues might see me.
   - [ ] Unfriendly services.
   - [ ] Staff talk badly to me because of my HIV status.
   - [ ] Made me wait longer than non-HIV patients.
   - [ ] Staff avoid touching me.
   - [ ] Staff using double gloves.
   - [ ] Staff stare at me or gossip about me.
   - [ ] Inconvenient; too far, no transportation.
   - [ ] No health insurance; high cost.
   - [ ] Poor quality medical care and treatment; don’t trust staff’s medical knowledge.
   - [ ] I was not sick enough; don’t want treatment; can treat myself.

Initials: ____________

Ref. code: 25605927040146EO
10. In the last 12 months, have you been to a healthcare facility?

☐ Yes.

No.

11. In the last 12 months, have any of the following happened to you in any health care facility because of your HIV status?

<table>
<thead>
<tr>
<th>Situation</th>
<th>Yes</th>
<th>No</th>
<th>Not Relevant</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.1 Health provider refused to attend to you or you were denied treatment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.2 You were given a condition to change your behaviour prior to receiving treatment.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.3 Have you ever been told to come back later, put last in queue, or made to wait longer than other patients?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.4 Your record was marked as being HIV positive in a way that let people around you know you are living with HIV.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.5 Health provider talked badly, scolded, or blamed you for having HIV.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.6 You received less care or attention than other patients.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.7 Health provider avoided touching your body.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.8 In the last 12 months, have you been admitted as an in-patient at a hospital?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If YES,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.8a Your bed was marked as being HIV positive in a way that let people around you know you are living with HIV.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.8b You had to stay in an area designated only for HIV positive patients or people living with HIV.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.8c Healthcare provider asked you to place your hospital robe in an area or basket specifically designated for HIV positive patients due to your HIV status.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

12. Have you ever decided not to go to a healthcare facility because of the following:

☐ Feeling ashamed of your HIV status.

☐ Feeling afraid that health facility staff stare or gossip about you.

☐ Feeling guilty about your HIV status.

13. How confidential do you think the medical records relating to your HIV status are?

☐ I am sure that my medical records will be kept completely confidential.

☐ I am not sure if my medical records will be kept confidential.

☐ I feel that my medical records are not being kept confidential at all.

---Thank you so much---

Initials: ____________________

Ref. code: 25605927040146EO
**BIOGRAPHY**

Name: Mr. Dennis C. Casing  
Date of Birth: December 29, 1982  
Educational Attainment:  
- 2007: Bachelor of Science in Nursing  
  (Iloilo Doctors’ College)  
- 2003: Bachelor of Arts in Psychology and Management  
  (University of the Philippines-Visayas)  
Work Experiences:  
- 2013 to Present:  
  ESL (English as Second Language) Instructor  
  (Wat Khaenork School), Ramkhamhaeng Institute of Languages, Ramkhamhaeng University  
  Bangkok, Thailand  
- 2008-2012:  
  Cardiovascular Post Anesthesia Care Unit Nurse  
  St. Luke’s Medical Center-Global City  
  Taguig City, Philippines