The People Living with HIV Stigma Index 2.0

THAILAND 2022-2023

Thai Women Living with HIV Foundation
Thai PLHIV Stigma Index Task Force Committee

Implementing Partners

Thai Women Living with HIV Foundation (TWLHF)	Thai PLHIV Stigma Index Task Force Committee
CAREMAT FOUNDATION	Health and Opportunity Network (HON)
Service workers in group (SWING)	Thai Drug User's Network (TDN)
Proud Association	MAP Foundation for the Health and Knowledge of Ethnic Labor
Little Birds Youth Network Foundations	Powerteen, Raks Thai Foundation

Technical Support

Research Institute for Health Sciences, Chiang Mai University	Institute for Population and Social Research, Mahidol University	Watipa

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5. Thailand MoPH – US CDC Collaboration Coordinating Unit (TUC)
6. The Global Fund Thailand
7. Ministry of Public Health (Thailand)

International Partners

1. International Stigma Index Partnership
2. Global Network of People living with HIV (GNP+)
3. The International Community of Women Living with HIV (ICW)

Preface

Stigma and discrimination against people living with HIV and other key populations vulnerable to HIV transmission and acquisition are critical issues that impact the health and quality of life of people living with and affected by HIV. These issues also present significant barriers to ending the global AIDS epidemic.

The 2022 version of the PLHIV Stigma Index in Thailand Survey 2.0 is a report detailing the stigma and discrimination faced by people living with HIV. This survey highlights the pivotal role of people living with HIV themselves, who were actively involved in designing the questions, collecting and analysing the data, and managing the project. The aim was to reflect the S&D they experience and use the findings to advocate for effective policy changes to address these issues.

The People Living with HIV Stigma Index Survey has been developed and refined since 2008 by the Global Network of People Living with HIV (GNP+), the International Community of Women Living with HIV (ICW), the International Planned Parenthood Federation (IPPF), Johns Hopkins University, and UNAIDS Headquarters. It has been implemented in over 100 countries worldwide, including Thailand, with the participation of more than 100,000 people living with HIV.

In Thailand, the project was conducted again in 2022 by the Thai Women Living with HIV Foundation in collaboration with key advisors, including the Thai PLHIV Stigma Index Task Force Committee, UNAIDS Thailand, the Division of AIDS and STIs, the Department of Disease Control, the Ministry of Public Health, and the Research Institute for Health Sciences, Chiang Mai University. Numerous organizations working with key populations also contributed, including the CAREMAT Foundation, the Health and Opportunity Network (HON), the Thai Drug Users Network (TDN), the SWING Foundation, the MAP Foundation for the Health and Knowledge of Ethnic Labor, the Proud Association, the Little Birds Youth Network, and the Powerteen Youth Network in Chiang Mai.

Various networks collaborated in data collection, with a total of 2,508 people living with HIV participating in the project. This included people from the general heterosexual male and female population, as well as those from key populations, such as transgender individuals, men who have sex with men, people who use drugs, sex workers, migrant workers, and vulnerable youth.

The organizing committee expresses its gratitude to the people living with HIV who provided their input, and to all organizations involved in the preparation of this report. It is hoped that the findings from this study will be utilized at the national level to inform policy development, improve measures, and guide HIV-related initiatives, ultimately leading to the elimination of stigma and discrimination against people living with HIV in Thailand.

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Thai Women Living with HIV Foundation (TWLHF)

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Thai PLHIV Stigma Index Task Force Committee

Foreword

Reducing stigma and discrimination related to HIV is one of Thailand's strategies to end the AIDS epidemic by 2030, as outlined in the National Strategy to End AIDS 2017–2030, which sets a clear goal to reduce HIV- and gender-related discrimination to less than 10%, aligning with global targets. Its core principles emphasize promoting equity, reducing disparities, and respecting, protecting, and upholding human rights and gender equality. Thailand has prioritized the key strategy of recognizing the importance of addressing stigma and discrimination related to HIV and gender and taking action to combat it.

Stigma and discrimination related to HIV significantly impact the daily lives and quality of life of people living with HIV. They face stress and depression due to social exclusion and discrimination, along with a lack of access to essential services, including healthcare and other support systems. While Thailand has made substantial progress in HIV prevention and response, reducing stigma and discrimination related to HIV and gender remains a critical challenge, especially in a social context where misconceptions and biases about HIV persist.

This Stigma Index 2.0 Study Report aims to promote and support the protection and advancement of the human rights of people living with HIV. It focuses on surveying and analysing the actual experiences of stigma and discrimination within various communities of people living with HIV in Thailand. The study was conducted in collaboration with diverse partners, including government agencies, community organizations, academic institutions, and international organizations, to ensure comprehensive and actionable data for developing targeted solutions to these challenges.

The Department of Disease Control, Ministry of Public Health, as the primary agency responsible for HIV prevention and the response in Thailand, would like to express its gratitude to all sectors for their support in this study. The Department extends its congratulations on the successful completion of this research. The findings and recommendations from this study will serve as vital information to drive efforts toward eliminating HIV- and gender-related stigma and discrimination in Thailand, achieving the established targets.

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Department of Disease Control, Ministry of Public Health

Acknowledgements

Thank you for the valuable experiences and courage of those facing the challenges of living with HIV in various aspects. Although it is difficult to reflect on one's own struggles, these experiences continue to affect emotions and overcoming them is not easy. This includes issues related to physical health, living with HIV, and coexisting with society for all groups of people living with HIV. Your experiences are valuable and meaningful, playing an essential role in driving policy change and fostering societal understanding to reduce stigma and discrimination.

We recognize the importance of collaboration among community organizations as part of the Thai People Living with HIV Stigma Index Task Force Committee, composed of community organizations working to address the issue of HIV/AIDS in Thailand. This collaboration is a crucial mechanism for advancing efforts and reaching key populations affected by HIV, which is vital for this work.

The People Living with HIV Stigma Index 2.0 could not have been successful without the participation, efforts, intellect, and dedication of many contributors, whose names are listed in the appendix. We also extend our gratitude to organizations that have supported this project, including UNAIDS, ICW, GNP+, and the Research Institute for Health Sciences at Chiang Mai University and Institute for Population and Social Research, Mahidol University who have provided support throughout the process. We hope that the data from this report will help reduce stigma and discrimination in Thailand.

The study and writing of this report were supported by the Global Fund through the Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health, and UNAIDS. France Government has been supportive of its dissemination through L'Initiative, a funding instrument operated by Expertise France to complement the work of the Global Fund to fight AIDS, Tuberculosis and Malaria.

Abbreviations and acronyms

AIDS	Acquired immunodeficiency syndrome
ANC	Antenatal care
ART	Antiretroviral therapy
ARV	Antiretroviral
CMU-RIHES	Chiang Mai University Research Institute for Health Sciences
DAS	Division of AIDS and STI
FAR	Foundation for AIDS Rights
GAM	Global AIDS Monitoring
GNP+	Global Network of People Living with HIV
HIV	Human immunodeficiency virus
ICW	International Community of Women Living with HIV
IOM	International Organization of Migration
IPPF	International Planned Parenthood Federation
LCR	Limited chain referral
MICS	Multiple Indicator Cluster Survey
PHI	Personal health information
PrEP	Pre-exposure prophylaxis
SRHR	Sexual and reproductive health and rights
TNP+	Thai Network of People Living with HIV/AIDS
TWLHF	Thai Women Living with HIV Foundation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
US CDC	U.S. Centers for Disease Control and Prevention
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
VBS	Venue-based sampling

Table of Contents

List of tables

List of figures

Key terms and definitions

People who use drugs	People who report using drugs at least once in their lifetime
Sex workers	People who report exchanging sex for money or goods at least once in their lifetime through any modality (such as internet, street and venue-based sex work)
Men who have sex with men	Men who self-identify as being gay or having sex with men at least once in their lifetime
Transgender people	People whose current gender identity differs from the gender they were assigned at birth
Young people	People aged 18-25 years are defined as "Youth" according to the definition from Thailand's Child Development and Youth Promotion Act, B.E. 2007 (Section 4), which specifies that "Youth" refers to individuals who are 18 to 25 years old.
Migrant workers	Migrant workers from Lao PDR, Myanmar and Cambodia
Kathoey	Transgender women

Executive Summary

The People Living with HIV Stigma Index 2.0 is research that uses a standardized tool to gather evidence on how stigma and discrimination impact the lives of people living with HIV. It is led by people living with HIV and is designed to be peer-led. It was developed to provide much-needed data and evidence that could be used to advocate for the rights of people living with and affected by HIV[1]. The first version of the People Living with HIV Stigma Index was implemented in 2009-2010 among 223 participants and was led by the Thai Network of People Living with HIV/AIDS (TNP+).

The study of the Stigma and Discrimination Index 2.0 in Thailand was led by the Thai Women Living with HIV Foundation and was conducted from August 2022 to January 2023. A total of 2,508 individuals living with HIV participated in the project. Among them, 895 participants were from four key population groups: 236 men who have sex with men, with data collected by the Caremat Foundation; 120 transgender individuals, with data collected by the Sister Foundation; 235 sex workers, with data collected by the Friends of Sex Workers Foundation; and 304 people who use drugs, with data collected by the Thailand Drug User Network. Additionally, 1,613 participants were from populations not classified as key populations. They consisted of 1,275 general individuals living with HIV and two specific sub-groups: 95 migrant workers, with data collected by the Rak Thai Foundation; and 243 youth, with data collected by the Little Birds Youth Network Foundation.

In addition to quantitative data collection and analysis, this study also conducted qualitative data collection and analysis. The participants were part of the quantitative survey, studying four key population groups: men who have sex with men; transgender individuals; sex workers; and people who use drugs. Three population groups significant in the Thai context were also included: youth; migrant workers; and women.

The purpose of the Stigma and Discrimination Index 2.0 study in Thailand was to explore the situation of stigma and discrimination faced by individuals living with HIV and to enhance their capacity for systematic data collection. The findings aim to empower individuals living with HIV to advocate for policy changes and public campaigns to reduce stigma and discrimination.

Thai People Living with HIV Stigma Index Task Force Committee was established to guide the recruitment process, liaise between the study team and the communities, interpret and disseminate findings, and carry out advocacy efforts. The committee was made up of leaders from communities of people living with HIV and key populations represented in the study. The committee collaborated with the Thai Women Living with HIV Foundation (TWLHF) and was engaged throughout the research process. A technical working group, comprised of academics from local universities and international agencies, assisted the task force committee on study design, data analysis, and report writing.

Study participants were people who self-reported that they were living with HIV and had been aware of their HIV status for at least 12 months, were over the age of 18 years, were mentally sound and capable of providing consent to participate, spoke Thai, Laos, Burmese or Cambodian, and were able to provide informed consent.

A total of 24 provinces from all 13 health regions were selected and participated. In all, 2,508 participants with a median age of 47 years were recruited through community venues, healthcare facilities, and

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[1] See https://www.stigmaindex.org for further details.

social networks. Of all participants, 47% (1,180) were born as males and 53% (1,328) were born as females. The proportions and numbers of participants according to specific population groups were as follows: men who have sex with men, 9% (236); transgender people, 5% (120); sex workers, 9% (235); people who use drugs, 12% (304); young people, 10% (243); and migrant workers, 4% (95).

The main findings of the People Living with HIV Stigma Index 2.0 in Thailand were that:

4. Approximately one-quarter (650/2,508) of participants had experienced stigma related to HIV in their community in their lifetime. Nearly 5% (118/2,508) reported experiencing it in the previous 12 months. This was higher among key populations: 10% (23/235) of sex workers; 8% (25/304) of people who use drugs; 8% (9/120) of transgender people; and 6% (14/236) of gay men and other men who have sex with men. Experiences of stigma related to sexual orientation were also reported: nine gay men and other men who have sex with men, one lesbian and two bisexual people reported this in the previous 12 months.
5. Of the 188 participants who reported experiencing stigma in the community in the previous 12 months, 22% had interrupted or discontinued antiretroviral therapy (ART) compared with 9% of participants who had not experienced stigma in the community in the previous 12 months.
6. A total of 16% of participants (393/2,508) reported experiencing discrimination in healthcare services within the past 12 months. Overall, there was no significant difference between males and females. However, the rate of reported discrimination was higher among transgender individuals (25%), sex workers (23%), and people who use drugs (19%). When broken down by gender, it was found that male sex workers (26%) experienced more discrimination in healthcare services in the past 12 months than female sex workers (18%). On the other hand, females who use drugs (21%) reported more discrimination in healthcare services over the past 12 months than males who use drugs (19%).
7. In all, 39% of participants experienced internalized stigma, as defined by GAM (feeling ashamed of living with HIV). Males had slightly higher levels of internalized stigma than females, at 40% and 38%, respectively. Additionally, three out of four participants (75%) found it difficult to disclose to others that they are living with HIV.
8. Many participants noted that fears of how others would respond if they tested positive made them hesitate to get an HIV test. However, the majority of participants (54%) responded that the time between when they thought they should first get an HIV test and when they actually took one was less than six months.
9. A total of 31% of participants reported effecting change and/or challenging stigma and showing resilience in the previous 12 months.

The report presents the main findings in greater detail as they relate to health and healthcare services, community, internalized stigma, human rights, and effecting change and resilience. It also includes a summary of the qualitative findings for specific key and other population groups – men who have sex with men, transgender people, people who use drugs, sex workers, young people, migrant workers, and women living with HIV.

Addressing and responding to stigma is not a simple process. The report concludes with recommendations, tailored to address different actionable drivers of stigma identified from this work, and are summarized as follows:

Improve public communication, family support and social engagement

General knowledge should increase so that people view HIV as a manageable chronic condition. Curate public messaging and normalize perceptions of HIV away from the fear and blame that was pervasive during the initial decades of the Thai HIV epidemic.

To achieve this, national and regional departments of health should enhance general knowledge about HIV and empathy for key population groups.

Strengthen the capacity of the healthcare workforce

Healthcare personnel, both HIV-related care providers and providers of other health services, should receive training on updated HIV care and treatment, as well as knowledge on human rights, sexual health rights, harm reduction, and person-centred mental healthcare.

Healthcare workers have a responsibility to maintain their skills and competencies and should be encouraged to seek out opportunities to bolster the quality of the services they provide and enhance knowledge and practices in relation to addressing bias and stigma and ensuring inclusivity in healthcare settings.

For students and early-career healthcare workers, awareness of diversity, equity, and inclusion within informative medical education should be strengthened. For example, universities and institutes and vocational training should promote up-to-date awareness about HIV and dispel myths, misconceptions, and misunderstandings about sexual orientation and gender diversity before healthcare workers graduate and start providing services.

Curriculums should be established that promote accurate comprehension of: the rights of people living with HIV; sexual health rights; fertility health; the rights of people with diverse sexual identities and groups of persons who are vulnerable to HIV; and laws relating to the promotion of rights to medical students, nurses, and other health professionals who are going to graduate and provide services in healthcare settings. These curriculums would reduce stigma and discrimination introduced by healthcare personnel.

Public and private institutions should accredit and offer in-service capacity-development opportunities to ensure that healthcare services are provided with an understanding and take a person-centred approach.

Improve the quality of healthcare and other services

Health systems policymakers, planners, and facility managers have a duty to ensure the best possible quality of care for their clients. Stigma and discrimination experienced in healthcare settings are particularly egregious as they negatively affect people when they are at their most vulnerable and seeking health services.

Recommended actions include tailoring healthcare services – and the competencies of healthcare providers – to meet the evolving health needs of diverse people living with HIV and strengthening “friendly” HIV and other services for young people. Monitoring progress and quality improvement and disaggregating and analysing data based on sex and gender identity, considering intersecting layers of identity and stigma, is important to ensure service quality that is free from discrimination.

Realize human rights in laws and policies

Thailand is a signatory to various human rights treaties, which are also reflected in the country's Constitution. The government of Thailand has a duty to protect the human dignity, rights, liberty, and equality of its people, including non-discrimination and progressive realization of the human right to the highest attainable standard of health.

There are existing laws and policies that need attention to create a more enabling environment for the HIV response in Thailand. The evidence from the findings of this research can help inform civil society efforts to ensure accountability and call for focused reform. It is the responsibility of duty bearers to provide for the rights of its people.

Recommended actions include repealing or reforming discriminatory policies that require HIV testing as a condition of new or continued employment and ensuring that HIV testing is voluntary in all circumstances. In addition, legal mechanisms to eliminate discriminatory practices and provide protection and remedies in cases of stigma and discrimination against various individuals, including transgender people and members of other key population groups, should be strengthened.

The Thai government should allocate enough and a continuous in-country budget to support HIV prevention and care programmes, particularly for the groups that are not supported by the Global Fund.

The government, including all relevant ministries, should allocate funding to support the HIV activities that are run by community organizations and non-governmental organizations that work on creating knowledge and understanding about HIV transmission, current effective care, and treatment of HIV that help people living with HIV to be healthy and live as equals with all people in society. The budget should be sufficient and continuous and it should be distributed to all target populations, including - but not limited to - key populations.

Respect and empower people living with HIV

Communities of people living with and most affected by HIV, including key population groups, often carry the responsibility to speak out and challenge stigma, as the people directly experiencing it. As such, the findings reflect the need for everyone to support and empower people living with HIV to know their rights and to demand them, for example, by ensuring and advocating for privacy and confidentiality.

In conclusion, the findings and process of conducting the People Living with HIV Stigma Index 2.0 in Thailand highlight the importance of context. Differences are evident in the findings across the regions of Thailand and also between groups and communities. For each individual who has experienced stigma or discrimination, the effects can be long-lasting. Therefore, even the findings reported that have been experienced by only a few individuals point to areas of concern and the need to ensure that appropriate services can address these concerns. As the recommendations suggest, efforts are needed to address and reduce social and structural determinants of stigma. It is hoped that the evidence presented in this report will be useful for policymakers, service providers, and communities to tailor such efforts.

1. Introduction

The People Living with HIV Stigma Index 2.0 study was conducted in Thailand from August 2022 to January 2023 and a qualitative study was undertaken in 2023. The study was led by the Thai Women Living with HIV Foundation (TWLHF) and supervised by the Thai People Living with HIV Stigma Index Task Force Committee. Communities led this research and will use the evidence to advocate for improved policies and practices to reduce stigma.

The People Living with HIV Stigma Index 2.0 is a standardized, peer-led research methodology designed to measure and document the experiences of stigma and discrimination faced by people living with HIV. It aims to understand and address the various forms of stigma to improve the quality of life and health outcomes for people living with HIV. The Stigma Index is designed and implemented by and for people living with HIV. In 2018, the questionnaire was updated (Stigma Index 2.0), and in 2020 a standardised methodology was launched to increase comparability between different contexts and across time. The process ensures that the information provided by participants is kept confidential and that their anonymity is protected. It empowers people living with HIV by involving them in the research process, thereby enhancing their skills and knowledge.

The findings are used to raise awareness, challenge stigma and discrimination, and promote policy and programmatic changes that improve the lives of people living with HIV. The process engages with the broader community, including healthcare providers, policymakers, and civil society organizations, to foster a supportive environment for people living with HIV and address stigma and discrimination at various levels.

The Thai People Living with HIV Stigma Index Task Force Committee

The Stigma Index 2.0 had to represent a diverse range of experiences, including intersectional stigma experienced by people of diverse gender identities, sexual orientations, ages and occupations. To ensure that it did so, the study team assembled the 19-member Thai People Living with HIV Stigma Index Task Force Committee to collaborate and monitor the implementation of the study. The committee was made up of leaders from communities of people living with HIV and key populations represented in the study (that is, men who have sex with men, sex workers, young people aged 18-24 years, transgender people, people who use drugs, and migrant workers). The committee was engaged throughout the research process and collaborated with TWLHF, which shares ownership of the Stigma Index 2.0. The task force's complete list of participating organizations is displayed in the appendix.

The Thai People Living with HIV Stigma Index Task Force Committee guided the recruitment process, liaised between the study team and the communities that members represent (to understand community perceptions of the study and relay feedback to the study team), interpreted and disseminated findings, and upon completion of the study, carried out advocacy efforts based on study findings.

Technical assistant working group

A technical working group comprised of academics from local universities and international agencies assisted on the design of the study, data collection, data analysis, and reporting. The appendix lists all the organizations that provided the technical support.

HIV context in Thailand

Thailand's successful implementation of key policies and strategies to prevent HIV has led to significant reductions in HIV acquisitions and AIDS-related deaths. However, progress is still needed to reach the 95-95-95 Global AIDS Strategy testing and treatment targets by 2025. In 2022, an estimated 560,000 adults (men 58%, women 42%) aged 15 and over were living with HIV in Thailand, representing just over 1% of the population. An estimated 9,200 people acquired HIV, with nearly half of these (4,400) aged 15-24, and there were approximately 11,000 AIDS-related deaths. Among people living with HIV, 90% knew their status, 81% were on treatment, and 79% were virally suppressed[2].

The HIV epidemic is concentrated among certain key populations (men who have sex with men, sex workers, transgender people, and people who use drugs) in Thailand; prevalence among men who have sex with men is estimated at 12% and among transwomen at 11%. Access to HIV services remains suboptimal for these populations, with Joint United Nations Programme on HIV/AIDS (UNAIDS) data estimating coverage of HIV prevention programmes to be approximately 50% among men who have sex with men and 44% among transgender people[3]. UNAIDS estimates that 68% of transgender people, 57% of sex workers, 53% of men who have sex with men, and 38% of people who inject drugs have tested for HIV and are aware of their status[4]. Stigma and discrimination remain significant barriers to improving access to HIV services for these populations.

Stigma and discrimination towards people living with HIV in Thailand

Decreasing stigma and discrimination has been a priority of Thailand's national HIV strategy, which people living with HIV have been involved in developing since 2014. However, stigma and discrimination towards people living with HIV persist. The 6th National Health Examination Survey, carried out in 2019-20, showed that 49% of people aged 20-59 years in Thailand held discriminatory attitudes towards people living with HIV[5]. This is a decrease from 2013-14 when the 5th National Health Examination Survey

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[2] UNAIDS (2023). UNAIDS DATA 2023. Available at: https://www.unaids.org/sites/default/files/media_asset/data-book-2023_en.pdf [Accessed 12 March 2024].

[3] Ibid.

[4] Ibid.

[5] Chautrakarn S, Ong-Artborirak P, Naksen W, Thongprachum A, Wungrath J, Chariyalertsak S, et al. (2023). Stigmatizing and discriminatory attitudes toward people living with HIV/AIDS (PLWHA) among general adult population: the results from the 6th Thai National Health Examination Survey (NHES VI). J Glob Health; 13.

found that 59% held discriminatory attitudes[6], but it remains concerning. In the most recent survey, 41% reported that they felt too disgusted to buy fresh food or ready-to-eat food from a shopkeeper or vendor whom they knew was living with HIV or AIDS, and 28% agreed with the statement that they would be ashamed if someone in their family was living with HIV or AIDS. The survey also highlighted misconceptions about HIV transmission, with 54% fearing that they could acquire HIV if they came into contact with the saliva of a person living with HIV[7].

Stigmatizing attitudes towards people living with HIV are also found in healthcare facilities. A study of more than 3,000 Thai healthcare personnel, clinical as well as non-clinical, found that more than half (52%) disagreed with the statement that women living with HIV should be allowed to have babies if they wished, and 48% believed that people acquired HIV because they engaged in irresponsible or immoral behaviours. Stigmatizing attitudes towards people living with HIV were lower among healthcare personnel whose main responsibilities were HIV and AIDS[8].

The general population in Thailand has been found to have discriminatory attitudes towards individuals living with HIV, as shown in the latest results of the Thailand Multiple Indicator Cluster Survey (MICS). In a 2016 survey, 24.5% of men and 27.5% of women reported having discriminatory attitudes toward people living with HIV[9]. The results of the MICS in 2019 were nearly identical, with 24.1% of men and 27.7% of women reporting these attitudes[10]. The 2022 survey showed an increase in discriminatory attitudes towards individuals living with HIV among men, from 24.1% to 28.4%, but a slight decline among women (27.7% to 26.7%)[11]. The data also highlight the pressing necessity to confront the gender and power dynamics inherent in HIV-related stigma. Overlapping stigma associated with HIV status, gender, sexual orientation, drug use, migrant status, and/or sex work contributes to delayed decisions regarding HIV testing and treatment, leading to a gradual decrease in new acquisitions among key populations.

Research from Thailand shows the negative effects of stigma on HIV service uptake, as well as quality of life. Several studies have documented social stigma surrounding pre-exposure prophylaxis (PrEP). One study of PrEP users from hospitals and key population-led health services found that 45% of clients in hospitals agreed that PrEP users are often viewed negatively by society (notably, this percentage was lower in key population-led health services, at 18%)[12]. Other qualitative studies have supported these findings. A study among transwomen listed social stigma as one of the barriers to PrEP uptake[13]. Another study among young cisgender men and transwomen who sell/trade sex in Thailand found reluctance

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6 Srithanaviboonchai K, Chariyalertsak S, Nontarak J, Assanangkornchai S, Kessomboon P, Putwatana P, et al. (2017) Stigmatizing attitudes toward people living with HIV among general adult Thai population: Results from the 5th Thai National Health Examination Survey (NHES). PLoS ONE 12 (11): e0187231.

7 Chautrakarn S et al. (2023). 6th Thai National Health Examination Survey (footnote 3).

8 Srithanaviboonchai K, Khemngern P, Chuayen J, Siraprapasiri T (2021). Increased Work Experience Associated with Less Stigmatizing Attitudes towards people living with HIV among Thai Healthcare Personnel. Int. J. Environ. Res. Public Health; 18.

9 National Statistical Office and United Nations Children's Fund, 2016.

10 National Statistical Office of Thailand, 2020.

11 (National Statistical Office of Thailand, 2023.

12 Chautrakarn S, Rayanakorn A, Intawong K, Chariyalertsak C, Khemngern P, Stonington S and Chariyalertsak S (2022) PrEP stigma among current and non-current PrEP users in Thailand: A comparison between hospital and key population-led health service settings. Front. Public Health 10:1019553.

13 Janamnuaysook R, Guo Y, Yu YJ, Phanuphak N, Kawichai S, MacDonell K et al. (2024). Lived experiences with pre-exposure prophylaxis uptake and adherence among transgender women in Thailand: a qualitative study. Sexual Health, 21(1).

to seek HIV care due to the stigma of being seen accessing HIV-related services[14]. Additionally, studies have found HIV-related stigma linked to depression[15] and negative self-image[16].

Several studies from Thailand have also documented stigma and discrimination towards key populations. A recent qualitative study among Thai transwomen living with HIV reported various forms of verbal and physical harassment, as well as internalized stigma[17]. Another qualitative study showed similar findings of transwomen in Thailand with intersecting identities, including ethnic minorities and sex workers, who reported experiencing discrimination when accessing healthcare, such as humiliation and restrictions of rights[18]. When it comes to men who have sex with men, UNAIDS estimates that nearly 10% avoid seeking healthcare due to stigma and discrimination[19].

People Living with HIV Stigma Index study in Thailand

The first Stigma Index study in Thailand was conducted between February 2009 and January 2010[20]. The project was implemented by the Foundation for AIDS Rights (FAR), together with the Thai Network of People Living with HIV/AIDS (TNP+). The 2009-2010 study found that stigma and discrimination were prevalent and occurred in a range of sectors, including the workplace, schools, community, and healthcare facilities. Of the 223 people living with HIV interviewed, 32% had lost their job or other form of income over the previous 12 months. HIV also directly influenced participants' ability to secure housing, with 15% reporting that they were forced to move or were unable to rent accommodation in the previous 12 months due to their HIV status.

The 2009-2010 Stigma Index revealed that 26% of people living with HIV had been excluded from attending a social event, such as a wedding, funeral, or party, and 12% had been excluded from cooking or eating with their family. The study also found that 20% of participants were denied health services, and 20% reported discriminatory reactions of health service providers upon discovering the

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[14] Truong JM, Chemnasiri T, Wirtz AL, Mon SHH, Varangrat A, Decker M et al. (2022) Diverse contexts and social factors among young cisgender men and transgender women who sell or trade sex in Bangkok and Pattaya, Thailand: formative research for a PrEP program implementation study, AIDS Care, 34:11, 1443-1451.

[15] Srithanaviboonchai K, Uthis P, Suktrakul S, Wiwatwongnawa R, Tangmunkongvorakul A, Wannachaiyakul S, Sripan P (2022). Association between Internalized Stigma and Depression among people living with HIV in Thailand. Int. J. Environ. Res. Public Health, 19,4471. See also Aurpibul, L, Tangmunkongvorakul A, Jirattikorn A, Ayuttacorn A, Musumari PM, Srithanaviboonchai K. (2022). Depressive symptoms, HIV disclosure, and HIV-related stigma among migrant workers living with HIV in Chiang Mai, Thailand. AIDS Care, 34(12), 1565–1571.

[16] Rayanakorn A, Ong-artborirak P, Ademi Z, Chariyalertsak S (2022). Predictors of Stigma and Health-Related Quality of Life Among people living with HIV in Northern Thailand. AIDS PATIENT CARE and STDs; 36(5), 186-193.

[17] De Lind Van Wijngaarden, J. W., & Fongkaew, K. (2021). "Being Born like This, I Have No Right to Make Anybody Listen to Me": Understanding Different Forms of Stigma among Thai Transgender Women Living with HIV in Thailand. Journal of Homosexuality, 68(14), 2533–2550.

[18] Srikummoon, P, Thanutan Y, Manojai N, Prasitwattanaseree S, Boonyapisomparn N, Kummaraka U et al. (2022). Discrimination against and Associated Stigma Experienced by Transgender Women with Intersectional Identities in Thailand. International Journal of Environmental Research and Public Health, 19(24), 16532.

[19] UNAIDS (2023) UNAIDS DATA 2023 (footnote 1).

[20] Thai Network of people living with HIV/AIDS (2010). Index of Stigma and Discrimination against people living with HIV/AIDS in Thailand. Available at: https://www.stigmaindex.org/wp-content/uploads/2022/04/Thailand-SI-Report-2010_QtExcluded.pdf.

participant's HIV status. People living with HIV in Thailand also reported high levels of internalized stigma manifesting as shame, guilt, and low self-esteem. Because of this, many people living with HIV avoided clinics and hospitals despite needing medical services.

It has been 13 years since the first Stigma Index study was conducted in the country. With improving HIV prevention and treatment strategies and evolving socioeconomic circumstances around HIV, a follow-up Stigma Index study was needed for Thailand. According to the recent Global AIDS Monitoring (GAM) guideline, the country also requires study data from the People Living with HIV Stigma Index to report to UNAIDS.

Background and rationale for the study

The UNAIDS Thailand office, through the Global Fund, provided support for the Thai Women Living with HIV Foundation (TWLHF) to conduct this study as part of a broader UNAIDS global mandate to use the findings to inform HIV programming priorities as the global and national HIV responses entered new phases of strategic planning and resource prioritization. Conducting the People Living with HIV Stigma Index 2.0 is in accordance with Strategy 4 of the Thailand National Strategy to End AIDS 2017-30: "***Adjust HIV perceptions and build capacity of individuals, families and communities along with strengthening a rights protection mechanism.***" The results of this study have been and will continue to be used to tailor the activities of the Costed National Work Plan to Reduce all Kinds of Stigma and Discrimination Related to HIV/AIDS 2021-25.

The goal of this study is to broaden understanding of the extent and forms of stigma and discrimination faced by people living with HIV and key populations living with HIV and use the findings to improve programmes and policies to achieve universal access to HIV prevention, treatment, care, and support.

2. Methodology

The Thailand People Living with HIV Stigma Index 2.0 study was designed and conducted according to the four core non-negotiable principles of Stigma Index:

1. The study must be led by networks of people living with HIV.
2. Implementation must follow the standardized methodology provided by the International People Living with HIV Stigma Index Partnership.
3. The study sample must be inclusive of all sub-populations of people living with HIV.
4. Implementation can only continue upon approval of the research protocol from the International People Living with HIV Stigma Index Partnership.

The TWLHF led the development of the study protocol under the supervision of the Thai People Living with HIV Stigma Index Task Force Committee. Academics of Chiang Mai University and Mahidol University assisted on the technical aspects of protocol development.

2.1 Study Design

This mixed methods study comprised a cross-sectional quantitative survey and a qualitative study. The study began with a quantitative survey using the People Living with HIV Stigma Index 2.0 questionnaire. The qualitative study was conducted among key population groups after the completion of the quantitative study. The interview guides used in the qualitative study were developed from the preliminary findings of the quantitative data.

The organizations leading the recruitment of specific populations are as follows: CAREMAT Foundation for men who have sex with men; Sisters Foundation for transgender people; Service Workers in Group for sex workers; Thai Drug User's Network for people who use drugs; Raks Thai Foundation for migrant workers; and Little Birds Youth Network Foundation for young people.

A nested qualitative study was undertaken with individual in-depth interviews with key informants from six population groups: men who have sex with men; transgender people; sex workers; people who use drugs; migrant workers; and young people. The in-depth interviews covered participants' basic information, disclosure status of living with HIV, experiences of stigma and discrimination, coping strategies, self-perception and self-esteem, healthcare utilization experiences, human rights, experiences of rights violations, experiences of stigma and discrimination beyond HIV status, and attitudes or perspectives on living with HIV. The interviews were transcribed word-for-word and supplemented with brief field notes taken by the interviewer after each interview. These data were then organized using an Excel spreadsheet and processed using thematic analysis. A separate report has been produced that outlines the methods and detailed findings from this qualitative study[21]. Where relevant, references to the findings have been included in the discussion section at the end of this report.

The Thai Women Living with HIV Foundation conducted a second qualitative study alongside the Stigma Index 2.0. The data collection methods used were in-depth interviews and focus group discussions. In addition, a detailed gender analysis taking an intersectional approach was undertaken to uncover overlapping experiences of stigma and discrimination across genders and/or associated with other identities. The study was undertaken to acknowledge all forms of stigma and discrimination related to sexual and reproductive health and rights (SRHR) and violence against women faced by Thai women living with HIV. The intention was to add to the findings from the Stigma Index 2.0 to develop HIV prevention policies and implementation guidelines to reduce stigma and discrimination experienced by women and girls living with HIV. A separate report has been produced that outlines the methods and detailed findings from this qualitative study[22]. Where relevant, references to the findings have been included in the discussion section at the end of this report.

An in-depth gender analysis was undertaken to uncover the overlapping discrimination faced by individuals living with HIV across various genders, as well as other marginalized identities.[23] The gender analysis adopted an intersectionality lens to explore how gender intersects with other marginalities, shaping diverse experiences of HIV stigma and discrimination across various population groups. It

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[21] A Qualitative Study of Stigma and Discrimination among 6 Key Population Groups living with HIV in Thailand. Draft 6 January 2024. [Ref needed in full @ Dr Arunrat]

[22] Thai Women Living with HIV Foundation (in draft). HIV/AIDS Stigma and Discrimination Against Thai Women Living with HIV (A Qualitative Study). Draft 9 Jan, 2024.

[23] Thailand: Gender Dynamics and Intersectionality in HIV Stigma Index 2.0. Report prepared by Suchada Thaweesit and Pennapa Saenkla, Mahidol University, Institute for Population and Social Research, 12 April 2024.

illuminated how such factors as sex characteristics, sexual orientation, health status, ethnicity, age, and behaviours intersect with gender and overlap with experiences of stigma, discrimination, resilience, health status, access to treatment, treatment adherence, human rights violations, responses to such violations, and engagement in efforts for change.

Participants' gender identities were categorized into four groups: cisgender women; cisgender men; transgender individuals; and non-binary individuals or those preferring not to identify their gender. Transgender individuals were further divided into two sub-categories: transwomen and transmen. This classification was based on the self-identified sex and gender provided by participants during their interviews[24]. By utilizing the terms, "cisgender men" and "cisgender women", this report acknowledges potential criticism regarding the essentialization of gender identity and the reinforcement of binary systems. However, it recognizes the diversities and fluidity within gender categories and aims to promote inclusivity and a broader understanding of gender diversity, distinguishing between cisgender and transgender individuals. Where relevant, reference to the findings has been included in the results and discussion sections of this report.

The remaining details in this section focus on the methods used for the Stigma Index 2.0.

2.2 Selection of Study Provinces

Thailand is geographically divided into 13 health regions and 76 provinces. The goal was to have at least one participating province in each of the 13 health regions. Participating provinces had to have active people living with HIV networks to help coordinate the survey and conduct data collection. Altogether, the participating provinces had to cover at least 50% of the total estimated number of people living with HIV in the country. Sample sizes for each health region would then be proportional to the size of the population of people living with HIV in the country.

To achieve the goal, these steps were followed to select the provinces and distribute the number of samples across the sites:

1. The study team found the latest numbers of estimated people living with HIV for each province, each health region, and the whole country.
2. It identified the provinces that had active networks of people living with HIV.
3. For each health region, it identified the provinces with the highest estimated number of people living with HIV and which had active networks of people living with HIV.

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[24] In the Stigma Index, two key questions are analysed to differentiate gender categories: question no. 2, which pertains to biological sex; and question no. 3, which relates to gender identity. In this report, cisgender women are defined as individuals who were assigned female sex at birth and who adhere to societal norms related to gender and/or sexual identity. Cisgender men are characterized as individuals assigned male at birth whose gender and/or sexual identity aligns with prevailing norms of sex/gender heteronormativity. For transgender persons: transwomen are individuals assigned male at birth, but their gender and sexual identity may diverge from the norms of sex/gender heteronormativity; and transmen are individuals assigned female at birth, but their gender and sexual identity may not correspond with their assigned sex. Non-binary individuals are those who do not strictly identify themselves as male or female, but may feel like a combination of genders or perceive themselves as having no gender at all.

4. The team added the provinces to the list, starting with the province with the highest estimated number of people living with HIV until the participating provinces covered at least 50% of people living with HIV in the country.
5. The team also included provinces in some health regions where there were active networks of people living with HIV. This was to promote the research and management skills of their peers, as well as to improve the representativeness of the provincial sites.

Finally, 24 provinces from all 13 health regions were selected and participated in the study.

2.3 Sample Size Estimation

To determine the appropriate sample sizes for the quantitative study of People Living with HIV Stigma Index Survey in Thailand, the team followed these steps:

Stage 1. Total sample size calculation

The sample size for the study was calculated using the online guidance on the People Living with HIV Stigma Index 2.0 sample size calculator.

The following indicators were used to estimate the sample size:

- Estimated prevalence of HIV = 17%
  This estimate was derived from the observed prevalence in the target population.
- Prevalence of healthcare avoidance due to stigma = 8.6%

According to the 2019 national surveillance of HIV-related stigma and discrimination in healthcare settings, 8.6% of participants avoided or delayed needed healthcare in the previous 12 months. This figure was doubled (8.6*2 = 17.2), in line with the recommendations for studies where all participants are recruited from healthcare facilities.

- Target precision = 0.03
  A precision level of 3% was selected, based on the recommendation that for estimating a prevalence between 10-20%, the target precision should be within the range of 3-5%.
- Confidence level = 95%
  A 95% confidence level was applied to ensure a high degree of certainty in the sample estimate.

Total calculated sample size = 2,432. To ensure adequate representation and account for any potential non-response or data loss, the sample size was rounded up to 2,500 participants.

Eligibility to participate in the Stigma Index 2.0 Survey was defined as follows:

Inclusion criteria:

- Aged 18 years or above
- Be aware of their status as people living with HIV for at least 12 months
- Are mentally sound and capable of providing informed consent to participate

- Had provided informed consent to participate and understand all elements of the study
- Speak Thai or Laos, Burmese or Cambodian for migrant workers from Lao PDR, Myanmar or Cambodia, respectively

Exclusion criteria:

- Physically or mentally unable to participate at the time of appointment
- Have already participated in the current study
- Key populations **not** living with HIV

Stage 2. Sample size of each province

Sample sizes for each health region were proportional to the size of the population of all people living with HIV in the country. For the health regions that had more than one participating province (1, 4, 5, 6, 10, 11, and 12), sample sizes for each province were proportional to the size of summation of the number of people living with HIV in the provinces participating in the study. In total, the participating provinces accounted for 55.7% of the country's estimated number of people living with HIV.

Table 1. Participating provinces by health region and sample size

Health region	No.	Province	Number of people living with HIV in the province	Number of people living with HIV in the health region	The percentage of people living with HIV in the health region proportional to the whole country (%)	Sample size for the whole region	Designed sample size for each province
1	1	Chiang Mai	18,284	54,398	12	299	139
	2	Chiang Rai	15,799				120
	3	Phayao	5,432				40
2	4	Phitsanulok	6,537	19,381	4	107	107
3	5	Nakhon Sawarn	5,914	15,188	3	84	84
4	6	Nakhon Nayok	1,528	39,901	9	220	53
	7	Lopburi	4,824				167
5	8	Ratchaburi	5,482	36,137	8	199	103
	9	Kanchanaburi	5,129				96
6	10	Chonburi	18,551	56,890	13	313	149
	11	Chantaburi	5,339				43
	12	Trad	2,373				19
	13	Rayong	9,041				73
	14	Chachoengsao	3,653				29
7	15	Khon Kaen	11,987	27,239	6	150	150
8	16	Udon Thani	8,772	25,571	6	141	141
9	17	Chiyaphum	4,719	28,656	6	158	158
10	18	Ubon Ratchathani	7,889	18,183	4	100	61
	19	Srisaket	5,100				39
11	20	Suratthani	7,982	29,293	6	161	73
	21	Nakhon Sri Thammarat	8,429				78
	22	Ranong	1,090				10
12	23	Songkhla	8,379	25,164	6	139	105
	24	Phatthalung	2,678				34
13	25	Bangkok	77,991	77,991	17	429	429
Total			252,902	453,992	100	2,500	2,500

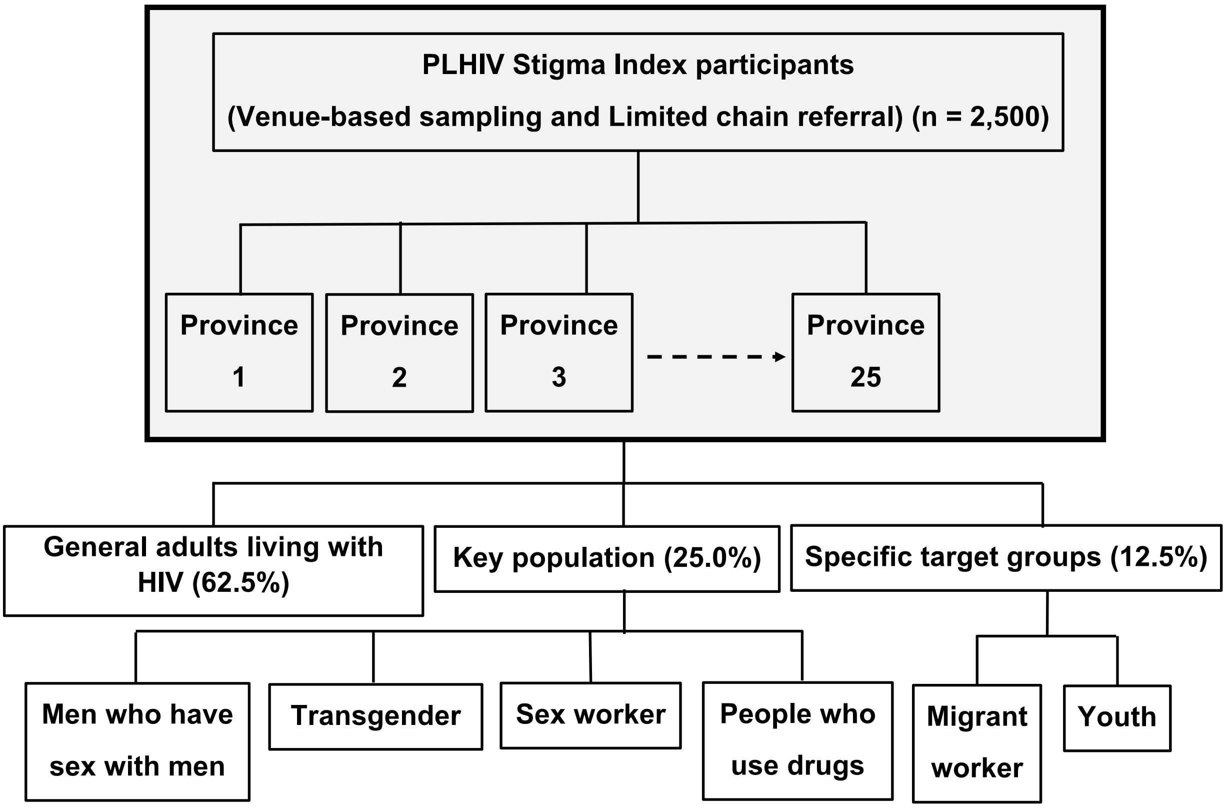
Stage 2. Sample size across sub-populations of people living with HIV

In addition to distributing samples across all regions of the country, the study team recruited participants from all important sub-groups of people living with HIV. This would help improve representativeness of the variety of people living with HIV in Thailand and help increase the generalizability of the survey results.

Besides the general adult population of people living with HIV, the study team determined six unreached groups of people living with HIV. These were four key population groups (men who have sex with men, transgender people, people who use drugs, and sex workers) and two specific target groups (migrant workers and young people). The two target groups were intentionally added due to their significance in the local Thai context.

According to the recommendation by the International People Living with HIV Stigma Index Partnership, the sample size of people from key populations would have to be at least 25% of the total sample size. To comply with this recommendation, the study planned to recruit 625 people (25% of total sample size) from four key populations (25% of total sample size). As there are two specific target groups, we planned to recruit 313 migrant workers and young people (12.5% of total sample size). As a result, 1,562 samples (62.5% of the overall sample size) remained and would be drawn from the general population of adults living with HIV (Figure 1).

Figure 1. Distribution of study participants



PLHIV Stigma Index participants
(Venue-based sampling and Limited chain referral) (n = 2,500)

Province 1 | Province 2 | Province 3 | Province 25

General adults living with HIV (62.5%)

Key population (25.0%)

Specific target groups (12.5%)

Men who have sex with men | Transgender | Sex worker | People who use drugs

Migrant worker | Youth

2.4 Sampling Strategy and Recruitment

In February 2020, the International Partnership of the People Living with HIV Stigma Index released a global sampling strategy framework to ensure the comparability of Stigma Index 2.0 data across countries and time points. This global framework proposed the combined use of two strategies: venue-based sampling (VBS), also referred to as "time location sampling"; and limited chain referral (LCR). This two-tiered sampling strategy was designed to capture the diverse and intersectional experiences of stigma more adequately from people living with HIV across all key populations and to ensure the inclusion of people living with HIV across the care continuum, including people who may not be accessing care.

All participants were recruited from the 24 target provinces. The general population of adults living with HIV, key populations, and specific target groups participants were recruited through VBS or LCR.

2.4.1 Venue-based sampling and recruitment

The VBS approach included:

- Conducting formative work to systematically map the universe of venues attended by people living with HIV in each province
- Proportionally recruiting participants at each venue

To schedule the interviews, the interviewers communicated with potential participants in a group setting by providing initial information on the day they came to receive services at the hospitals. After that, coordination was done via phone or chat programs to explain the research objectives. Once they understood, the data collector scheduled a date, time, and place for the interview. To ensure the inclusion of people living with HIV who were not accessing healthcare, venues included traditional HIV treatment facilities and other spaces where people living with HIV might socialize, seek support, or access other services, such as drop-in centres, support groups, social gathering spaces, hotspots for meeting sexual partners, and faith-based venues.

VBS included the following steps:

Formative work: Venue identification and selection	1.	Study staff and the Thai People Living with HIV Stigma Index Task Force Committee members created a list of known venues and people living with HIV services, as well as possible key informants in each province based on existing knowledge.
	2.	Key informants were interviewed and asked to provide names of all local venues frequented by people living with HIV in their province; key informants also nominated other key informants.
	3.	Key informant interviews were continued until saturation of information about the venues had been reached.
	4.	Data collectors synthesized and de-duplicated the list of venue names.
	5.	Data collectors visited each venue listed and filled in a "venue assessment form".
	6.	Eligible venues were chosen as study sites.

Stigma Index 2.0 data collection	7.	Data collectors set proportional recruitment targets at each site.
	8.	Data collectors visited each study site and recruited participants for the Stigma Index 2.0 study until the target sample size was reached.

2.4.2 Limited chain-referral sampling and recruitment

Potential participants for the study who were less likely to be contacted using VBS, such as people who were not receiving HIV care or members of key populations and specific target groups, were recruited using the LCR method. Seed participants who had participated in the study and were closely linked to the populations that the study was attempting to target were identified and offered three to six business cards to pass on to contacts they believed might be eligible and interested in participating; to ensure diversity of the sample, each seed participant was limited to referring not more than six people. No financial incentive was offered for the recruitment of other participants. Business cards were not tracked or coded; the only information on the business cards was the study contact information.

The study team aimed to recruit about 70% of the overall sample through venue-based time location sampling and 30% through limited chain referral. Enrolment and interview data were tracked on a biweekly basis to identify representation of different affected populations. Adjustments to the sampling strategy were made to increase recruitment of underrepresented populations.

2.4.3 Qualitative participant sampling and recruitment

To obtain unique and different perspectives on discriminatory experiences of people living with HIV, key informants were purposively selected from six groups: men who have sex with men; transgender individuals; sex workers; people who use drugs; cross-border migrant workers; and young people. The participants in the qualitative study were purposively selected from the quantitative study participants. Qualitative study participants were diverse in terms of age, gender, socioeconomic status, and experience related to stigma and discrimination. Thirty people living with HIV from each group (180 in total) were selected for in-depth interviews, depending on the saturation of information received.

In addition, the Thai Women Living with HIV Foundation undertook a qualitative study with 36 women living with HIV in three focus groups in three provinces; another 17 women living with HIV were interviewed in depth. Each focus group consisted of 11-14 participants – Chiang Mai (11), Lop Buri (11) and Nakhon Sri Thammarat (14) – from 17 July to 30 September 2023[25].

2.5 Instruments

2.5.1 Stigma Index 2.0 questionnaire

The Thai People Living with HIV Stigma Index quantitative survey used the standard People Living with HIV Stigma Index 2.0 questionnaire provided by the International People Living with HIV Stigma Index Partnership. The technical team translated the questionnaire into Thai and consulted the Thai

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[25] See HIV/AIDS Stigma and Discrimination Against Thai Women Living with HIV (A Qualitative Study), by Thai Women Living with HIV Foundation. First draft 9 January 2024.

People Living with HIV Stigma Task Force to modify words and language for the Thai context while staying true to the original content. The questionnaire was then translated back into English to detect inconsistencies with the original version.

2.5.2 Qualitative study interview guides

The qualitative study interview guides were developed according to the preliminary results of the quantitative survey. There were six versions of the interview guides, one for each distinct population group. The content of the first part of the interview guidelines was all the same; however, the content of the second part varied depending on the circumstances of each group.

2.6 Training

All eight field coordinators and 54 interviewers were people living with HIV and represented four key populations, young people and migrant workers. The key members of the provincial networks of people living with HIV who had already revealed their HIV status to the public were potential staff. They were asked to join the team and then choose to participate voluntarily. They were then provided with training at a three-day on-site workshop in Bangkok (18 to 20 July 2022). This met the requirements of the Stigma Index study and was in line with the project goal of improving the research capacity of community members.

The Technical Advisors and Programmer/Data Manager supported TWLHF to provide training for the project staff. The objectives of this training were to make sure that the project staff understood the concepts and significance of the Stigma Index and were able to carry out the interviews using the Stigma Index questionnaire and the interview guides for the qualitative aspect. The trainee/project staff who made up the interviewer team also had a chance to give feedback on the language used and to modify the approach so that it could be better understood in local contexts. Other suggestions included having the survey in paper format (where the internet was not available, such as in mountainous and remote areas) and translating a version into Shan (a local language) for migrant populations. Towards the end of the workshop, the team also had an opportunity to do initial planning for data collection.

The training content included the premises and uses of quantitative and qualitative research, study designs, data collection process (including using the digital data collection tool, REDCap), ethical considerations, gender awareness, and human rights, dealing with difficult emotional and/or unexpected situations, referring people for counselling or further sources of advice and information data management, QA/QC procedures, and details of the Stigma Index questionnaire.

In addition, selected interviewers from the six population groups were trained in qualitative research. This included interview techniques, field notes techniques, transcribing the conversation, qualitative data analysis, and qualitative research report writing.

2.7 Eligibility Screening

For the quantitative study, participants were asked to complete a brief face-to-face screening procedure to determine their eligibility. Prior to asking any screening questions, the interviewer briefly described the purpose of the study, the types of screening questions that would be asked, any risks and benefits of participating in the screening, and the voluntary nature of the screening procedure. During the interview, participants could request copies of the information sheet that was prepared. The participant was asked to provide verbal consent to participate and, if provided, the interviewer marked the electronic screening form to indicate that consent was obtained and then proceeded to verbally ask the screening questions. The interviewer recorded participant responses via a brief electronic screening survey. Only the participant ID – comprised of three components: country, province and evaluation ID, not their name – was recorded on this electronic form.

The screening questionnaire and eligibility criteria, including age, relied entirely on self-reporting; participants were asked to provide information that included the number of months or years since HIV diagnosis and to self-identify if they were a member of a key population. In addition to confirming participant eligibility, the Data Coordinator used screening data to monitor recruitment quotas for key populations and inform recruitment efforts and strategies.

2.8 Study Visit Procedures

Once a participant's eligibility was verified, they were enrolled and proceeded with a one-time study visit. This visit consisted of: 1) an informed consent process; 2) collection of contact details; 3) Stigma Index study data collection; 4) referrals; and 5) incentives. Study visits were conducted where it was private and comfortable for the interviewees to do so; venues visited included government hospitals, drop-in centres, temples and churches, and cafés.

2.8.1 Informed consent process

Each participant met with a trained study staff member in a private room to go over the information sheet and an informed consent form. The interviewer reviewed the consent form with the participant and gave the participant the opportunity to read the form and ask any questions. The participant was asked to provide written consent by signing the form with their name or initials. If they wanted, participants could keep a paper copy of the information sheet. The consent of the qualitative study participants was gathered in the same way, except for the screening process.

2.8.2 Contact form

Once a participant's eligibility had been confirmed and they had consented to participate in the Stigma Index study, they were asked to complete a brief contact form electronically via REDCap, including preferred name and pronouns, contact details, and the province where they normally accessed healthcare services. The actual names of the participants were not included in the contact forms. The interviewers were instructed to create separate Excel files to link the study database and contact information if needed. Information in these link files included the date and time of interviews, preferred name, and study ID. They were also asked whether they consented to be contacted in the future and what their preferred method of communication was.

This contact form was used to ensure that each participant was unique (so that there were no duplicate participants enrolled in the study) and to allow the study team to contact participants if needed, for example, to provide information on referrals. The contact forms were stored in a password-protected electronic REDCap database.

2.8.3 Quantitative data collection

Each interview was conducted in a private room and completed on a tablet using REDCap. A trained interviewer read the questions and response options to each participant and entered the answers on a smart device on behalf of the participant. Due to the length of the questionnaire, participants could take breaks whenever they chose throughout the interview. The average interview was around 40 minutes.

The Global People Living with HIV Stigma Index 2.0 questionnaire collects data on several domains, including:

- Demographics
- Disclosure of HIV status to friends, family members, colleagues, and peers
- Experience of stigma and discrimination
- Internalized stigma and resilience
- Interactions with healthcare services
- Human rights and effecting change
- Stigma and discrimination experienced for reasons other than HIV status

The interviews were primarily quantitative in nature; however, participants had the option of providing a qualitative narrative describing their experiences at the end of the study via an open-ended note page.

2.8.4 Qualitative data collection

In-depth interviews, conducted in a private place, were used for qualitative data collection. The conversation was digitally recorded upon the consent of the participant. A person living with HIV, trained as an interviewer and with gender and nationality matched if possible, asked each participant the open-ended questions listed in the interview guides. Other issues were probed according to the answers given by the participants. The investigators developed the interview guides used in the qualitative study using preliminary results collected from the Stigma Index 2.0 quantitative study. Each group's interview guide was unique from the others. The core questions in the interview guides were the same. Particular questions were included in the interview guides to address issues raised by specific key population groups.

2.8.5 Referrals

The TWLHF, the Thai People Living with HIV Stigma Index Task Force Committee, and the advisory committee came up with lists of relevant national services. The data collectors worked locally in each province in the months preceding data collection to identify appropriate resources. The completed referral sheet was submitted to the regional team leader for review and approval. One uniform template was created for each province and provided to participants from that area. At the time of the interview, participants were provided with an information sheet with a list of local and national services and contact details.

2.8.6 Incentive

All participants (venue-based, limited chain referral and qualitative) were provided with 300 baht (approximately USD 9) for their participation.

2.9 Data Management

2.9.1 Data quality

There were two levels of quality control for data collected during the Stigma Index survey:

1. The questionnaire was programmed in REDCap with skip patterns to reduce participant burden and fatigue and forced responses (with the option to elect "prefer not to answer") to prevent overlooking questions or accidentally missing data.
2. On a regular basis throughout the data collection period, the Data Manager reviewed the electronic database to certify the quality of the interviewer's work.

The Data Manager carried out a quality check of each completed questionnaire. If it was not satisfactory, the Data Manager would alert the team leader who might ask the interviewer to revisit the interviewee to resolve inconsistent answers and/or provide additional training to the interviewer. These checks could be done using information in the contact forms and Excel link files.

2.9.2 Data management

Study instruments were programmed into REDCap as online data collection forms. Once data collection forms were submitted (in real time for online access by link or once reconnected to WiFi if offline collection was used), the data were accessible only via the secured REDCap database; it was not stored on portable devices (tablets). All REDCap data were managed and stored by CMU-RIHES; access to REDCap was granted only to key CMU-RIHES staff members, including the Data Manager, Project Assistant, and Technical Advisor.

2.10 Data Analysis

2.10.1 Quantitative data analysis

Data were cleaned and checked for consistency. All variables were run for descriptive results. Cross-tabulations were conducted using independent variables (participants' sex, age group, years known living with HIV, key population group, and region lived in) and dependent variables (Stigma Index results). Preliminary results were introduced to the team via a series of five online consultative sessions. More analyses were conducted according to the suggestions of the team. Composite indicators were also computed according to the Global AIDS Monitoring (GAM) suggestion and used as the main outcomes for cross-tabulations. These included experienced stigma in the community, experienced stigma in HIV care, and experienced stigma in non-HIV care. SPSS software was used to analyse data.

2.10.2 Qualitative data analysis

All of the in-depth interviews were transcribed verbatim and coded in Thai in order to discover categories and emerging themes. The Excel software program was used in the coding process, and the initial coding scheme was developed in line with the topics outlined in the interview guides. Thematic analysis was used in this qualitative study. Thematic analysis is a useful qualitative method when conducting psychological research and similar as it is a method for identifying, analysing, and reporting patterns within the data. Thematic analysis acknowledges the ways individuals make meaning of their own experiences while recognizing the broader social context and how that may be reflected in individual experiences.

2.10.3 Gender analysis

A gender analysis was commissioned to further review the data from the Stigma Index 2.0. It used a conceptual framework aligned with the recommendations of the International Community of Women Living with HIV/AIDS (ICW), using a gender and intersectionality lens. The analysis focused on considering the diverse experiences of individuals living with HIV across various gender identities, sexual orientations, behaviours that increase vulnerability, and other marginalized attributes to address the combination of HIV stigma and discrimination effectively. It shows the importance of gender-disaggregated data to understand different experiences among people living with HIV.

Participants' gender identities were categorized into four groups: cisgender women; cisgender men; transgender individuals; and non-binary individuals/those who prefer not to disclose their gender. Additionally, transgender individuals were further divided into two sub-categories: transgender women and transgender men. This classification was based on two key questions in the survey questionnaire: one on biological sex and the other on gender identity. Cisgender women are defined as individuals who were assigned female sex at birth and who adhere to societal norms related to gender and/or sexual identity. Cisgender men are characterized as individuals assigned male at birth whose gender and/or sexual identity aligns with prevailing norms of sex/gender heteronormativity. Transwomen are individuals assigned male at birth, but their gender and sexual identity may diverge from the norms of sex/gender heteronormativity. Transmen refer to individuals assigned to females at birth, but their gender and sexual identity may not correspond with their assigned sex. Non-binary individuals are those who do not strictly identify themselves as men or women but may feel like a combination of genders or perceive themselves as having no gender at all. (See detail of operation definition for the study in Annex 10.1.)

Underpinning the analysis is an acknowledgement that an individual's gender identity can be fluid and changeable over their life course. However, the report relies on the self-identified sex and gender provided by respondents during their interviews.

2.11 Ethical Considerations

Ethical approval was obtained from the Research Ethics Committee of the Faculty of Medicine, Chiang Mai University, in 2022. The approval number is 236/2565.

2.11.1 Informed consent procedures

Informed consent was obtained from each study participant prior to screening, enrolment, and initiation of any study procedures or assessments. During the screening process, each participant met in a private room with a trained interviewer, who asked for their verbal consent to participate and used a brief eligibility screening survey. The interviewer described the voluntary nature of the eligibility screening and the types of screening questions to be asked.

Participants who provided verbal consent were asked the screening questions; participants who were eligible and wished to continue with the study then received the information sheet and an informed consent form. The interviewer reviewed the consent form with the participant and emphasized the confidential and voluntary nature of their participation in this study. This included their right to refuse to participate in the interview or skip any questions, as well as their right to stop the interview process at any time if they felt uncomfortable. The participant was given time to read the information sheet and informed consent form and given the option to have the forms read aloud to them. The participant was given the opportunity to ask questions and take time to consider their decision. Then the participant was asked to provide written consent. All materials used were in the Thai language.

2.11.2 Potential risks to participants

Potential risks were being uncomfortable or emotionally upset because of the questions asked in the assessment interviews, as well as breaches of confidentiality.

Discomfort or distress during the study: It was possible that certain questions might make participants feel uncomfortable. However, the risk to the participant was no greater than that encountered in standard counselling relationships.

Breach of confidentiality: As in any study, there was a risk of an inadvertent breach of confidentiality. This could result in the participant's HIV status or other information becoming known to someone who should not know. As a result, the participant might face stigmatizing treatment or experience discrimination in the workplace, loss of access to services, media exposure, or physical violence.

2.11.3 Alternatives for research participation

Participants had the option to refuse to participate in this research and could stop their participation at any time.

2.11.4 Protection against risks

Potential coercion and undue influence: The stipends were not inappropriately large and were consistent with local practices to prevent undue influence. The study team members believed they met these conditions by providing a stipend of 300 baht (approximately USD 9). A local Institutional Review Board reviewed and approved the interview stipend they proposed. To protect from potential coercion, data collectors were provided with training on protecting human participants, the voluntary nature of participation, and acceptable recruitment language when approaching participants.

Discomfort or distress during the research: Participants were instructed that they did not have to answer any question they did not wish to. Participants experiencing mild distress during the assessments were offered a small break prior to completing the assessment. In the unlikely event that a participant experienced considerable distress, they would be referred (if needed) to mental health and social support services.

Confidentiality of study data: The project ensured that participant information remained confidential. This was done by training staff on confidentiality and using assigned study ID numbers so that participant names were stored separately from survey responses. Staff who conducted participant recruitment, screening, and interviews had completed all required ethical certifications and training, including human subject protection, informed consent, quality management, confidentiality, and reporting of adverse events. No identifying information was presented in publications, presentations, or any other format.

2.11.5 Potential benefits for participants

Apart from each participant receiving 300 baht (USD 9), they might benefit in the future from information learned from this study (for example, reduced HIV-related stigma and discrimination as a result of applying the findings of this study). Participants might appreciate the opportunity to contribute to their communities. They might have found the process of going through the questionnaire interesting and empowering, which might have allowed them to consider some issues that they had not thought about in detail. They might also have learned things about themselves, their rights, or other topics as a result of participating in the study. Irrespective of a participant's decision to participate or not, the study team provided a list of professional support services in the local community to anyone who wanted information on relevant resources.

3. Results

In all, 2,508 participants were recruited through community venues and social networks. Most (53%) were female. The median age of the participants was 47 years old. Nearly 5% identified themselves as transgender. Most participants lived in the Central region of the country (32%). For participants who were from key populations, most were people who use drugs (12%), followed by men who have sex with men (9%), sex workers (9%), and transgender people (5%). For the two specific target groups, young people and migrant workers comprised nearly 10% and 4% of the samples, respectively (Table 2).

Table 2 Demographic characteristics of the participants (N=2,508)

Characteristic	Total	
	%	n
Sex at birth		
Male	47	1,180
Female	53	1,328
Age (median = 47, SD = 11.5)		
18-24	8	201
25-49	55	1,389
50+	37	918
Gender identity		
Women	55	1367
Men	37	934
Transgender	5	120
Do not identify as women, men, or transgender	1	35
Prefer not to answer	2	52
Location and Region		
Bangkok	18	447
Central Region	32	805
Northern Region	17	432
Northeastern Region	19	481
Southern Region	14	343
Population group		
Men who have sex with men	9	236
Transgender people	5	120
Sex workers	9	235
People who use drugs	12	304
Young people (aged 18-25 years old)	10	243
Migrant workers	4	95
Currently belong to or used to be a member of these groups		
Racial, ethnic, or religious minority	1	30
Indigenous/aboriginal group	3	71
Living with a disability	5	113
Refugee or asylum seeker	0.2	6
Internally displaced person	1	20
Incarcerated/in prison	1	36

Participants were recruited from the 24 provinces, which covered all 13 health regions (Table 3). The actual number of participants from each province and participating provinces was slightly different from what had been planned. In health region 5, Samut Sakhon joined the survey. In regions 6 and 11, Chantaburi and Ranong, respectively, did not participate due to unavailability. The quotas of participants in these provinces were relocated to other provinces within the same health regions. In total, the participating provinces accounted for 55.7% of the country's estimated number of people living with HIV (Table 2). Table 3 provides a breakdown of actual participants by province and health region.

Table 3. Actual participants by province and health region

Health region	No.	Province	Designed sample size	Actual number of participants	% actual number compared to the designed sample size
1	1	Chiang Mai	139	170	122
	2	Chiang Rai	120	115	96
	3	Phayao	40	44	110
2	4	Phitsanulok	107	103	96
3	5	Nakhon Sawarn	84	74	88
4	6	Nakhon Nayok	53	53	100
	7	Lopburi	167	167	100
5	8	Ratchaburi	103	71	69
	9	Kanchanaburi	96	63	66
	10	Samut Sakhon (new)	-	44	n/a
6	11	Chonburi	149	200	134
	-	Chantaburi	43	Not participated	n/a
	12	Trad	19	23	121
	13	Rayong	73	81	111
	14	Chachoengsao	29	29	100
7	15	Khon Kaen	150	142	95
8	16	Udon Thani	141	113	80
9	17	Chiyaphum	158	103	65
10	18	Ubon Ratchathani	61	75	123
	19	Srisaket	39	48	123
11	20	Suratthani	73	78	107
	21	Nakhon Sri Thammarat	78	94	121
	-	Ranong	10	Not participated	n/a
12	22	Songkhla	105	105	100
	23	Phatthalung	34	66	194
13	24	Bangkok	429	447	104
Total			2,500	2,508	100

Among participants, the average duration of living with HIV varied across gender identities. Cisgender women participants, on average, had been living with HIV for the longest at approximately 17 years. Transwomen had, on average, been living with HIV for 11 years. Cisgender women had the highest percentage (71%) of people living with HIV for more than 10 years. Less than 20% of cisgender women participants were part of groups or networks of people living with HIV, and cisgender women had the highest percentage of people who were not part of these groups or networks (Table 4).

Table 4. Key demographic characteristics of participants in the Stigma Index 2.0 by gender identities

Gender identity	Cisgender women N=1,303 % (n)	Cisgender men N=921 % (n)	Transgender women N=182 % (n)	Transgender men N=15 % (n)	Non-binary/ don't specify gender identity N=87 % (n)
Years of living with HIV (N=2,442)					
-Average years; (Mean)	17	14	11	12	13
-Living with HIV for 10 years or less than 10 years	29 (373)	45(405)	63(114)	53(8)	62(51)
- Living with HIV for more than 10 years	71(898)	55(488)	37(67)	47(7)	38(31)
Being a member of group/network of people living with HIV (N=2,508)					
-No	23(305)	38(351)	33(60)	33(5)	46 (40)
-Yes	77 (998)	62 (570)	67 (122)	67 (10)	54 (47)
Having a sexual partner/spouse (N=2,508)					
-Have a sexual partner/ a spouse	54(704)	51(473)	51(92)	67(10)	57(50)
-Do not have a sexual partner/ a spouse	46 (599)	49 (448)	49 (90)	33 (5)	43 (37)
HIV status of partners/spouses (N=1,329)					
-A spouse/partner is HIV negative	39(274)	33(155)	29(27)	50(5)	18(9)
-A spouse/partner is HIV positive	47 (330)	51 (239)	26 (24)	50 (5)	30 (15)
-Don't know a spouse's / partner's HIV status	14(100)	17(79)	45(41)	0(0)	52 (26)

Participants who identified as cisgender women accounted for the highest proportion of sex workers (33%), followed by transwomen (29%) and non-binary individuals (9%). Some 56% of participants who were people who use drugs identified as cisgender men (cisgender women made up 27% of this group and transwomen 13%). Among participants who were migrant workers, 48% identified as cisgender women and 42% identified as cisgender men. Cisgender men made up the highest percentage (48%) of young people, followed by cisgender women (40%).

Ethnic minority participants were prominent among cisgender women and transwomen, with percentages of 48% and 8%, respectively. Cisgender men constituted 45% of disabled individuals and cisgender women 43%. Cisgender men accounted for 64% of people in prisons, with cisgender women at 25% (see Table 5).

Table 5. Distribution of participants categorized by marginalized identities across genders

Gender identity	Ciswomen % (n)	Cismen % (n)	Transwomen % (n)	Transmen % (n)	Non-binary/don't specify gender identity % (n)
Sex workers (N=235)	33 (77)	28 (66)	29 (4)	1 (3)	9 (20)
People who use drugs (N=304)	27 (83)	56 (170)	13 (40)	1 (3)	3 (8)
Migrant workers (N=95)	48 (46)	42 (42)	2 (2)	1 (1)	4 (4)
Young people (N=201)	40 (80)	48 (97)	8 (15)	1 (1)	4 (8)
Ethnic minorities (N=95)	48 (46)	37 (35)	8 (8)	3 (3)	1 (1)
Disabled persons (N=113)	43 (49)	45 (51)	8 (9)	1 (1)	3 (3)
Refugees/displaced people (N=26)	39 (10)	39 (10)	12 (3)	4 (1)	8 (2)
People in prisons (N=36)	25 (9)	64 (23)	8 (3)	3 (1)	0 (0)

3.1 Health and Healthcare Services

The majority of participants reported being in good health at the time of completing the survey. Table 6 shows experiences of co-infections in the previous 12 months, including tuberculosis and sexually transmitted infections. Some participants indicated experiences with non-communicable diseases and a few had mental health concerns over the same period (see Table 6).

Table 6. Self-reported health of participants classified by gender identities (N=2,508)

Health state	Gender identities					Total N=2,508 % (n)
	Cisgender women N=1,303 % (n)	Cisgender men N=921 % (n)	Transgender women N=182 % (n)	Transgender men N=15 % (n)	Non-binary/don't specify gender N=87 % (n)	
In general, how would you describe your health at the moment?						
-Good	70 (916)	69 (637)	74 (135)	67 (10)	75 (65)	70 (1,763)
-Satisfactory	28 (358)	28 (256)	23 (42)	33 (5)	25 (22)	27 (683)
-Bad	2 (29)	3 (28)	3 (5)	0 (0)	0 (0)	3 (62)
In the last 12 months, have you been diagnosed with any of the following illnesses?						
-Tuberculosis	11 (143)	10 (95)	12 (21)	13 (2)	8 (7)	11 (268)
-Hepatitis virus	12 (150)	15 (141)	17 (31)	7 (1)	11 (10)	13 (333)
-Sexually transmitted infections (e.g., syphilis, gonorrhoea, chlamydia)	8 (107)	10 (92)	23 (41)	0.00 (0)	18 (16)	10 (256)
-Mental health conditions (e.g., anxiety, depression, insomnia, post-traumatic stress disorder)	13 (171)	11 (101)	15 (27)	7 (1)	14 (12)	12 (312)
-Non-communicable diseases	38 (497)	30 (277)	29 (52)	27 (4)	25 (22)	34 (852)
-Opportunistic infections	7 (92)	6 (59)	8 (15)	13 (2)	6 (5)	7 (173)
-Alcohol or substance addiction	5 (69)	8 (76)	6 (11)	0 (0)	5 (4)	6 (160)

Around 8% to 13% of participants across genders reported being diagnosed with tuberculosis in the previous 12 months. Cisgender women had the highest proportion (38%) of diagnoses for non-communicable diseases, and transwomen reported the highest proportions for sexually transmitted infections (23%), viral hepatitis (17%), and mental health conditions (15%).

Overall, 16% of participants reported experiencing at least one form of stigma and discrimination in healthcare[26] settings in the previous 12 months. These experiences included at least one form of HIV-related discrimination when seeking HIV and non-HIV-specific health services. This was equal between male and female participants. One-quarter of participants in the age group of 20-24 years reported experiencing stigma and discrimination in healthcare in the previous 12 months. It was lower for older age groups: 17% of participants in the age group of 25-49 years and 12% of participants aged 50 years and older reported this. It was higher among key populations: 25% of transgender people, 23% of sex workers, 19% of people who use drugs and 15% of gay men and other men who have sex with men reported experiencing at least one form of stigma and discrimination in the previous 12 months (see Table 7).

Table 7. Experiences of HIV-related discrimination when seeking HIV and non-HIV-specific health services in healthcare settings in the previous 12 months by age, population, sex groups (N=2,508)

Characteristics		HIV and non-HIV-specific health services % (n/N)	HIV services % (n/N)	Non-HIV-specific health services % (n/N)
Age group	18-19	24 (8/33)	15 (5/33)	20 (3/15)
	20-24	25 (42/168)	20 (36/168)	19 (18/95)
	25-49	17 (231/1,389)	14 (179/1,384)	14 (122/875)
	50+	12 (112/918)	9 (84/918)	10 (62/609)
Population group	Men who have sex with men	15 (36/236)	12 (29/236)	18 (15/84)
	Transgender people	25 (30/120)	22 (26/120)	13 (9/71)
	Sex workers	23 (54/235)	20 (44/235)	19 (20/103)
	People who use drugs	19 (59/304)	15 (45/304)	13 (24/182)
	Migrant workers	19 (18/95)	18 (17/94)	11 (4/38)
Sex at birth	Female	16 (208/1,328)	12 (159/1,326)	13 (114/890)
	Male	16 (185/1,180)	12 (/145/1,177)	13 (91/704)
Total		**16 (393/2,508)**	**12(304/2,503)**	**13 (205/1,594)**

Approximately 12% of participants had experienced at least one form of stigma and discrimination in HIV-specific health services, and nearly 13% had experienced it in non-HIV-specific health services. Table 8 provides more detailed findings about experiences of HIV-related discrimination in HIV-specific health services, broken down by population groupings.

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[26] Based on GAM definition, participants of the study are asked if they experienced any of the following forms of HIV-related discrimination when seeking HIV and non-HIV-specific health services in the last 12 months:

- Denial of care due to HIV status
- Advised not to have sex because of HIV status
- Being the subject of gossip or negative talk because of HIV status
- Verbal abuse because of HIV status
- Physical abuse because of HIV status
- Avoidance of physical contact because of HIV status
- Sharing of HIV status without consent

The data from Table 8 highlights that discrimination within HIV-specific health services is notably higher than in non-HIV-specific services, with transgender individuals and young people experiencing elevated instances of verbal abuse and avoidance of physical contact. Discrimination manifests in various forms, including denial of services, advisement against sexual activity, and unauthorized disclosure of HIV status.

Table 8. Experiences of HIV-related discrimination in HIV-specific health services in the previous 12 months by target populations and sex (N=2,503)

	Discriminatory experience in HIV-specific health services during the last 12 months % (n)								
	Men who have sex with men N=236 % (n)	Transgender people N=120 % (n)	Sex workers N=235 % (n)	People who use drugs N=304 % (n)	Migrant workers N=94 % (n)	Young people N=243 % (n)	Total N=2,503 % (n)	Male N=1,177 % (n)	Female N=1,320 % (n)
Denial of health services because of your HIV status	3 (7)	6 (7)	4 (9)	4 (11)	1 (1)	3 (8)	2 (44)	2(25)	1(19)
Being advised not to have sex because of your HIV status	5 (11)	10 (12)	9 (21)	6 (19)	13 (12)	10 (25)	5 (121)	5(59)	5(62)
Being talked badly about or gossiped about because of your HIV status	3 (7)	3 (4)	3 (8)	4 (12)	4 (4)	5 (11)	3 (71)	3(29)	3(42)
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	4 (10)	6 (7)	6 (14)	4 (12)	5 (5)	6 (15)	4 (87)	3(38)	4(49)
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (4)	0 (0)	0.3(4)
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	1 (2)	4 (5)	3 (6)	3 (9)	2 (2)	5 (12)	4 (94)	3(35)	4(58)
Telling other people about your HIV status without your consent	2 (5)	4 (5)	3 (8)	3 (10)	3 (3)	3 (8)	2 (51)	2(27)	2(24)

Table A.1 in the Annex summarizes discrimination in HIV-specific health services by gender over the past year. Transmen experienced high rates of denial of services and negative gossip, both at 7%. Transwomen were most frequently advised against having sex and subjected to verbal abuse, at rates of 7% and 5%, respectively. Cisgender women faced the highest avoidance of physical contact at 5%. This data highlights discrimination disparities among gender groups within HIV-specific healthcare settings.

Table 9 analyses access to non-HIV-specific health services from diverse groups over the last year. The overall engagement rate stood at 64%, with females (67%) accessing services more frequently than males (60%). This data illustrates significant variances in healthcare access among key populations, Transgender people (59%) and people who use drugs (60%) reported the highest rates of service utilization, while men who have sex with men had the lowest at 36%.

Table 9. HIV-related discrimination in non-HIV-specific health services in the last 12 months (N=2,508)

	Sought healthcare for non-HIV related health services during the last 12 months								
	Men who have sex with men (N=236) % (n)	Transgender people (N=120) % (n)	Sex workers (N=235) % (n)	People who use drugs (N=304) % (n)	Migrant workers (N=94) % (n)	Young people (N=243) % (n)	Total (N=2,508) % (n)	Male N=1,180) % (n)	Female (N=1,328) % (n)
Yes, in last 12 months	36 (84)	59 (71)	44 (103)	60 (182)	40 (38)	55 (110)	64 (1,595)	60 (704)	67 (890)

Table 10 shows discrimination in non-HIV-specific health services, revealing distinct patterns. Transgender people and sex workers each face a 3% rate of service denial, with young people slightly higher at 5%. Men who have sex with men, transgender people, and sex workers report 8-9% denial in dental care. Migrant workers face the highest advisories against sex at 11%. Verbal abuse ranges from 1-4% across all groups, while physical abuse is negligible. Sex workers and young people notably experience 6-8% avoidance of physical contact, with young people also most subjected to non-consensual HIV status disclosure at 4%.

Table 10. Experiences of HIV-related discrimination in non-HIV-specific health services in the previous 12 months (N=1,554)

	Discriminatory experience in non-HIV-specific health services during the last 12 months								
	Men who have sex with men N=84 % (n)	Transgender people N=71 % (n)	Sex workers N=103 % (n)	People who use drugs N=182 % (n)	Migrant workers N=38 % (n)	Young people N=110 % (n)	Total N=1,594 % (n)	Male N=704 % (n)	Female N=890 % (n)
Denial of health services because of your HIV status	0 (0)	4 (3)	3 (3)	2 (3)	0 (0)	5 (5)	2 (24)	2 (12)	1(12)
Denial of dental care because of your HIV status	8 (7)	9 (6)	9 (9)	7 (12)	0 (0)	6 (6)	5 (80)	5 (38)	5(41)
Being advised not to have sex because of your HIV status	7 (6)	3 (2)	5 (5)	3 (6)	11 (4)	6 (7)	3 (46)	3 (19)	3(27)
Being talked badly about or gossiped about because of your HIV status	4 (3)	3 (2)	6 (6)	2 (3)	0 (0)	3 (3)	2 (37)	2 (15)	3(22)
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	1 (1)	4 (3)	3 (3)	2 (3)	3 (1)	3 (3)	3 (48)	3 (19)	3(29)
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	0(0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0.1 (2)	0 (0)	0.2 (2)
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	1(1)	1(1)	6 (6)	3 (6)	3 (1)	8 (9)	5 (83)	5 (35)	5 (48)
Telling other people about your HIV status without your consent	2(2)	1(1)	1 (1)	2(4)	0 (0)	4 (4)	2 (30)	1 (10)	2(20)

Table A.2 in the Annex shows HIV-related discrimination in non-HIV-specific health services, highlighting gender-based disparities. Non-binary individuals face the highest denial of services at 6%, and both cisgender and transwomen frequently experience verbal abuse at 4%. Cisgender men and women report a higher avoidance of physical contact than other groups, and cisgender women also see the non-consensual HIV status disclosure at 2%. Specific analysis among cisgender women living with HIV highlighted young ciswomen anticipated higher discrimination in healthcare settings at 20% (Table A.3).

3.1.1 Experience with healthcare workers

Nearly 14% of female participants reported having "had a bad experience" with a healthcare worker compared with 12% of males in the previous 12 months. Among key population groups, more than one-fifth (22%) of sex workers reported having a bad experience with a healthcare worker in the previous 12 months, followed by 19% of transgender people, 16% of people who use drugs, 13% of young people, 15% of migrant workers and 12% of men who have sex with men. One participant commented:

"The healthcare workers showed their disdain clearly. They put on gloves sometimes and chose to handle things cautiously. We can see that with regular people who are not [living with HIV], they would interact differently with those patients. They would touch and care for them. However, when it comes to us [people living with HIV], they would distance themselves and talk to us from afar, showing their disdain. It's like they have a different way of dealing with [people living with HIV]. Asking if this affects our mental state ... well, it does."

(Female, person who uses drugs, 45 years old)

Several participants commented on stigmatizing behaviours from health workers and some also reported on healthcare workers showing encouraging behaviour:

"Since the very beginning, a nurse has been there, providing support and talking to me, explaining how things are. She told me not to be sad because she knew what had happened; I cried and felt so sorrowful. Both my parents had died [of AIDS-related causes]. But I never thought it would happen to me, and I cried inconsolably as I didn't know what to do; it was all so dark. The nurse would say, 'There's a way to prevail, to connect, and to meet people, and it will become easier.' So, I express my heartfelt gratitude to that nurse for making it possible for me to be where I am today because, otherwise, it would have been so gloomy. That nurse is a kind and caring person, extremely kind."

(Transgender person, sex worker, 34 years old)

A total of 18% of transwomen reported having "had a bad experience" with healthcare providers. It is noteworthy that 4% of cisgender men, 3% of transwomen and 1% of cisgender women avoided seeking health services in the previous 12 months due to concerns about potential disclosure of their drug use.

3.1.2 HIV testing

Many participants noted that fears about how others would respond if they tested positive made them hesitate to get an HIV test. However, the majority of participants (54%) responded that the time between when they thought they should first get an HIV test and when they actually took one was less than six months. However, there were variations between key population groups. While 72% of young people, 70% of migrant workers, and 67% of men who have sex with men took a first test within six months, the percentage was lower among sex workers (57%), people who use drugs (49%), and transgender people (48%). This also varied between age groups, with a higher percentage of younger people than older people responding that it took them six months or less from first thinking of taking an HIV test to actually taking one.

Table 11. Time from first thinking of getting an HIV test to taking one by age groups (N=1,945)

	Aged 18-19 N=10 % (n)	Aged 20-24 N=67 % (n)	Aged 25-49 N=1,102 % (n)	Aged ≥ 50 N=766 %(n)	Total N=1,945 % (n)
6 months or less	70 (7)	73 (49)	53 (579)	53 (407)	54 (1,042)
More than 6 months to 2 years	10 (1)	16 (11)	23 (258)	18 (139)	21 (409)
More than 2 years	0 (0)	3 (2)	7 (73)	7 (54)	7 (129)
I don't know/can't remember	20 (2)	8 (5)	17 (192)	22 (166)	19 (365)

Cisgender women were the group with the least time between contemplating and taking their first HIV test. Specifically, of those who took less than six months to have their first HIV test after first thinking about it, 50% (524) were cisgender women. Similarly of those for whom the test took place between six months and two years from the time first thinking of taking an HIV test, 53% (216) were cisgender women.

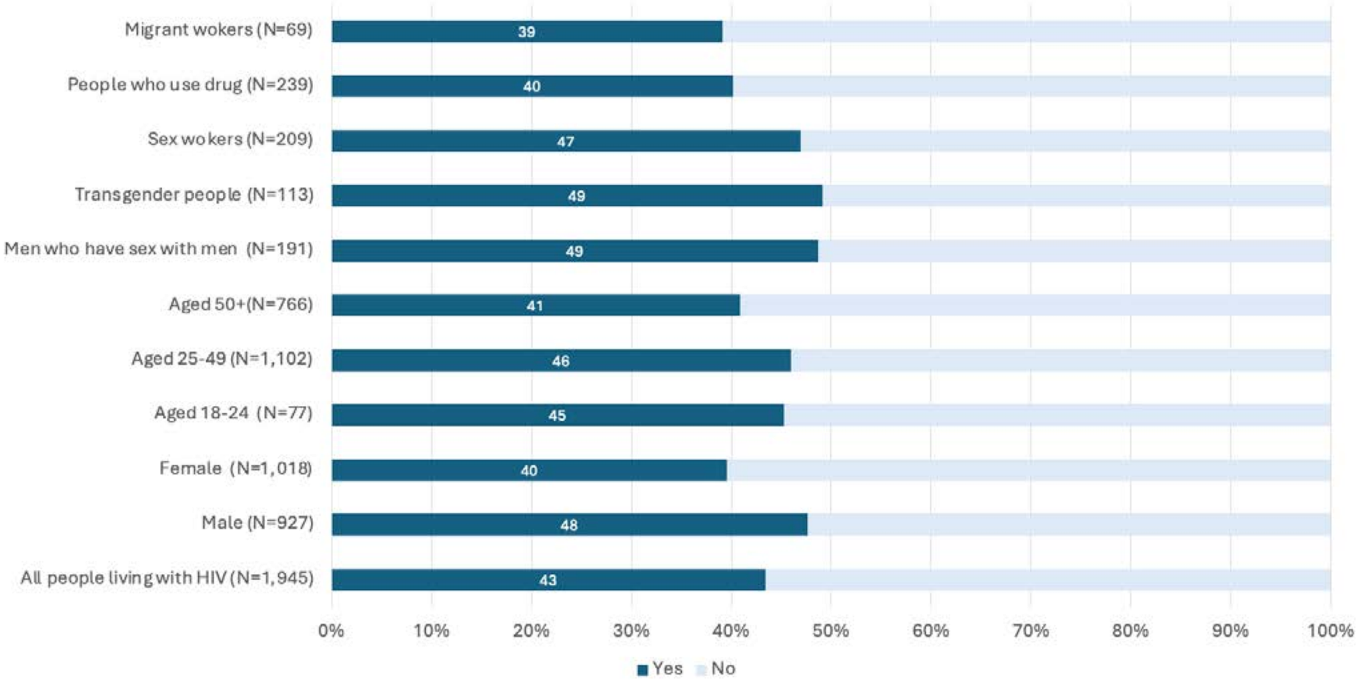
Table 12. Time from first thinking of getting an HIV test to taking one across gender identities (N=1,945)

Time from first thinking of taking the first HIV testing	Gender identities				
	Cisgender women N=998 % (n)	Cisgender men N=697 % (n)	Transgender women N=163 % (n)	Transgender men N=12 % (n)	Non-binary/ don't want to identify gender N=75 % (n)
6 months or less	50 (524)	37 (390)	8 (83)	1 (7)	4 (38)
More than 6 months to 2 years	53 (216)	31.5 (129)	11 (44)	0.5 (3)	4 (17)
More than 2 years	55 (71)	32.5 (42)	11 (14)	0 (0)	1.5 (2)
Don't know/can't remember	51 (187)	37 (136)	6 (22)	1 (2)	5 (18)

Some 43% of the participants (845/1,945) noted fears about how other people would respond if they tested positive for HIV. Nearly 40% (403/1,018) of female participants and 48% (442/927) of male participants responded that fears about other people's responses if they tested positive for HIV made them hesitate to get an HIV test. Close to half of transgender people (55/112) and men who have sex with men (93/191) (49% for both groups) noted that fears about how other people would respond if they tested positive made them hesitate to get tested. The percentage was slightly lower among sex workers (97/208) (47%), young people (41%) (41/100), people who use drugs (40%) (96/239), and migrant workers (39%) (27/69).

In the Northern, Northeastern, Central, and Bangkok regions, 44% to 48% of participants responded that fears about others' reactions caused them to hesitate to get HIV tested. This was notably lower in the Southern region (29%).

Figure 2. Did fears about how other people would respond if you tested positive make you hesitate to get tested for HIV?



3.1.3 Time to treatment

Of all the participants, 98% reported currently receiving or previously receiving ARV treatment. Approximately one-fifth of female and male participants started taking ART immediately or on the day they received their HIV diagnosis (20% and 21%, respectively). Approximately 46% of young people and 41% of men who have sex with men reported starting ART immediately or on the day of diagnosis. This was the case for 29% of sex workers, 26% of migrant workers, 23% of transgender people, and 22% of people who use drugs.

Table 13. Time to starting ART after HIV diagnosis by population groups (N=2,449)

	Men who have sex with men N=226 % (n)	Trans gender people N=94 % (n)	Sex workers N=92 % (n)	People who use drugs N=301 % (n)	Migrant workers N=91 % (n)	Age			Total N=2,449 % (n)	Male N=1,146 % (n)	Female N=1,303 % (n)
						18-24 N=193 % (n)	25-49 N=1,361 % (n)	50+ N=895 % (n)			
Immediately – or the same day I was diagnosed	41 (93)	23 (27)	29 (67)	22 (66)	26 (24)	46 (89)	24 (326)	18 (160)	24 (575)	27 (305)	24 (270
>1 day to 1 month (30 days) after being diagnosed	36 (81)	29 (34)	32 (72)	23 (70)	42 (38)	20 (39)	31 (425)	26 (228)	28 (692)	30 (344)	28 (348)
>1 month to 6 months after being diagnosed	8 (18)	18 (21)	15 (35)	24 (73)	15 (14)	3 (6)	16 (218)	16 (144)	15 (368)	16 (180)	15 (188)
>6 months to 2 years after being diagnosed	7 (17)	16 (19)	8 (19)	11 (33)	9 (8)	2 (5)	10 (134)	13 (118)	10 (257)	10 (119)	11 (138)
>2 years after being diagnosed	5 (11)	9 (5)	9 (21)	12 (35)	4 (4)	3 (5)	9 (126)	17 (149)	11 (280)	7 (85)	11 (195)
I can't remember	3 (6)	4 (5)	6 (14)	8 (24)	3 (3)	26 (49)	10 (132)	11 (96)	11 (277)	(113)	11 (164)

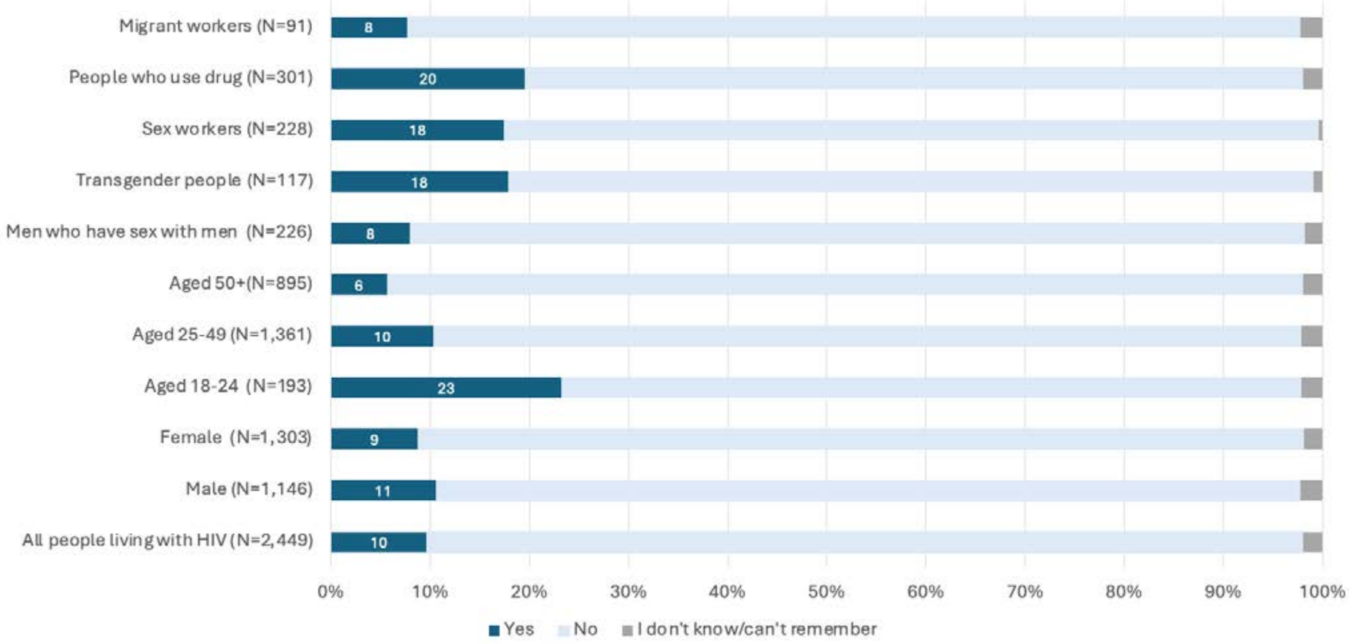
Many participants reported commencing treatment within one month of being diagnosed with HIV, including three-quarters of men who have sex with men and two-thirds of young people and migrant workers. Slower treatment initiation was noted for people who use drugs and transgender people, with about 50% or less starting treatment within one month (52% and 45%, respectively). Across all groups, half of people aged 25 years and above also indicated starting treatment within one month, compared to two-thirds of those younger than 25 years. This suggests that attention to stigma and other barriers to ARV uptake may be needed to support older people diagnosed with HIV to start treatment sooner.

3.1.4 Treatment and treatment interruption(s)

The results showed that over 95% of participants from all genders were currently receiving ARV treatment, except for transmen. The group with the highest proportion of individuals receiving ARV treatment were ciswomen (98%) and the lowest proportion were transmen (80%)

A total of 10% of participants (237/2,449) reported ever interrupted or stopped ARV treatment. The proportion was higher among males (11%) than females (9%). The percentage was highest in the 20-24 age group (25%) and lowest in the 50 years or older age group (6%). Among key population groups, it was highest among young people (23%), followed by people who use drugs (20%), transgender people (18%), sex workers (18%), men who have sex with men (8%), and migrant workers (8%) (see Figure 3).

Figure 3. Have you ever interrupted or stopped your HIV (antiretroviral) treatment? (N=2,449)



Among the 237 individuals who reported that they had ever stopped taking ARV therapy, 29% cited fear of disclosing their HIV status, and 1% cited expectation of discriminatory practices from medical professionals. In all, 31% of cisgender women who ever stopped taking ARV therapy reported worrying that someone would find out their HIV status as a reason for doing so. The percentage was slightly lower for cisgender men participants (30%). A total of 9% of female participants and 6% of male participants reported not being ready to deal with their HIV status as a reason for stopping treatment.

Of the 188 participants who reported experiencing stigma in the community in the previous 12 months, 22% had interrupted or discontinued antiretroviral therapy (ART) compared with 9% of participants who had not experienced stigma in the community in the previous 12 months.

Transwomen reported the most reasons for hesitating, delaying or not accessing HIV treatment. Transwomen had the highest proportion of people discontinuing or inconsistently adhering to HIV antiretroviral medication (17%), while 10% of cismen and 9% of ciswomen discontinued or inconsistently adhered to HIV antiretroviral medication (see Table 14).

Table 14. Adherence to ARV treatment by gender identity (N=2,449)

Adherence to ARV treatment	Gender identities					Total N=2,449 % (n)
	Cisgender women N=1,282 % (n)	Cisgender men N=893 % (n)	Transwomen N=178 % (n)	Transmen N=12 % (n)	Non-binary/ don't specify gender N=84 % (n)	
The time taken to make decision before starting antiretroviral medication after being diagnosed with HIV (N=2,449)						
Taking medication immediately or on the same day as diagnosis	21 (264)	28 (250)	22 (40)	33 (4)	20 (17)	24 (575)
Have a reason for not taking HIV antiretroviral medication in the past 12 months out of concern that others will know HIV-positive status (N=2,449)						
Never	95 (1,213)	92 (820)	90 (160)	100(12)	90 (76)	93 (2,281)
Ever	5 (69)	8 (73)	10 (18)	0 (0)	10 (8)	6.9 (168)
Stopping HIV antiretroviral medication or inconsistent medication adherence (N=2,449)						
Never	89 (1,144)	88 (786)	82 (146)	92 (11)	89 (75)	88 (2,162)
Ever	9 (114)	10	17 (30)	8 (1)	7 (6)	10 (237)
Don't know/cannot remember	2 (24)	2 (21)	1 (2)	0 (0)	4 (3)	2 (50)
Reasons related to HIV stigma that have led to stopping HIV antiretroviral medication in the past 12 months (N=237)						
Worries about their HIV-positive status being revealed or disclosed to others	31 (35)	30 (26)	20 (6)	0 (0)	17 (1)	29 (68)
Reasons unrelated to HIV stigma that have led to stopping HIV antiretroviral medication in the past 12 months (N=237)						
Unable to go to the hospital to receive medication	11 (12)	10 (9)	7 (2)	0 (0)	0 (0)	10 (23)
Unable to tolerate the side effects of the ARV	13 (15)	7 (6)	10 (3)	0 (0)	33 (2)	11 (26)
Feels that undergoing treatment is unnecessary	6 (7)	13 (11)	3 (1)	0 (0)	0 (0)	8 (19)

3.1.5 Viral load

Approximately 77% of participants reported that their most recent viral load test in the previous 12 months showed an undetectable viral load; 8% were not virally suppressed. Approximately 2% had not had a viral load test in the 12 months, 1% had never had one, and 6% did not know what viral load or suppression were.

Table 15 shows that more than half of participants from all genders report an undetectable viral load in their blood in the latest testing, with ciswomen and transwomen having the highest proportion (80%). Among cismen, the rate of undetectable viral load was 73%, for non-binary or unspecified genders, it was 69%, and for transmen, it was 78%.

Table 15. Viral load test in the previous 12 months by gender identity (N=2,082)

The results of the latest blood viral load test within the past 12 months	Gender identities					Total N=2,082 % (n)
	Cisgender women N=1,093 % (n)	Cisgender men N=741 % (n)	Transwomen N=165 % (n)	Transmen N=9 % (n)	Non-binary/ don't specify gender N=74 % (n)	
Viral load is undetectable	80 (877)	73 (538)	80 (132)	78 (7)	69 (51)	77 (1,605)
Viral load is detectable	8 (86)	10 (72)	2 (4)	11 (1)	14 (10)	8 (173)
Have not undergone viral load testing in the past 12 months.	1 (14)	3 (20)	2 (4)	0 (0)	4 (3)	2 (41)
Have undergone viral load testing and are currently awaiting the results	4 (45)	6 (46)	12 (19)	11 (1)	8 (6)	6 (117)
Have never undergone viral load testing	0 (4)	1 (8)	1 (1)	0 (0)	0 (0)	1 (13)
Unaware of blood viral load or undetectable viral load	6 (67)	8 (57)	3 (5)	0 (0)	5 (4)	6 (133)

Note: Only among participants who can remember

The data also indicated that migrant women living with HIV reported the highest proportion of unaware of blood viral load or viral suppression at 27% (9/34). While 10% (4/39) of women who are ethnic, religious minorities, Indigenous/aboriginal, and living with HIV had the highest proportion of individuals who had not undergone viral load testing in the past 12 months, 5% (2/39) were unaware of blood viral load or viral suppression.

3.1.6 Sexual and reproductive health and rights

The data indicates persistent but relatively low levels of bias and rights violations by healthcare professionals towards people living with HIV, especially among sex workers, people who use drugs, migrant workers, and younger people. Migrant workers and young people reported the highest rates of being advised against parenthood, reaching 9%. Some 6% of young people were told that using a specific method of contraception was a prerequisite for receiving HIV treatment. Young adults aged 18-24 experienced more frequent advising against parenthood and higher rates of contraception denial than older individuals. While non-consensual sterilization was rare, its occurrence underscores the gravity of rights violations faced by these groups.

Table 16. Experiences of bias and rights violations from healthcare professionals regarding sexual and reproductive health in the past 12 months by age, population groups

	Ever experienced within the past 12 months reported by all participants						
	Age group			Sex workers % (n/N)	People who use drugs % (n/N)	Migrant workers % (n/N)	Total % (n/N)
	18-24 % (n/N)	25-49 % (n/N)	50+ % (n/N)				
Advised you not to be mother/father a child	9 (11/126)	5 (36/806)	4 (18/429)	5 (6/115)	6 (11/178)	9 (6/70)	5 (65/1,363)
Pressured or incentivized you to get sterilized	3 (4/129)	2 (15/852)	1 (6/452)	2 (3/123)	0 (0/181)	3 (2/72)	2 (24/1,433)
Sterilized you without your knowledge or consent	0 (0/123)	0.1 (1/843)	0.2 (1/453)	0 (0/127)	0 (0/183)	0 (0/69)	0.1 (1/1,419)
Denied your contraception and family planning services	0 (0/125)	0.4 (3/831)	0.2 (1/436)	0.9 (1/115)	2 (3/172)	0 (0/68)	0.3 (4/1,392)
Told you that you had to use (a specific method of) contraception in order to get your HIV (antiretroviral) treatment	6 (8/133)	2 (17/880)	4 (16/462)	4 (5/120)	3 (6/182)	1 (1/69)	3 (41/1,475)

About 9% of women living with HIV reported receiving biased services and violations of their sexual and reproductive health rights within the past 12 months. Among the participants, 11 were pressured to use specific contraceptive methods, eight were pressured not to breastfeed, six were pressured to take antiretroviral drugs during pregnancy, and five were pressured to terminate their pregnancy. Additionally, five participants were advised to terminate their pregnancy, and three were prohibited or forced not to terminate it.

However, these findings should be interpreted with caution as they come from a study that surveyed all women living with HIV who participated in the project, including both those who had received sexual and reproductive health services and those who had not. This may have caused the percentage of rights violations to be skewed from what it truly is.

Table 17. Women living with HIV who experienced bias and rights violations from healthcare professionals regarding sexual and reproductive health

Bias from healthcare professionals regarding services related to sexual and reproductive health	Ever experienced within the past 12 months % (n)	Ever experienced more than 12 months ago % (n)
Recommend termination of pregnancy (N=824)	0.6 (5)	14 (111)
Pressure to use a specific contraceptive method (N=869)	1 (11)	16 (139)
Pressure for using a specific childbirth method (N=806)	0.1 (1)	10 (83)
Pressure for using a specific breastfeeding method (N=799)	1 (8)	19 (151)
Pressure for taking antiviral drugs during pregnancy (N=796)	0.8 (6)	14 (108)
Pressure for termination of pregnancy (N=796)	0.6 (5)	6 (50)
Forbid terminating pregnancy (N=793)	0.4 (3)	2 (19)

In one example from the nested qualitative study, a young woman from a Central province in Thailand described how she kept her HIV status secret for two years after learning about her HIV status at an antenatal care (ANC) clinic. Constant pressure from nurses to bring her partner for testing fuelled her anxiety and even led her to consider abortion and abandon ANC visits altogether. She described how she decided to keep the baby and her husband tested negative. Unfortunately, he chose to leave her and later, his new wife publicly disclosed her HIV status at their shared workplace. Facing stigma and discrimination, the young woman was forced to change her workplace.

Focus group discussions revealed that women living with HIV who also use drugs have stopped or interrupted treatment because they did not have funds for travel costs. For people who had money, they favoured spending it on drugs over visiting the clinic. A woman said that she avoided going to the ANC clinic because of concerns that she would test positive for drugs and face legal action. Moreover, several women living with HIV who also use drugs said that they would be blamed and told to stop using drugs if they disclosed their drug use to healthcare providers. This caused them stress and they were unwilling to come to the ANC clinic because quitting drugs was not easy. This demonstrated the continued misunderstanding by some ANC clinic personnel about harm reduction for pregnant women.

3.2 Stigma in the Community[27]

Approximately one-quarter (650/2,508) of participants had experienced stigma related to HIV in their community in their lifetime. Nearly 5% (118/2,508) reported experiencing it in the previous 12 months.

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[27] GAM indicator: Number of participants living with HIV who agreed that one or more of the following eight experiences happened to them because of their HIV status in the previous 12 months: 1) Have you felt excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status? 2) Have you felt excluded from religious activities or places of worship because of your HIV status? 3) Have you felt excluded from family activities because of your HIV status? (yes, no, don't know, prefer not to answer) 4) Have you felt that family members have made discriminatory remarks or gossiped about you because of your HIV status? 5) Has someone verbally harassed you (e.g., yelled, scolded or was otherwise verbally abusive) because of your HIV status? 6) Has someone physically harassed you (e.g., pushed, hit or was otherwise physically abusive) because of your HIV status? 7) Have you been refused employment or a work opportunity because of your HIV status? 8) Have you lost a source of income or job because of your HIV status?

This was higher among key populations: 10% (23/235) of sex workers, 8% (25/304) of people who use drugs, 8% (9/120) of transgender people and 6% (14/236) of gay men and other men who have sex with men reported experiences of stigma and discrimination in the community in the previous 12 months.

Experiences of stigma related to sexual orientation were also reported: nine gay men and other men who have sex with men, one lesbian, and two bisexual people reported this in the previous 12 months.

More than one-quarter of participants reported ever experiencing stigma in the community. Nearly 5% reported experiencing it in the previous 12 months; the percentage was even higher for most key and other affected population groups (see Table 18).

It is promising to note that for all groups, experiences of stigma over the previous 12 months were markedly lower than over a longer period ("ever" in someone's lifetime), most notably for transgender people and sex workers. While this does not dismiss the lasting impact that these experiences of stigma may have, hopefully it is an indication that such incidents may now be reducing.

Table 18. Experiences in stigma and discrimination in the community in the past 12 months and ever in their lifetime (N=2,508)

Characteristics In the past 12 months		**Reported experiencing stigma (GAM indicator) % (n/N)**	
		Ever in the lifetime	
Age group	18-24	9 (18/201)	28 (56/201)
	25-49	5 (69/1,389)	26 (363/1,389)
	50+	3 (31/918)	25 (231/918)
Population group	Men who have sex with men	6 (14/236)	19 (44/236)
	Transgender people	8 (9/120)	37 (44/120)
	Sex workers	10 (23/235)	32 (74/235)
	People who use drugs	8 (25/304)	33 (99/304)
	Migrant workers	4 (4/95)	19 (18/95)
Sex at birth	Male	5 (55/1,180)	25 (289/1,180)
	Female	5 (63/1,328)	27 (1,328)
Total		**5 (118/2,508)**	**26 (650/2,508)**

The most common form of discrimination in the community during the last 12 months reported by participants was gossip (3%), followed by being verbally harassed (2%) and being excluded from social gatherings (1%). More detailed information about other forms of discrimination in the community less experienced by participants is provided in Table 19.

Table 19. Experienced stigma and discrimination in the community

Stigma and discrimination may have experienced because of HIV status in the past 12 months	Yes; % (n/N)
Have you ever been excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status?	1 (33/2,422)
Have you ever been excluded from religious activities or places of worship because of your HIV status?	0 (8/2,429)
Have you ever been excluded from family activities because of your HIV status?	1 (17/2,434)
Have you ever been aware of family members making discriminatory remarks or gossiping about you because of your HIV status?	1 (33/2,448)
Have you ever been aware of other people (other than family members) making discriminatory remarks or gossiping about you because of your HIV status?	3 (71/2,430)
Has someone ever verbally harassed you (e.g., yelled, scolded, or was otherwise verbally abusive) because of your HIV status?	2 (54/2,433)
Has someone ever blackmailed you because of your HIV status?	1 (21/2,427)
Has someone every physically harassed or hurt you (e.g., pushed, hit, or was otherwise physically abusive) because of your HIV status?	0 (9/2,427)
Have you ever been refused employment or lost a source of income or job because of your HIV status?	1 (22/2,427)
Has your job description or the nature of your job ever been changed, or have you ever been denied a promotion, because of your HIV status?	0 (9/2,139)
Has your wife/husband, partner(s) or child(ren) ever experienced discrimination because of your HIV status?	1 (13/2,190)

Transwomen experience higher rates of stigma, at 6%, particularly in terms of exclusion from social and religious activities (3%). Ciswomen are slightly more affected by family remarks, with an incidence of 2%. Transwomen face significant challenges, with a 3% higher rate of exclusion from social and religious activities. (Table A.4)

Table A.4 shows that younger women living with HIV (18-24 years) experience the highest levels of discrimination, with 13% reporting exclusion or derogatory remarks compared with 5% of those aged 25-49 and 4% of those over 50. Discriminatory incidents include exclusion from social gatherings, which affects 4% of the youngest group and around 1% of the older groups, and discriminatory remarks from family and others, which are more frequently reported by younger women. This data suggests that stigma and discrimination decrease with age among women living with HIV.

Table 20. Experienced stigma and discrimination in the community in the past 12 months among women living with HV by age group

Stigma and discrimination may have been experienced because of HIV status in the community in the past 12 months	Women living with HIV			
	18-24 % (n/N)	25-49 % (n/N)	50+ % (n/N)	Total % (n/N)
Have you ever been excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status?	4 (3/78)	1 (9/671)	1 (6/531)	1 (18/1,280)
Have you ever been excluded from religious activities or places of worship because of your HIV status?	0 (0/78)	0.2 (1/673)	0.4 (2/532)	0.2 (3/1,283)
Have you ever been excluded from family activities because of your HIV status?	0 (0/80)	0.6(4/678)	0.8 (4/531)	0.6 (8/1,289)
Have you ever been aware of family members making discriminatory remarks or gossiping about you because of your HIV status?	6 (5/81)	2(14/681)	1 (6/537)	2 (25/1,299)
Have you ever been aware of other people (other than family members) making discriminatory remarks or gossiping about you because of your HIV status?	9 (7/79)	2.06 (14/678)	2 (12/537)	3 (33/1,294)
Has someone ever verbally harassed you (e.g., yelled, scolded, or was otherwise verbally abusive) because of your HIV status?	3 (2/79)	0.3 (2/679)	0.4 (2/534)	0.5 (6/1,292)
Has someone ever blackmailed you because of your HIV status?	0 (0/74)	0.8 (5/635)	0.8 (4/489)	0.8 (9/1,198)
At least one of above based on GAM indicator definition	12 (10/81)	5 (33/683)	4 (20/539)	5 (63/1,303)

Note: Women living with HIV refers to females at birth who are living with HIV

3.3 Internalized Stigma[1]

In total, 39% of participants experienced internalized stigma, as defined by GAM (feeling ashamed of living with HIV). Males had slightly higher levels of internalized stigma than females, at 40% and 38%, respectively. Internalized stigma was particularly high among key populations, at 50% in men who have sex with men, 46% in people who use drugs, 45% in transgender individuals, and 44% in sex workers (Table 21). Three out of four participants (75%) found it difficult to disclose to others that they are living with HIV, with youth (49%) reporting this feeling more than other age groups.

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[1] GAM indicator: I am ashamed that I am HIV-positive (agree/disagree/prefer not to answer).

Table 21. Reported feeling ashamed that I am HIV positive (N=2,508)

Characteristics		Reported experiencing internalized stigma (GAM indicator) % (n/N)
Age group	18-24	49 (99/201)
	25-49	42 (590/1,389)
	50+	32 (289/918)
Population group	Men who have sex with men	50 (118/236)
	Transgender people	45 (54/120)
	Sex workers	44 (104/235)
	People who use drugs	46(140/304)
	Migrant workers	58 (55/95)
Sex at birth	Male	40 (476/1,180)
	Female	38 (502/1,328)
Total		39 (978/2,508)

Table 22 shows a disaggregation of negative impacts of HIV in the last 12 months according to gender identity. Notably, between one-quarter and one-third of transwomen reported that HIV has negatively impacted their ability to form close relationships, find love, achieve personal or professional goals, and their desire to have children. Nearly one-third of cisgender women also reported negative impacts of HIV on their desire to have children, as did almost half of the transmen who answered this question.

Table 22. Experienced negative impacts of HIV in the last 12 months by gender identities

Items indicating impacts	Gender identities					Total % (n/N)
	Cisgender women % (n/N)	Cisgender men % (n/N)	Transgender women % (n/N)	Transgender men % (n/N)	Non-binary/ don't want to identify gender % (n/N)	
a. Negatively affected my self-confidence (N=2,476)	17 (218/1,290)	18 (164/903)	21 (39/182)	21 (3/14)	18 (16/87)	17 (440/2,476)
b. Negatively affected my self-respect (N=2,476)	10 (122/1,291)	11 (96/901)	15 (28/182)	13 (2/15)	7 (6/87)	10 (254/2,476)
c. Negatively affected my ability to respect others (N=2,476)	8 (103/1,284)	8 (69/899)	10 (18/182)	7 (1/15)	6 (5/87)	8 (196/2,476)
d. Negatively affected my ability to manage stress (N=2,473)	16 (261/1,287)	16 (145/904)	19 (35/181)	20 (3/15)	16 (14/86)	19 (458/2,473)

Items indicating impacts	Gender identities					Total % (n/N)
	Cisgender women % (n/N)	Cisgender men % (n/N)	Transgender women % (n/N)	Transgender men % (n/N)	Non-binary/ don't want to identify gender % (n/N)	
e Negatively affected my ability to have close and stable relationships with others (N=2,454)	14 (183/1,279)	14 (121/895)	24 (44/180)	0.00 (0/14)	20 (17/86)	15 (365/2,454)
f. Negatively affected my ability to find love (N=2,372)	17 (210/1,216)	19 (164/885)	34 (59/172)	14 (2/14)	21 (18/85)	19 (453/2,372)
g. Negatively affected my desire to have children (N=1,390)	32 (233/740)	29 (158/554)	36 (18/50)	45 (4/9)	22 (8/37)	30 (421/1,390)
h. Negatively affected my ability to achieve personal or professional goals (N=2,399)	19 (237/1,236)	18 (158/885)	24 (44/180)	29 (4/14)	13 (11/84)	19 (454/2,399)
i. Negatively affected my ability to participate in the community (N=2,435)	10 (132/1,269)	11 (93/887)	15 (27/179)	13 (2/15)	6 (5/85)	11 (259/2,435)
j. Negatively affected my ability to practice the religion/faith of my choice (N=2,420)	6 (73/1,269)	7 (61/875)	14 (24/177)	7 (1/15)	6 (5/84)	7 (164/2,420)

The findings in Table 23 show that gender identities may influence internalized stigmatization differently. Most gender groups show low levels of internalized stigmatization (0-3 points). However, transwomen exhibited the highest prevalence of high internalized stigmatization (8-12 points) at 19%. Individuals who are non-binary or don't want to specify gender followed at 11%. Cisgender women and cisgender men demonstrated similar proportions of high internalized stigmatization levels, at around 10%.

Table 23. Percentage of participants experiencing internalized stigma by gender identities and levels of stigmatization (N=2,508)

Gender identities	Ciswomen % (n)	Cismen % (n)	Transwomen % (n)	Transmen % (n)	Non-binary/ don't specify gender identity % (n)	Total %(n)
Low level (0-3 scores)	60 (787)	57 (525)	49 (89)	60 (9)	62 (54)	58 (1,464)
Moderate level (4-7 scores)	29 (384)	33 (306)	32 (59)	33 (5)	26 (23)	31 (777)
High level (8-12 scores)	10 (132)	10 (90)	19 (34)	7 (1)	11 (10)	11 (267)

More than three-quarters of participants (75%) found it difficult to tell people that they were living with HIV, and more than two-thirds (67%) responded that they hid their HIV status from others. One participant reported:

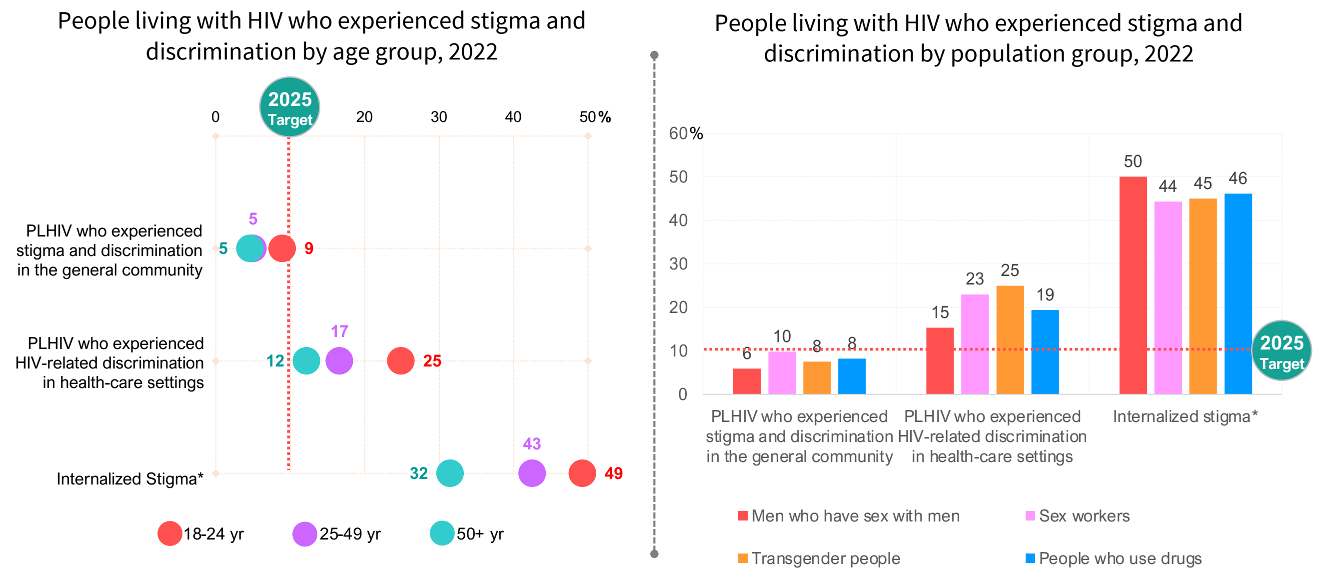
> *"I chose to conceal my HIV status from others; I felt that if they were to find out, my friends might become distant, resentful, and even have thoughts of not wanting to be close to us. But that means I must keep some distance from my friends, and keeping the secret makes me feel stressed and despaired."*
>
> (Transgender person, migrant worker, 47 years)

Table 24. Internalized stigma (N=2,508)

Please tell me if, in general, you agree or disagree with the following statements	Yes; % (n)
It is difficult to tell people that I am HIV positive	75 (1,871)
Being HIV positive makes me feel dirty	22 (554)
I feel guilty that I am HIV positive	33 (831)
I am ashamed that I am HIV positive	39 (979)
I sometimes feel worthless because I am HIV	29 (723)
I hide my HIV status from others	67 (1,679)

Overall, 39% of participants reported that they were ashamed that they were living with HIV. This feeling decreased the longer the person had been living with HIV. Some 53% of those living with HIV for less than 10 years were ashamed of their status compared with 34% of those living with HIV for 10-19 years and 32% of those living with HIV for 20 years or more.

Figure 4. Experiences of stigma and discrimination, including internalized stigma (taken from responses to "I am ashamed that I am HIV positive"), disaggregated by age and key population group



Source: Prepared by www.aidsdatahub.org based on Thailand Stigma Index 2022

* Internalized stigma data derived from the respondents who report "I am ashamed that I am HIV positive"

Many participants also noted that they had chosen not to attend social gatherings due to their HIV status (20%) or chosen not to seek social support (20%). Some participants commented:

> *"My self-confidence took a nosedive. It felt like I was different from other people in a negative way ... so many of us just gradually withdrew from general society and associated only with others like us. It felt like we were being pushed to the margins of society ... I felt like I couldn't get back to mainstream society. It's like you've devalued yourself."*
>
> (Man who has sex with men, 30 years)

> *"I was constantly criticized, ridiculed, and teased a lot back then by some colleagues and even some friends from school. It left scars in my heart, resentment buried deep inside. I used to blame myself, but looking back, it's not something to blame oneself for; it's just a natural occurrence. It's more about the society's refusal to accept, which leads to these scars in the heart. I used to isolate myself, think negatively, and want to escape from society altogether."*
>
> (Man who has sex with men, 48 years)

Despite high levels of internalized stigma, 15% of participants reported that their HIV status had positively impacted their ability to respect themselves compared with 10% of participants who believed their HIV status had negatively impacted their ability to respect themselves; 12% reported a positive impact on their ability to respect others compared with 8% who believed their HIV status had negatively impacted this ability.

Table 25. HIV status and ability to meet needs over the previous 12 months

Experience	Total (N)	Has been positively affected by my HIV status % (n)	Has not been affected by my HIV status % (n)	Has been negatively affected by my HIV status % (n)
My self-confidence	2,476	13 (328)	69 (1,708)	18 (440)
My self-respect	2,476	15 (376)	75 (1,846)	10 (254)
My ability to respect others	2,467	12 (306)	80 (1,965)	8 (196)
My ability to cope with stress	2,473	11 (282)	70 (1,733)	19 (458)
My ability to have close and secure relationships with others	2,454	11 (259)	75 (1,830)	15 (365)
My ability to find love	2,372	10 (240)	71 (1,679)	19 (453)
My desire to have children	1,390	5 (64)	65 (950)	30 (421)
My ability to achieve personal and/or professional goals	2,399	11 (260)	70 (1,685)	19 (454)
My ability to contribute to my community	2,435	10 (250)	79 (1,926)	11 (259)
My ability to practice a religion/ faith as I want to	2,420	10 (245)	83 (2,011)	7 (164)

In the qualitative interviews, participants also spoke about how finding out their HIV status had a positive impact on self-care. A participant commented:

"Talking about the impact, in one dimension, it's actually a good thing. Because once we [acquired HIV], suddenly, it's like, 'Hey, we need to take care of ourselves.' In the past, we never really looked after ourselves. But after becoming HIV positive, I started to realize the importance of my own body. I thought, 'Hmm, we should start taking care of ourselves, like eating healthier, getting enough rest.' Unlike before [getting HIV] when we didn't really, um, think much about our own worth."

(Man who has sex with men 43 years)

Transgender women reported the highest rates of negative impact of their HIV status in terms of limiting their self-confidence (21%), maintaining close and stable relationships with others (24%), experiencing romantic love (34%), participating in the community (15%), and adhering to activities/practices aligned with personal beliefs or convictions (14%). Cisgender women had higher percentages of negative impacts of their HIV status than positive impacts. This is evident in certain abilities, including self-confidence (negative 17%; positive 14%), stress management (negative 20%; positive 12%), maintaining close and stable relationships with others (negative 14%; positive 11%), experiencing romantic love (negative 17%; positive 11%), desire to have children (negative 31%; positive 5%), and personal or professional goal achievement (negative 19%; positive 11%). Cisgender women reported a higher prevalence of positive effects in such aspects as self-esteem, consideration for others, involvement in community activities, and adherence to personal beliefs or convictions.

Internalized stigma might have some roles in social isolation among participants living with HIV. Almost 20% reported that they had chosen not to attend social gatherings, not to seek social support, and not to apply for a job, and decided not to have sex during the last 12 months. (Table 26)

Table 26. Social isolation

Have ever done the following thing because of HIV status in the past 12 months?	Yes; % (n/N)
Chosen not to attend social gatherings	20 (475/2,406)
Avoided going to a clinic or hospital when I needed to	9 (213/2,449)
Have chosen not to apply for a job(s)	19 (378/1,999)
Have chosen not to seek social support	20 (451/2,301)
Have isolated myself from family and/or friends	11 (276/2,431)
Decided not to have sex	18 (415/2,259)

3.4 Human Rights

A total of 14% of participants experienced at least one rights abuse in their lifetime. Almost 3% had experienced at least one rights abuse in the previous 12 months.

Approximately 4% of participants were forced to get tested for HIV or disclose their HIV status to apply for a job or get a pension plan. One participant reported:

> *"It was just about a month ago … I was already employed. It turned out that everyone who got a job would undergo blood tests. But I didn't quite understand why; if you're already at the workplace, why did you have to do blood tests? It was bad, especially for people living with HIV. Then I quit as there was nothing I could do and I knew it was not right."*
>
> (Man who has sex with men, 43 years)

Participants also noted being forced to get tested for HIV or disclose their status in order to get medical insurance (6%) and healthcare services (5%).

Participants were asked about their knowledge of laws in Thailand to protect people living with HIV from discrimination. The majority of participants did not know if there were laws (61%), almost one-third (32%) answered that there were laws, and 8% answered that there were no laws.

Table 27. Experiences of any abuse of your rights in the past 12 months (N=2,508)

Characteristics		Experienced any abuse of rights % (n/N)
Age group	18-24	8 (15/201)
	25-49	3 (39/1,389)
	50+	1 (13/918)
Population group	Men who have sex with men	4 (10/236)
	Transgender people	8 (9/120)
	Sex workers	7 (17/235)
	People who use drugs	4 (11/304)
	Migrant workers	1 (1/95)
Sex at birth	Male	4 (44/1,180)
	Female	2 (23/1,328)
Total		**3 (67/2,508)**

Table 28 shows fewer violations of rights related to being pressured to test for HIV or disclose their status among people living with HIV in Thailand in the previous 12 months compared to any period before that. The decline of being pressured recently (within the past 12 months) to test for HIV or disclose their status among respondents can be observed across gender identities.

For most groups, it can be observed that reported rights violations appear to have reduced in the past 12 months compared with the period more than 12 months ago. The exception is for the people who identified as non-binary and responded to this question, who have either indicated no change or a small increase (for example, one to two people reported having experienced a rights violation) within the previous 12 months (highlighted in grey in Table 28). The other exception is for a transwoman, who reported that in the past 12 months, she had been denied residency or permission to stay in another country because of her HIV status; this compared with none indicating they had experienced that in the past more than 12 months ago (highlighted in grey in Table 28). Overall, the number of people who responded to this question is small.

Table 28. Rights violations related to HIV status by gender identity (N=2,508)

Experiencing rights violation	Gender identity					
	Cisgender women N=1303 % (n)	Cisgender men N=921 % (n)	Transgender women N=182 % (n)	Transgender men N=15 % (n)	Non-binary/ don't specify gender identity N=87 % (n)	Total N=2508 %(n)
Apply for a visa or apply for residency/citizenship in the country						
Yes, within the past 12 months	0.0 (0)	0.2 (2)	1.1 (2)	0.00 (0)	1.15 (1)	0.20 (5)
Yes, more than 12 months ago	0.8 (10)	2.2 (20)	1.1 (2)	0.00 (0)	2.30 (2)	1.36 (34)
Don't want to answer	0.7 (9)	0.2 (2)	0.6 (1)	0.00 (0)	1.15 (1)	0.52 (13)
Apply for a job or receive retirement benefits						
Yes, within the past 12 months	0.2 (2)	0.5 (5)	1.7 (3)	0.00 (0)	1.15 (1)	0.44 (11)
Yes, more than 12 months ago	2.9 (38)	4.7 (43)	7.1 (13)	0.00 (0)	2.30 (2)	3.83 (96)
Don't want to answer	0.6 (8)	0.3 (3)	0.6 (1)	0.00 (0)	0.00 (0)	0.48 (12)
Enrol in an educational institution or receive educational scholarships/grants						
Yes, within the past 12 months	0.1 (1)	0.2 (2)	0.6 (1)	0.00 (0)	2.30 (2)	0.24 (6)
Yes, more than 12 months ago	0.9 (12)	1.2 (11)	1.1 (2)	0.00 (0)	0.00 (0)	1.00 (25)
Don't want to answer	1.7 (22)	1.1 (10)	0.6 (1)	0.0 (0)	1.2 (1)	1.4 (34)
Receive healthcare services or medical care						
Yes, within the past 12 months	0.2 (3)	0.9 (8)	1.7 (3)	0.0 (0)	2.3 (2)	0.6 (16)
Yes, more than 12 months ago	4.5 (59)	4.9 (45)	4.4 (8)	0.0 (0)	2.3 (2)	4.6 (114)
Don't want to answer	0.5 (7)	0.3 (3)	0.6 (1)	0.0 (0)	0.0 (0)	0.4 (11)
Purchase health insurance						
Yes, within the past 12 months	0.5 (6)	1.5 (14)	1.1 (2)	0.0 (0)	3.5 (3)	1.0 (25)
Yes, more than 12 months ago	5.1 (66)	4.3 (40)	6.6 (12)	6.7 (1)	5.8 (5)	4.9 (124)
Don't want to answer	0.4 (5)	0.4 (4)	0.6 (1)	0.0 (0)	0.0 (0)	0.4 (10)

Experiencing rights violation	Gender identity					
	Cisgender women N=1303 % (n)	Cisgender men N=921 % (n)	Transgender women N=182 % (n)	Transgender men N=15 % (n)	Non-binary/ don't specify gender identity N=87 % (n)	Total N=2508 %(n)
Was arrested or taken to court on a charge related to my HIV status						
Yes, within the past 12 months	0.0 (0)	0.00 (0)	0.0 (0)	0.0 (0)	1.2 (1)	0.04 (1)
Yes, more than 12 months ago	0.2 (3)	0.5 (5)	0.0 (0)	0.0 (0)	0.0 (0)	0.3 (8)
Don't want to answer	0.4 (5)	0.2 (2)	0.0 (0)	0.0(0)	1.2 (1)	0.3 (8)
Was detained or quarantined because of my HIV status						
Yes, within the past 12 months	0.0 (0)	0.1 (1)	0.0 (0)	0.0 (0)	1.2 (1)	0.1 (2)
Yes, more than 12 months ago	0.2 (3)	0.8 (7)	0.0 (0)	0.0 (0)	0.0 (0)	0.4 (10)
Don't want to answer	0.4 (5)	0.3 (3)	0.0 (0)	0.0 (0)	2.3 (2)	0.4 (10)
Was denied a visa or permission to enter another country because of my HIV status						
Yes, within the past 12 months	0.0 (0)	0.1 (1)	0.6 (1)	0.0 (0)	1.2 (1)	0.1 (3)
Yes, more than 12 months ago	0.3 (4)	1.4 (13)	1.1 (2)	0.0 (0)	0.0 (0)	0.8 (19)
Don't want to answer	0.8 (10)	0.5 (5)	0.0(0)	0.0 (0)	3.5 (3)	0.7 (18)
Was denied residency or permission to stay in another country because of my HIV status						
Yes, within the past 12 months	0.0 (0)	0.00 (0)	0.6 (1)	0.0 (0)	1.2(1)	0.1 (2)
Yes, more than 12 months ago	0.2 (2)	0.3 (3)	0.0 (0)	0.0 (0)	0.0 (0)	0.2 (5)
Don't want to answer	0.5 (6)	0.2 (2)	0.0 (0)	0.0 (0)	3.5 (3)	0.4 (11)
Was forced to disclose my HIV status publicly or my status was publicly disclosed without my consent						
Yes, within the past 12 months	0.0 (0)	0.00 (0)	0.0 (0)	0.0 (0)	2.3 (2)	0.1 (2)
Yes, more than 12 months ago	2.2 (28)	1.4 (13)	1.1 (2)	0.0 (0)	1.2 (1)	1.8 (44)
Don't want to answer	0.3 (4)	0.2 (2)	0.0 (0)	0.0 (0)	2.3 (2)	0.3 (8)

Experiencing rights violation	Gender identity					
	Cisgender women N=1303 % (n)	Cisgender men N=921 % (n)	Transgender women N=182 % (n)	Transgender men N=15 % (n)	Non-binary/ don't specify gender identity N=87 % (n)	Total N=2508 %(n)
Was forced to have sex when I did not want to						
Yes, within the past 12 months	0.2 (3)	0.0 (0)	1.1 (2)	0.0 (0)	2.3 (2)	0.3 (7)
Yes, more than 12 months ago	2.5 (32)	0.9 (8)	4.9 (9)	0.0 (0)	2.3 (2)	2.0 (51)
Don't want to answer	1.1 (14)	0.4 (4)	0.6 (1)	0.0 (0)	2.3 (2)	0.8 (21)
Was denied access to a domestic violence shelter						
Yes, within the past 12 months	0.1 (1)	0.2 (2)	0.6 (1)	0.0 (0)	1.2 (1)	0.2 (5)
Yes, more than 12 months ago	0.3 (4)	0.0 (0)	0.0 (0)	0.0 (0)	0.0 (0)	0.2 (4)
Don't want to answer	0.2 (3)	0.0 (0)	0.0(0)	0.0 (0)	5.8 (5)	0.3 (8)
My partner(s) could not access (public/private/community-led) health services						
Yes, within the past 12 months	0.6 (8)	0.3 (3)	1.7 (3)	0.0 (0)	2.3 (2)	0.6 (16)
Yes, more than 12 months ago	1.5 (20)	1.6 (15)	2.2 (4)	0.0 (0)	1.2 (1)	1.6 (40)
Don't want to answer	2.7 (35)	2.5 (23)	3.3 (6)	6.7 (1)	8.1 (7)	2.9 (72)

As already noted, 3% (67/2,508) reported they had experienced at least one rights abuse in the previous 12 months. Among those, 6% (4/67) reported doing something about the matter.

Three out of four who did something about the matter reported contacting a community organization/ network of people living with HIV for support. One person reported filing a complaint. No one spoke out publicly and no one contacted a government official or politician.

Of those who did something about the matter, two out of four reported that the matter had been dealt with.

3.5 Effecting Change and Resilience

A total of 31% of participants reported effecting change and/or challenging stigma and showing resilience in the previous 12 months.

Some 21% of participants who had been living with HIV for 20 or more years reported at least one resilient activity in the previous 12 months. Approximately 17% of participants who had been living with HIV for 10-19 years engaged in at least one resilient activity in the previous 12 months, and approximately 10% of participants who had been living with HIV for less than 10 years engaged in a resilient activity in the previous 12 months.

A total of 23% of participants had provided emotional, financial or other support to help someone living with HIV deal with stigma and/or discrimination; 11% had done so in the previous 12 months. About 22% of participants had participated in an organization or educational campaign working to address stigma and discrimination against people living with HIV; 17% of participants had challenged or educated someone who had engaged in discrimination or stigma against them. Similarly, 18% had challenged or educated someone who had engaged in stigma or discrimination against other people living with HIV. One participant commented:

> *"You need to have positive thinking. For example, management of HIV has come a long way. We don't need to be as afraid as before. It's not as easily transmitted as it used to be. Now, we can have children and a proper family. We don't have to worry that eating together will lead to [acquiring HIV]. We can live with this disease and behave just like other people in every way. I have learned about U=U. And another thing is that HIV is not as scary or deadly as it used to be."*
>
> (Female, young person, 24 years)

Table 29. Actions taken to affect change within the last 12 months and any time before that (N=2,508)

Have you done any of the following?	Yes, within the last 12 months N=2,508 % (n)	Yes, but not within the last 12 months N=2,508 % (n)
Challenged or educated someone who was engaging in stigma or discrimination against you	7 (162)	10 (252)
Challenged or educated someone who was engaging in stigma or discrimination against other people living with HIV	7 (167)	11 (267)
Provided emotional, financial or other support to help someone living with HIV deal with stigma and/or discrimination	11 (273)	12 (305)
Participated in an organization or educational campaign working to address stigma and discrimination against people living with HIV	11 (287)	11 (265)
Encouraged a community leader to take action about issues of stigma and discrimination against people living with HIV	5 (124)	8 (200)
Encouraged a government leader or a politician to take action about issues of stigma and discrimination against people living with HIV	2 (56)	5 (121)
Spoke to the media about issues of stigma and discrimination against people living with HIV	1 (20)	3 (86)

Table 30 shows the actions taken by participants of different genders to enact change. Transgender women primarily focused on offering support in mental health, financial matters or other areas to aid individuals living with HIV in coping with stigma and/or discrimination (16%) and engaging in organizations or campaigns aimed at providing knowledge to address stigma and discrimination against individuals living with HIV (15%). Cisgender women were predominantly involved in participating in organizations or campaigns aimed at providing knowledge to address stigma and discrimination against individuals living with HIV (11%) and in offering support in mental health, financial matters or other areas to assist individuals living with HIV in dealing with stigma and/or discrimination (11%).

Table 30. Gender identities and actions for changes (N=2,508)

Taking actions for changes	Gender identities				
	Ciswomen N=1303 % (n)	Cismen N=921 % (n)	Transwomen N=182 % (n)	Transmen N=15	Non-binary/ don't specify gender N=87
Challenging or providing knowledge to those involved in discriminating against or acting against you					
Yes, within the past 12 months	7 (88)	5 (46)	9 (16)	14 (2)	12 (10)
Yes, more than 12 months ago	10 (134)	9 (85)	11 (21)	13 (2)	11 (10)
Do nothing	83 (1,081)	86 (790)	80 (145)	73 (11)	77 (67)
Challenging or providing knowledge to those involved in stigmatizing or acting discriminatory towards other individuals living with HIV					
Yes, within the past 12 months	7 (91)	5 (46)	9 (17)	7 (1)	14 (12)
Yes, more than 12 months ago	11 (146)	9 (85)	14 (25)	20 (3)	9 (8)
Do nothing	82 (1,066)	86 (790)	77 (140)	73 (11)	77 (67)
Offering support in mental health, financial aspects, or other areas to aid individuals living with HIV in dealing with stigma and/or discrimination					
Yes, within the past 12 months	11 (138)	10 (89)	16 (30)	0 (0)	18 (16)
Yes, more than 12 months ago	13 (165)	10 (93)	20 (36)	20 (3)	9 (8)
Do nothing	76 (1,000)	80 (739)	64 (116)	80 (12)	73 (63)
Participating in organizations or campaigns aimed at providing knowledge to manage stigma and discrimination against individuals living with HIV					
Yes, within the past 12 months	11 (146)	10 (97)	15 (28)	7 (1)	17 (15)
Yes, more than 12 months ago	11 (145)	10 (88)	12 (22)	7 (1)	10 (9)
Do nothing	78 (1,012)	80 (736)	73 (132)	86 (13)	72 (63)
Promoting community leaders to address issues related to stigma and discrimination against individuals living with HIV					
Yes, within the past 12 months	5 (64)	5 (42)	4 (7)	7 (1)	12 (10)
Yes, more than 12 months ago	10 (132)	5 (47)	7 (13)	7 (1)	8.05 (7)
Do nothing	85 (1,107)	90(832)	89 (162)	6 (13)	80 (70)

Taking actions for changes	Gender identities				
	Ciswomen N=1303 % (n)	Cismen N=921 % (n)	Transwomen N=182 % (n)	Transmen N=15	Non-binary/ don't specify gender N=87
Promoting government officials or politicians to take action on issues related to stigma and discrimination against individuals living with HIV					
Yes, within the past 12 months	3 (36)	1 (14)	0 (0)	0 (0)	7 (6)
Yes, more than 12 months ago	5 (71)	4 (36)	3 (6)	7 (1)	8 (7)
Do nothing	92 (1,196)	95 (871)	97 (176)	93 (14)	85 (74)
Engaging with the media to discuss issues regarding stigma and discrimination against individuals living with HIV					
Yes, within the past 12 months	0.6 (8)	0.8 (7)	0.6 (1)	0 (0)	5 (4)
Yes, more than 12 months ago	4 (47)	3 (28)	3 (6)	13 (2)	3 (3)
Do nothing	95 (1,248)	96 (886)	96 (175)	87 (13)	98 (80)

3.6. Stigma and Discriminatin Experienced for Reasons Other than HIV Status

The report also measured stigma and discrimination experienced for reasons other than HIV. In this section, two additional groups were included in the analysis: lesbian participants (n=69) and bisexual participants (n=57). Among the groups, transgender participants reported experiencing the highest levels of discrimination, followed by people who use drugs. Across the groups, low percentages of participants reported experiencing stigma and discrimination for reasons other than HIV in the previous 12 months.

The study also surveyed participants on their levels of disclosure among other people within the same population group, friends and family, as well as the general community. The results showed that the proportion of disclosure was highest among transgender participants, followed by lesbian participants, men who have sex with men, people who use drugs, and sex workers; it was lowest among bisexual participants.

3.6.1 Transgender and people whose gender identity differs from the sex they were assigned at birth

Among transgender participants (n=286), approximately one-fourth (26%) reported ever being verbally harassed because of their gender identity. For nearly 6%, it had happened in the previous 12 months.

Nearly 19% felt that family members had ever made discriminatory remarks or gossiped about them because of their gender identity; approximately 1% reported that it had happened to them but not in the previous 12 months. About 16% (47 participants) reported ever feeling excluded from family activities because of their gender identity; only one participant reported this happening in the previous 12 months. About 7% reported ever being physically harassed or hurt because of their gender identity, with 1% stating that it was not in the previous 12 months. Seven percent reported having been afraid to seek health services because of their gender identity, with 1% stating that it was not in the previous 12 months

Disclosure among transgender participants was higher than among the other population groups. Just over 83% reported that other transgender people or people whose gender identity differed from the sex they were assigned at birth knew of their gender identity. Similarly, 82% reported that family and friends knew of their gender identity while 72% reported that other people in the community knew their gender identity.

3.6.2 People who use drugs

Among people who use drugs (n=304), 28% reported ever feeling excluded from family activities because they were using or had used drugs, with 5% reporting that they had felt so in the previous 12 months. Furthermore, 28% felt that family members had made discriminatory remarks or gossiped about them because they were using or had used drugs, and 6% had felt so in the previous 12 months. Similarly, 28% had ever felt afraid to seek health services due to worries that someone might learn that they were using or had used drugs, and 27% reported that they had ever avoided seeking health services due to these worries.

Almost 24% reported ever being verbally harassed because they were using or had used drugs, with nearly 5% reporting experiencing it in the previous 12 months. Approximately 6% reported ever being physically harassed or hurt because they were using or had used drugs, with 1% reporting experiencing it in the previous 12 months.

Almost two-thirds (66%) reported that other people who use drugs knew that they were using or had used drugs. Approximately 62% reported that friends and family knew, while slightly above one-third (36%) reported that other people in the community knew.

3.6.3 Sex workers

Among sex workers (n=235), 12% ever felt excluded from family activities because they were a sex worker and/or sold sex, and 10% felt that family members had made discriminatory remarks or gossiped about them based on this. Just over 11% reported ever feeling afraid of seeking healthcare services because someone might find out they were a sex worker and/or sold sex, and 8% reported ever having avoided seeking healthcare services due to these worries.

Just over 12% reported ever being verbally harassed based on being a sex worker and/or selling sex, and slightly above 6% reported ever being physically harassed or hurt because they were a sex worker and/or sold sex. Fewer participants reported that it had happened in the previous 12 months (three participants reported being verbally harassed and one participant reported being physically harassed in the previous 12 months).

Less than half of sex workers (49%) reported that other sex workers or peers in the sex work community knew that they were a sex worker and/or sold sex. A little above one-quarter (26%) reported that family or friends knew; 12% reported that other people in the community knew.

The qualitative study found that sex workers felt compelled to conceal their HIV status and their profession. Aside from triggering stigma, other results include difficulties in sustaining their livelihoods and/or challenges in seeking help from healthcare providers or relief organizations when incidents of physical harm, violence or rights violations occur.

3.6.4 Men who have sex with men or who ever had sex with another man

Among men who have sex with men (n=231), nearly 11% reported ever feeling excluded from family activities due to being gay and/or having sex with men and that family members had made discriminatory remarks or gossiped about them based on this, although a lower percentage reported that it had happened in the previous 12 months (1%). Approximately 12% reported ever feeling afraid to seek healthcare services due to worries of someone finding out that they were gay and/or had sex with men (1% in the previous 12 months) and 7% reported having avoided seeking healthcare services due to these worries (1% in the previous 12 months).

Almost 19% reported having ever been verbally harassed due to being gay and/or having sex with men, with 2% reporting having been so in the previous 12 months. Approximately 7% reported ever being physically harassed or hurt due to being gay and/or having sex with men, although no participants reported being physically harassed based on these grounds in the previous 12 months.

Three-quarters (75%) reported that other men who have sex with men knew that they were gay and/or had sex with men. Almost 70% reported that family or other friends knew, and 55% reported that other people in the community knew.

3.6.5 Lesbian participants

Among lesbian participants (n=69), 23% had ever felt excluded from family activities because of being lesbian and/or having sex with women, and 29% had ever felt that family members had made discriminatory remarks or gossiped about them based on this. Five participants (7%) had felt afraid to seek health services because they were worried someone would find out they were lesbian and/or had sex with women, and three participants (4%) had avoided seeking health services based on this. However, only 0-1.4% reported that these experiences had happened in the previous 12 months.

One-fifth (20%) of participants reported being verbally harassed because of being lesbian and/or having sex with women, and five participants (7%) reported having been physically harassed or hurt because of this. However, no participants reported that it had happened in the previous 12 months.

Disclosure among lesbian participants was relatively high compared with the other population groups. Approximately 78% reported that other people who identified as lesbian/gay/having sex with women knew that they were lesbian/gay/having sex with women, 73% reported that friends and family knew, and 58% reported that other people in their community knew.

3.6.6 Bisexual participants

Among bisexual participants (n=57), the percentage who reported experiencing discrimination for reasons other than HIV status was generally lower than among other population groups, and the percentage of people who had experienced it in the previous 12 months was low (between 0% and 2%). Eight participants (14%) had ever felt excluded from family activities because they were bisexual and/or had sex with men and women, and seven participants (12%) had felt that family members made discriminatory remarks or gossiped about them because of this.

One participant reported having felt afraid to seek health services in the previous 12 months because they were afraid that someone would find out they were bisexual and/or had sex with women and men. However, no participants reported avoiding seeking health services because of this in the previous 12 months. Four participants (7%) had been verbally harassed based on these reasons, but no participants reported being verbally harassed in the previous 12 months. One participant reported being physically harassed or hurt in the previous 12 months due to being bisexual and/or having sex with men and women.

Disclosure among bisexual participants was the lowest among the population groups. While the other population groups reported the highest disclosure among people of the same population groups, bisexual participants reported higher levels of disclosure among family and friends; 47% reported that, in general, their family and friends knew. Nearly 39% reported that others who were bisexual and/or had sex with men and women knew while approximately 23% reported that others in the community knew.

4. Results from the In-Depth Interviews from the Nested Qualitative Study

Qualitative studies were conducted among seven groups of participants as a nested qualitative study to enhance the results of the Stigma Index 2.0 survey. These included four key populations (men who have sex with men, transgender people, sex workers, and people who use drugs) and three specific populations (migrant workers, young people, and women living with HIV). Table 31 summarizes the characteristics of this qualitative sub-study.

Table 31. Summary of characteristics of qualitative participants

Population group	No. of participant		Age range	Region lived	Remarks
	In-depth interview	Focus group			
Men who have sex with men	30	-	20-59	Most were from the Northern	2 were migrants
Transgender people	30	-	21-54	Most were from the Eastern	Most were also sex workers
Sex workers	30	-	18-41	Bangkok and Eastern	Most were gay men
People who use drugs	30	-	34-66	Northern and Southern	15 men, 15 women
Migrant workers	30	-	20-56	Central and Northern	13 men, 17 women
Young people	24	-	19-25	Most were from the Northern	13 men, 11 women
Women living with HIV	17	-	20-64	Northern, Central, Bangkok, and Southern	
	-	36	19-68	Northern, Central, and Southern	3 focus group discussions

4.1 Men who have sex with men

For the men who have sex with men group, 30 key informants were recruited. Their age ranged from 20 to 59 years and had various occupations and income levels. Some were engaged in private business or freelance work, while others were salaried employees in either the government or private sector, with monthly income ranging from 7,000 to 80,000 baht. Some individuals worked as daily wage labourers, earning 300 baht per day. The majority had completed an undergraduate degree, some had completed lower secondary education, and a few were currently pursuing their education. Furthermore, two participants were Thai nationals who belonged to the Mon ethnicity. They had been living in Chiang Mai for over 30 years.

All participants experienced negative encounters related to their sexual orientation during childhood. They were teased, bullied and generally not accepted. However, the severity of these experiences varied depending on their age. Those over 40 years old tended to encounter more challenges in terms of self-acceptance regarding their sexual orientation. This could be influenced by their life experience and social environment, as well as their individual behaviours and expressions of their identity. Many of these men have and do experience(d) internalized stigma, diminishing their self-worth due to their sexual orientation and HIV status. They described relying on their own self-determination and problem-solving skills, without any organization extending a fair hand of protection and assistance.

Encounters with teasing and discrimination were common and occurred in various settings, including within the community, during job applications, and while working with colleagues. Everyone interviewed in this group has struggled with their situation, having difficulty accepting their own HIV status, experiencing stress and anxiety in navigating their lives, and often concealing their HIV status from others due to uncertainties about potential negative consequences. Discretion was sought and privacy was valued in accessing HIV and other care. For example, as one participant described:

"On the day I went to pick up my medication, I was quite hesitant because I had not disclosed my situation much. I would try to avoid running into the same group of people at the clinic. Even though the clinics were physically combined, when it came to picking up the medication, there was a prescription slip, and I had to go to the medication dispensing room. So, in situations like these, I had to be discreet because many service units did not provide privacy."

(Man who has sex with men, 42 years)

Participants sometimes encountered stigma and discrimination from healthcare providers, both knowingly and unknowingly. For example:

"The healthcare provider, well, he didn't really respect privacy much. There were moments when he would casually read someone else's blood test results, which is a very private matter. We didn't want anyone to know. We didn't want people to find out about the blood test results."

(Man who has sex with men, 26 years)

"Every time on the appointment day, our queue card clearly states how many days are left, but the health staff didn't read where we had filled it in. Instead, they call out loud like, 'You ... Are you taking your medication consistently? Do you have HIV? Are you taking your medication on time? How many pills do you have left? How many days of medication do you have left?' They ask us these questions at the queue card counter."

(Man who has sex with men, 33 years)

This manifested in unequal treatment, such as being scheduled last among a group of dental patients, having to pay extra for medical equipment used for personal protective equipment for healthcare providers and other infection control measures, being forced to undergo blood tests or display blood test results before receiving treatment, and a lack of understanding from medical staff who tended to focus solely on treatment without considering the holistic needs of the person within their communities. For example:

"Once, I got into an accident and went to an emergency room. The healthcare providers knew that I was HIV positive. Some of them looked at me and said the equipment that had been used with me couldn't be reused, so I had to bear the cost for that. I didn't know if it was right, but I had to pay extra."

(Man who has sex with men, 23 years)

Many fear, worry about, or lack confidence in disclosing their status to a potential lover and are not yet ready to build a future with a steady partner because they feel unworthy of love and relationships. They described resilience, as they courageously transcend deep-seated emotions and despair to effectively manage their lives. Furthermore, they have adapted and changed their perspective on living with HIV.

Each man in this group has taken their own time to accept their situation, possibly due to different life circumstances. Each key informant sees value in themselves, and yet, they still hope to eventually be cured of HIV.

4.2 Transgender People

For the transgender people group, 30 key informants were recruited. Their age ranged from 21 to 54 years, with the majority between 30 and 49 years. Most worked in the Pattaya area in various occupations, such as restaurant staff, bar worker, karaoke employee, masseuse, and hotel staff. Some had their own businesses. Fourteen participants (almost half) had a history of illegal drug use that could lead to dependency, and 11 continued to use such drugs when the opportunity arose. These key informants mostly came from the Northeastern and Eastern regions of Thailand. The economic situation of their families varied from moderate to relatively poor, with many of them coming from farming backgrounds, relying on manual labour, and some families were burdened with debt. The majority of these participants completed high school and all 30 had sold sex. Some of the group had been sex workers before transitioning to their current occupation. Most were encouraged by friends or older colleagues to sell sex due to the potential financial windfall. However, when diagnosed with HIV, some shifted from selling sex to starting their own business.

The participants shared their personal stories of how they came to work in Pattaya. These stories included experiences in various occupations, including showgirl, sex worker and an association with "Kathoeys"[2] (transgender women). They talked about interactions with clients (particularly in sex work), drug use, being stigmatized as unprofessional, dealing with law enforcement, prison, and legal issues.

Upon being diagnosed with HIV, many spoke about disclosing their status to partner(s), getting blood tests, sharing blood test results with those they wanted to inform, and the necessity of revealing blood test results, which was almost equivalent to involuntary disclosure.

Participants discussed experiences related to their identity, self-discovery, and gender expression. This included family dynamics, their journey with their gender identity, and the expectations of being a "son", such as participating in religious ceremonies.

They also described encounters with stigmatization and bullying, both within and outside of school, and how these experiences drove them to develop resilience and self-assertion. As one participant recalled:

"Society imposed these norms. I might have also been influenced by [my] parents. I was pressured and faced intense opposition from both my father and mother. My father scolded me, hit me, and tried to make me into a man."

(Transman, 48 years)

In the workplace, they faced challenges related to their gender identity and sex work, making choices about how to perform their duties. They talked about being stigmatized because of their HIV status, getting fired when their status became known, facing community stigmatization, and being treated as men – when inside, they felt like women. For example,

"When I worked as a server at a Chinese-style banquet, the owner was Muslim who said things like, 'I thought he was a woman. I thought, this is a woman. Is this a ladyboy? This is against our religion, it's wrong.' They said it directly like that … He then forced me to quit the job."

(Transwoman, 33 years)

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[2] Kathoey is an identity that in English may be best described as a transgender woman or effeminate man. Source: https://en.wikipedia.org/wiki/Kathoey

Some individuals shared reasons for not seeking medical treatment, including experiencing stigma in hospital, being selected for dental clinics, experiences in all-male wards, non-private healthcare services, outreach voluntary counselling and testing, anxiety about using postal systems for ARV drug delivery, seeking alternative treatments using traditional medicine, or opting for rest and recovery without hospital treatment. For example:

"This is another situation that occurred at a state hospital. I went there for a dental procedure, but my medical history was on record there. The health staff entered my data, and they knew that I was in B24 status. On that day, they asked me to be the last in line, saying that I would be the last to be treated, so they could sterilize the equipment. They had to protect other cases because, if I had gone first, other cases might not have been safe."

(Transgender person, 53 years)

Participants described how negative experiences in a healthcare setting create barriers to accessing services. For example:

"It makes us feel like, 'Oh, I don't want to go there anymore, it's tiresome. Why do we have to encounter someone like this?' …. Trust me, nobody wants to receive something negative. We want to receive positive energy, but it's like the health staff always have a bad attitude, grumbling, and getting angry for no reason. It's been a while, but I know that it's not just about their bad way of speaking; it's their attitudes."

(Transgender person, 34 years)

Regarding human rights and experiences related to rights violations, participants spoke of undergoing HIV testing due to referral for syphilis treatment, getting blood tests before employment or surgery, undergoing blood tests for foreign work visas or in prison, and the necessity of disclosing blood test results for HIV to obtain compensation from insurance companies. For example:

"Regarding work, it's like, 'Hey, maybe this person isn't suitable for this role because he's not a real man or woman.' I was relocated at first, when I initially started working, thinking that my position might not be suitable in that regard. Even though I knew I could work effectively in that position, the senior staff wouldn't accept it."

(Transgender person, 35 years)

Some participants spoke of the layers of negative experiences associated with their gender identity and anticipated how that could have been exacerbated by stigma associated with HIV. For example:

"My rights were violated because I tried to ordain as a Buddhist monk once, but I was denied. Maybe it wasn't just about HIV; they might have seen me as not a real man … My request was rejected, saying that I couldn't ordain because I hadn't rid myself of my transgender identity. However, if they found out I was HIV positive, they probably wouldn't have accepted me either."

(Transgender person, 48 years)

Participants also shared experiences related to self-worth and self-care, emphasizing the importance of acceptance from family and a positive outlook when living with HIV.

4.3 Sex Workers

For the sex worker group, 30 key informants were recruited. All of them resided in either Bangkok or Pattaya. The group was made up of four cisgender women and 26 individuals who were either transgender, non-binary, or preferred not to say. Some were also foreign nationals living with HIV. Their ages ranged from 18 to 41 years. Thai participants often lived with friends or family or rented rooms individually. Non-Thai participants typically shared accommodation with friends or stayed in the service establishment where they worked.

Regarding their work, most sold sex within an establishment where they could meet potential customers. Some freelanced and used public spaces or apps to find clients. For many, sex work was not their primary occupation but rather a supplementary source of income. It is important to note that several of the participants, particularly those who identify as gay, gender non-binary, or foreign national, have complex and intersecting identities where they had experienced stigma.

The interviews revealed that sex workers faced stigma and discrimination from healthcare workers. Participants described differential treatment and perceived increased expenses for medical procedures due to their HIV status. For example:

> *"The most recent consultation was about the surgery I was planning to have ... We discussed the additional cost of the equipment ... They said they had to be careful and made it extra because it seemed like the health staff had the same attitudes with my HIV. The equipment they use needs to be thoroughly sterilized, about 3-4 rounds, while for the general population, it might just involve soaking it in a medical solution once."*
>
> (Transgender sex worker, 32 years)

The quality of healthcare services remained problematic, making some individuals hesitant to seek care. Issues included impolite language, raising of voices, providing less attention and care to people living with HIV compared with other visitors to the health service, emphasizing self-protection to prevent transmitting the virus to others, or even making threats if people living with HIV did not adhere to medication and the treatment regimen. While care was not denied, sex workers living with HIV and foreign nationals, in particular, described experiencing harsh language and incomplete assistance for their issues from healthcare providers.

The group described instances where, after they disclosed their HIV status to their employer, they were treated differently and negatively compared with before their disclosure. The sex workers attributed this differential treatment to their HIV status. Participants described how repeated mal-treatment eroded self-esteem, causing the internalization of stigma and a self-perception of being less valuable, engaging in self-blame, and increasingly withdrawing from mainstream society. Participants indicated that these issues were still prevalent.

When comparing being stigmatized as a person living with HIV and as a sex worker, it was found that being a sex worker tended to lead to a greater increase in violence as a result of having HIV. They have to cope with their health status, which requires managing their entire lives and sometimes leads to the belief that death might be a preferable option at this moment. This reflects the roots of the repeated harmful stigma experienced by individuals in this group.

4.4 People Who Use Drugs

For the people who use drugs group, 30 key informants were recruited. Their age ranged from 34 to 66 years, with an equal number of males and females (15 each). Most people reported chronically low income and explained that stigma affected them in various ways, such as eroding their mental health, quality of daily life, self-esteem, and relationships with family members.

They described being labelled, in addition to feeling excluded socially. For example, they spoke about how people who formerly used drugs were often suspected by police and communities when crimes occurred. The group discussed this in relation to petty theft, in particular. They also described being prohibited from interacting with young people in the community because they were seen as "bad people". For example:

"We're not siding with ourselves. Some people are good, you know, but the good things they do, others don't see. They focus on the bad. Try looking at your friends who've passed through. There are very few bad people and many good ones. But it's like one rotten fish, it spoils the whole bunch. As soon as they see drug users, they think they're no good. No matter what they do, it won't change anything, because their thinking is like that now. They've labelled it and stuck it on their foreheads that they're no good. What can you do with this kind of thinking? It just makes people lose hope."

(Person who uses drugs, male, 53 years)

Group participants explained how the stigma and labelling they experienced diminished their self-esteem and self-worth and affected their employment opportunities as they were viewed as untrustworthy individuals with a bad history. They described a vicious cycle of joblessness, lower income, and recidivist drug use that was fuelled by stigma.

Participants detailed reasons for using drugs, including relaxation, stress relief, and increasing energy and stamina for work. Some saw drug use as enabling them to work longer hours and earn more income for themselves and their families, rationalizing drug use as a way to alleviate financial difficulties. Participants related that people who had never used drugs did not see these aspects. Participants spoke about feeling judged as "bad" individuals, prone to petty crime, unemployable, and susceptible to earning money through inappropriate means.

Participants described the burden they felt from such stereotypes and explained that it discouraged them from doing good deeds since they assumed that nobody would notice or care. For example:

"When we attend large gatherings like funerals, there may be people who view us negatively. There have been times when we went to help with their work, doing various tasks, but sometimes they might not let us do anything. We're not sure why, maybe it's specific to certain individuals or groups, not everyone. When we go somewhere and assist with their tasks, how they perceive us can vary, and sometimes it's in a negative or unfavourable light."

(Person who uses drugs, female, 48 years)

Some individuals internalized these negative perceptions to the point where they contemplated suicide.

Participants described experiences of stigma in a healthcare setting, including the withholding of dental services, additional expenses, and negative attitudes from healthcare providers. For example:

"I went to the hospital to have a tooth extraction and initially got the first spot in the queue, but it ended up being the last. After waiting for a while, the final result was that I didn't get the tooth removed."

(Person who uses drugs, male, 45 years)

"The healthcare workers showed their disdain quite clearly. They put on gloves sometimes and chose to handle things cautiously. We can see that with regular people who are not [HIV positive], they would interact differently with those patients. They would touch and care for them. However, when it comes to us, they would distance themselves and talk to us from afar, showing their disdain very clearly. It's like they have a different way of dealing with [individuals living with HIV than individuals who are not]. They ask if it affects our mental state; well, it does affect our mental state."

(Person who uses drugs, female, 45 years)

People living with HIV who also have a history of drug use often face layers of stigma. Participants described a desire for acceptance and opportunities.

4.5 Migrant Workers

For the migrant workers group, 30 key informants were recruited. They comprised non-Thai cross-border migrants living with HIV who had come to Thailand for work (17 females, nine males, and four individuals of diverse gender identity). They were aged between 20 to 56 years and had been living in Thailand for 10 to 34 years. Their daily incomes ranged from 300 baht (minimum wage labour) to 1,900 baht (sales occupation). Eleven participants did not have their own income and seven were homemakers who primarily relied on their husband's income to support the household.

Participants described how their HIV status had impacted their feelings and lives and also those of their families. They described this impact over time. Several participants related how being open about living with HIV was a source of fear. The group members were most concerned about the potential disclosure of their HIV status to the community, in the workplace, and to others.

Participants described negative experiences when diagnosed with HIV, in accessing ART, and in clinical interactions. Some described experiences where their sexual and reproductive health choices had been denied or disrespected, with pressure from doctors to avoid having children. For example:

"The officials recommend birth control methods, such as using condoms during sexual intercourse, and advised against having children. They emphasized that having children would not be good due to the mother's HIV status."

(Migrant worker, female, 52 years)

"The hospital staff recommend that individuals with HIV should not have children anymore. They advise using condoms during sexual intercourse and recommend sterilization as a form of birth control."

(Migrant worker, female, 40 years)

Some participants reported experiencing disrespectful communication, inadequate attention or care that differed from what they observed for other clients in the healthcare setting, delayed medical treatment, prolonged wait times, or being placed at the end of the queue. As one participant described:

"The translators and hospital staff, once they realize that someone is living with HIV, they don't want to provide service and their facial expressions show their displeasure. They speak in a condescending manner. When the hospital staff calls out names, they often say it in Burmese and it's not clear, so it's hard to understand. This leads to the staff checking documents and asking why the person didn't come when their name was called, with a tone that makes you feel bad, making you not want to receive services at the hospital. When the staff takes a medical history and learns that the person has HIV, they add an extra layer of gloves and masks on top of what they were already wearing, making you feel stigmatized, even though they don't come into direct contact with the person's body."

(Migrant worker, male, 34 years)

In one example, services were withheld due to the HIV status of the individual:

"The doctor in the examination room refused to do the surgery and gave the reason that having HIV makes it impossible to use the surgical scope equipment. This is because this type of equipment is expensive and needs to be inserted into their own uterus, which can be dangerous for HIV-positive individuals. They said that if they used the instrument on me, it would render it unusable for other patients."

(Migrant worker, female, 47 years)

Participants described facing situations where their HIV status had been disclosed to others without their consent. Participants gave examples of healthcare providers avoiding physical contact with them or touching their personal belongings, as well as withholding clinical treatment.

Participants related challenges associated with repeat HIV testing for purposes, such as renewing work documents, obtaining work permits, health check-ups, and pre-employment blood tests. When tested for HIV at their workplace and receiving a positive result, some had faced certain restrictive practices or had been charged additional fees to avoid being laid off.

In terms of internalized stigma, many participants explained that they felt inferior because of their HIV status. They described how this led to feelings of inadequacy, self-blame, diminished self-esteem, and a sense of detachment from society. They saw themselves as different from others in their community and described actively avoiding social interactions. Some individuals mentioned that they distanced themselves from romantic partners and relationships, limited social interactions in their community, and avoided new friendships.

4.6 Young People

For the young people group, 24 key informants were recruited. Their age ranged from 19 to 25 years. It was made up of 12 males, 11 females, and one transgender individual. Participants described diverse experiences of stigma and discrimination. For example, their families prohibited them from participating in school activities due to concerns for their safety and well-being. Consequently, participants were forced to comply with their families' wishes and miss out on school camps and other activities despite their strong desire to attend.

Some individuals had to delay their education due to residing in state welfare shelters in the past when ARV drugs were not readily available. Those shelters did not prioritize education, and there was a perception that children living with HIV were more vulnerable to illness and also that investment in their education had been discouraged. Young people reported a sense of missed opportunity and stunted life trajectory, including their career prospects and overall stability. Some were even denied access to education when school administrators learned of their HIV status, leading their parents to find alternative schools located far from their homes to avoid the local community becoming aware of HIV in their family.

Some young people described their friends or romantic partners taking labels from their medications and searching for information about the drugs online without their permission. Participants perceived this as a violation of their rights. Most had strategies for keeping their medication discreet, such as placing their medication in bottles of other vitamins or supplements or removing the ARV labels. Some individuals described explaining their medication to their friends when they had experienced a violation of their privacy. Some also chose to disclose their HIV status to their friends and partners after they had gained a level of understanding and acceptance.

Some participants described being evicted from their dormitories when the owners learned about their HIV status and/or being ordered to remove their belongings from the dormitory without any prior notice. Others described being teased at school, where their HIV status had been taunted by a friend:

> *"I had a group of peers who seemed to be against me; it's like they were always teasing me. Whenever I did something, they didn't like, they would mock me, saying, 'Hey, you have AIDS.' I had a close friend. We used to socialize together with other peers, but he told others in the group that I had AIDS – because he knew that my parents had AIDS or something like that. When I was a kid, I didn't think much of it, being teased, it's like I was teased until I got used to it."*
>
> (Male, 20 years)

One participant explained how such an incident had a severe impact on their mental well-being as they felt unfairly treated. The participant had previously been productively involved in activities in the dormitory, which was supported by a charitable organization that covered educational expenses and reduced costs for young people coming from different districts in Thailand to study in the city. They incurred personal expenses related to accommodation and travel when they had to move out and had to adapt to new environments and make new friends. This experience taught the participant that disclosing one's HIV status can be dangerous and requires careful consideration as they must be more cautious about their own well-being.

Some participants described being hired by a company and passing the probation period, only to resign after learning that they would be required to undergo mandatory health and blood tests. Participants gave these examples to show how their experiences had taught them to be extra cautious about disclosing their HIV status. They also gave examples of feeling vulnerable to threats by co-workers or rival peers that their HIV status would be disclosed if they did not succumb during disagreements or conflicts.

Some participants related being asked to take photos or videos of themselves to create promotional media for fundraising by a charitable organization. This request made them feel embarrassed and worried that their HIV status would be disclosed. Nevertheless, they also felt an obligation to reciprocate the charity's support despite the imposition. Some also faced threats and had their pictures posted online without their consent. For example:

"One person would use our pictures to promote a charity which is related to HIV or something. I didn't like her using our pictures for any charity. It's like we feel scared that other people might see the photos, or we don't want anyone to see them at all, or we're afraid it will stick with us forever. I was afraid that that woman would come and search for our pictures and stuff like that. We can't really tell her that we don't want anything like that. We can't tell her anything because she has status."

(Male, 23 years)

To address this issue, some young people sought guidance from HIV advocacy leaders and received advice on how to block those who posted their photos from intruding into their online private space.

Some participants described negative experiences in healthcare settings where their sexual and reproductive health choices had been denied or disrespected, with pressure from doctors to avoid having children. For example:

"The nurse said that if you know you have an infection, you shouldn't have children. 'Just get sterilized ... Yes, get sterilized.' Nurses often say this, and when friends go to give birth, nurses usually say something like, 'Just get sterilized, you don't need to have children anymore. Whether it's contagious or not, you should get sterilized'."

(Female, 22 years)

"I've encountered it before, but it wasn't a nurse in the room where I got my HIV test. I met a nurse downstairs, back when I was thinking about having a child. I went to ask the doctor I was seeing upstairs. The nurse who checked my card downstairs told me that 'It's impossible to have a child, how could it be possible with my condition?' I mean, you're a nurse, and you're saying this to me. It's a big hospital, I wanted to leave a comment, you know. But the nurse in the room taking care of me was nice. It was the nurse downstairs who scolded and scolded."

(Female, 24 years)

Other participants described being denied the opportunity to travel abroad for tourism, education, or work or to be with their partner because some countries require an HIV test as part of the visa application process. They, therefore, had to change their travel plans and reassess their life goals.

4.7 Women Living with HIV

The Thai Women Living with HIV Foundation led an in-depth qualitative study among women living with HIV as part of the national study. The goal was to acknowledge all forms of stigma and discrimination related to sexual and reproductive health and rights (SRHR) and violence against women faced by Thai women living with HIV. There were no major differences identified from the study when compared with the quantitative results from the Stigma Index 2.0 survey.

However, the study highlighted additional nuances and in-depth perspectives. It found that women face the same HIV stigma and discrimination as other groups of people who live with HIV in most areas. However, they face particular stigma and prejudice when it comes to reproductive health and rights, such as the ability to have a partner and children, or access family planning, prenatal care, labour, and postpartum care, as well as the right to an abortion. While other groups don't have to face these stigma and discrimination.

Some gender disparities were noticed, such as experiences in accessing testing and receiving an HIV diagnosis. Most of the women interviewed found out about their HIV status when they attended an ANC clinic or in screening during pregnancy. Some were tested when their husband was unwell, and the doctor asked them to get tested because of their husband's HIV status. As a result, many women did not have much time to prepare themselves for coping with the stress or taking care of themselves and leading their lives after finding out that they were living with HIV.

In one example, a woman described feeling pressured whenever she went to the hospital because the nurse always asked her to bring her partner to get an HIV test. As a result, she considered having an abortion and avoided going to the ANC clinic. In the end, she did not receive help in accessing abortion services because officials claimed that the pregnancy was too advanced to be terminated, and the healthcare facility did not provide abortion services.

- Women using drugs faced additional stigma, such as anticipated stigma from nurses pressuring them to stop using drugs. They described fearing pressure to choose between using drugs and taking ARVs. They feared that they might be tested for the drugs and that the ANC clinic would send them to the police.
- The women described experiences of stigma and the withholding of the full range of SRHR services, such as information about and access to safe abortion services (abortion is legal in Thailand). Participants described moral prejudice against abortion and recounted that healthcare providers at both ANC and HIV services would not provide information to consider about having an abortion. Women also described that their contraceptive choices were limited to the implant. They spoke about experiences of discrimination in cervical cancer screening, such as being delayed to the end of the line for a smear test when the provider realized that they were living with HIV.
- All the mothers interviewed who had children living with HIV felt guilty that they could not prevent their children from acquiring HIV. Thailand now has a strong programme to prevent vertical transmission of HIV.

More than half of women living with HIV who had partners or previous partners said that they experienced intimate partner violence in different forms. Some experienced many forms of intimate partner violence, including physical abuse, verbal abuse, and emotional abuse. These experiences were often heightened around fears of forced disclosure of HIV status.

Women living with HIV face layers of stigma associated with their gender identity and expectations about being "good" wives and mothers, and gender inequality in which men dominate and women follow. The way society views gender roles is another crucial component. Women were instructed, for instance, not to discuss or learn about sex, nor to feel sexual desire. These affect women's rights related to decisions on reproductive health, access to reproductive health services, and self-protection against HIV.

5. Discussion

The People Living with HIV Stigma Index 2.0 has provided much-needed data and evidence that could be used to advocate for the rights of people living with and affected by HIV[3]. The goal of this study was to broaden understanding of the extent and forms of stigma and discrimination faced by people living with HIV and key populations living with HIV, and use the findings to improve programmes and policies to achieve universal access to HIV prevention, treatment, care, and support. The specific objectives of Thailand's People Living with HIV Stigma Index 2.0 were to describe experiences related to stigma and discrimination among people living with HIV in Thailand and to increase capacity to gather data systematically to be used in policy advocacy to eliminate stigma and discrimination against people living with HIV.

In Thailand, the People Living with HIV Stigma Index 2.0 was conducted from August 2022 to January 2023. Previously, a version of the People Living with HIV Stigma Index was implemented in 2009-2010. Given the very different approaches to sampling and different methods involved, it is not possible to make direct comparisons between the results.

That said, the first Stigma Index study in Thailand (2009/2010) found that people living with HIV in Thailand reported high levels of internalized stigma, manifesting as embarrassment (64%), guilt (48%), self-blame (43%), and low self-esteem (44%). While it is not possible to make a direct comparison, the findings from the 2022/2023 implementation of the People Living with HIV Stigma Index 2.0 found that more than one-third of participants surveyed (40%) reported experiencing high levels of internalized stigma. Experiences were highest among young people living with HIV (49%) and those who identified as being a man who has sex with men (50%), a person who uses drugs (46%), a transgender woman (45%), and/or a sex worker (44%).

This study also found that a high proportion of transgender women had negative effects from living with HIV in terms of their ability to form close relationships, find love, achieve personal or professional goals, and their desire to have children. Nearly one-third of cisgender women also reported negative impacts of HIV on their desire to have children. Programmes and funding supporting women's rights and empowering women living with HIV have been lacking in the past.

The high levels of internalized stigma reported in 2022/3 mirror those noted in 2009/10, indicating that much more must be done to address internalized stigma.

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[3] See https://www.stigmaindex.org for further details.

The disaggregated results show the importance of considering age and gender identity in understanding experiences of stigma. The findings and quotations from the qualitative analysis illustrate the value of a mixed methods approach within the Stigma Index 2.0.

In summary, the main findings of the People Living with HIV Stigma Index 2.0 in Thailand were that approximately one-quarter (650/2,508) of participants had experienced stigma related to HIV in their community in their lifetime. Nearly 5% (118/2,508) reported experiencing it in the previous 12 months. This was higher among key populations: 10% (23/235) of sex workers, 8% (25/304) of people who use drugs, 8% (9/120) of transgender people, and 6% (14/236) of gay men and other men who have sex with men reported experiences of stigma and discrimination in the community in the previous 12 months.

Experiences of stigma related to sexual orientation were also reported: nine gay men and other men who have sex with men, one lesbian and two bisexual people reported this in the previous 12 months. Of the 188 participants who reported experiencing stigma in the community in the previous 12 months, 22% had interrupted or discontinued antiretroviral therapy (ART) compared with 9% of participants who had not experienced stigma in the community in the previous 12 months.

About 16% of all participants (393/2,508) reported experiencing stigma in healthcare settings in the previous 12 months. This was notably higher among transgender people (25%, 30/120 participants), sex workers (23%, 54/235 participants), and people who use drugs (19%, 59/304 participants). No difference was shown between female and male respondents (each reporting 16%, 208/1328 and 185/1118 respectively), as shown in Table 7.

Nearly 40% of participants reported experiencing internalized stigma. Approximately 39% of participants answered that they felt ashamed of living with HIV, and three-quarters (75%) found it difficult to tell others that they were living with HIV. Many participants noted that fears of how others would respond if they tested positive made them hesitate to get an HIV test. However, the majority of participants (54%) responded that the time between when they thought they should first get an HIV test and when they actually took one was less than six months. A total of 31% of participants reported effecting change and/or challenging stigma and showing resilience in the previous 12 months.

The results from the People Living with HIV Stigma Index 2.0 highlight the resilience and diversity of people living with HIV in Thailand today. By taking an intersectional view, focusing on both common and unique experiences of people living with HIV, the study has illuminated several important areas for consideration in the national response to stigma in Thailand.

The community analysis workshop in Pattaya in September 2023 provided an opportunity to shape the presentation and discussion of the results presented here. In particular, it is clear that taking a holistic approach that considers a whole person – rather than focusing only on prevention or treatment of a virus or disease – is at the heart of addressing stigma. Taking the "whole self" into account includes being aware of the interrelationship between physical and mental health, love, feeling human, sexual desires, and hopes for the future. Communities demand and can clearly articulate their very human needs and rights to have love, sex, hope, and respect, which do not (and should not) change because of living with HIV.

Participants generally perceived a change in recent times, with important decreases in negative experiences in the previous 12 months compared with other time periods.

"You need to have positive thinking. For example, management of HIV has come a long way ... We can live with this disease and behave just like other people in every way. I have learned about U=U ... HIV is not as scary or deadly as it used to be."

(Female, young person, 24 years)

For example, a decrease in rights violations was reported for the previous 12 months compared with earlier periods (see Table 28). Noting that the number of participants who responded to that question was relatively small, there was a decrease in reporting of experiences of rights violations within the past 12 months across several areas for most groups, with the exception of those identifying as non-binary. It is promising to note that for all groups, experiences of stigma over the previous 12 months were markedly lower than over a longer time period ("ever" in someone's lifetime), most notably for transgender people and sex workers (as shown in Table 18). While this does not dismiss the lasting impact that these experiences of stigma may have, hopefully it is an indication that such incidents may now be reducing.

Participants reported showing leadership in speaking out against stigma and supporting their peers in effecting change. Although some progress has been documented, it appears that strengthening reporting and responses to rights violations would bolster the national HIV response.

However, almost 3% of participants (67/2,508) experienced at least one rights abuse in the previous 12 months, and that is unacceptable. Pressured or forced HIV testing and/or disclosure to apply for a job or get a pension plan remains an area where potential rights violations are still occurring. Some 15% (380/2,508) participants reported being tested without their knowledge in the previous 12 months highlighting an area for continued concern, attention, and redress.

The results point to links between stigma and delays in accessing testing. Nearly half of all key population groups indicated that fears about how other people would respond if you tested positive resulted in hesitation to get tested for HIV.

Stigma was also associated with fluctuations in treatment adherence – approximately one in three participants indicated that worrying that someone would find out their HIV status was a reason for stopping ART in the previous 12 months. The results showed a statistically significant correlation between gender identity and the decision on whether or not to delay the initiation of ARV treatment. The results pointed to concerns about others knowing their HIV status as a reason for not taking ARV medication in the previous 12 months.

More than half of participants from all genders had an undetectable viral load in their latest testing. The gender analysis showed that intersectional marginalization may have restricted access to services and/or treatment adherence, given that women living with HIV who also belonged to an ethnic minority or migrant population had the highest rate of detectable virus among participants.

Overall, just over one in six participants reported experiencing at least one form of stigma and discrimination in HIV-related and other healthcare settings in the previous 12 months. Age was a factor, with one-quarter of participants aged 20-24 years reporting such experiences in the previous 12 months. Similarly, approximately one-quarter of participants were associated with a key population group – in particular, being transgender or selling sex.

The effects of stigma were apparent in SRHR services, with cisgender women reporting the most examples of discrimination in the previous 12 months. Participants also noted that their HIV status negatively affected their desire to have children and find love, demonstrating a detrimental effect on intimacy and romantic relationships. A key discussion point that emerged at the community analysis workshop of the results from the survey was the importance of stopping the forced or coerced sterilization of pregnant people living with HIV.

Nearly 40% of participants (n=979) reported experiencing internalized stigma. The percentage was higher among key populations. Over one in five transwomen reported that their HIV status limited their self-confidence and had a negative impact on maintaining close relationships; this was the highest proportion of any group. Attention is needed to support people living with HIV, throughout the life course, to enable reaching their full potential and having the best quality of life. Such high percentages suggest that it is likely that internalized stigma influenced many participants' responses across the survey. For example:

"I felt like I couldn't get back to mainstream society. It's like you've devalued yourself."

(Man who has sex with men, 30 years)

Others, however, reported that HIV had a positive impact on their life, such as increasing awareness and respect for their body. For example:

"Talking about the impact, in one dimension, it's actually a good thing. Because once we [acquired HIV], suddenly, it's like, 'Hey, we need to take care of ourselves.' In the past, we never really looked after ourselves. But after becoming HIV positive, I started to realize the importance of my own body."

(Man who has sex with men, 43 years)

The qualitative interviews and community analysis workshop highlighted that healthcare providers can be either (or both) a positive and negative force for people living with HIV in navigating their experiences of health and illness and in making sense of their HIV diagnosis. Quality of care is a critical component of ensuring these interactions are positive and, ideally, would include awareness and acknowledgement of mental health.

From the nested qualitative study and the in-depth interviews with key informants, it is evident that people experience stigma at different times and in evolving ways throughout their lives. When considering the intersecting dimensions of various identities, such as sexual orientation, sex work, using drugs, having been to prison, and being a person living with HIV, society often holds negative stereotypes and perceptions about one or more of these experiences and identities. The layers show how intertwined and inseparable stigma can be.

From the in-depth interviews with the seven sub-groups of people living with HIV, it is evident that participants from each group shared similar experiences in various aspects of being subjected to stigma and discrimination. These sub-groups are: the four key population groups of people living with HIV (men who have sex with men, transgender women, sex workers, and people who use drugs), and young people, migrants, and women. These experiences include discrimination in their home communities, healthcare services, and worksites, as well as violations of their rights and internalized stigma.

If we consider the complex intersectionality of various identities that are often devalued by society, it not only affects the negative feelings that stigmatized individuals have about themselves or the actions taken against them, but also influences their healthcare behaviours and relationships with others. Stigma experienced in the community can affect decisions to seek medical treatment, adherence to medication, staying within the healthcare system, and re-entering treatment after discontinuation or leaving the healthcare system.

As the results show, HIV-related stigma does not occur only in healthcare settings. Likewise, stigma experienced in healthcare settings is not limited to HIV.

Thailand's successful implementation of key policies and strategies to prevent HIV has led to significant reductions in HIV acquisitions and AIDS-related deaths. However, as noted in the introduction, progress is still needed to reach the 95-95-95 Global AIDS Strategy testing and treatment targets by 2025. The results from this study indicated that even though decreasing stigma and discrimination has been a priority of Thailand's national HIV strategy, which people living with HIV have been involved in developing since 2014, stigma and discrimination towards people living with HIV persist. Aligned with the findings of other recent studies, the results indicate that stigmatizing attitudes towards people living with HIV are evident in healthcare facilities[4].

HIV in Thailand is concentrated among certain key populations (men who have sex with men, sex workers, transgender people, and people who use drugs) in Thailand; estimated prevalence among men who have sex with men is 12% and among transwomen, 11%. The results of this study indicate that stigma experienced by these groups may create barriers to accessing HIV services.

Research from Thailand shows the negative effects of stigma on HIV service uptake, as well as quality of life[5,6,7]. The results from this study in relation to internalized stigma can also be understood alongside findings from other studies that found HIV-related stigma linked to depression[8] and negative self-image[9].

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5.1 Limitations

One targeted province did not join the actual data collection due to unavailability of interviewers at the time. The intended participants from this province were reallocated to another province in the same health region.

Due to the impracticality of the procedures, the formative work to map all venues for the venue-based sampling was not completed properly in several provinces. The proportion of participants recruited through the limited chain referral strategy was a lot lower than expected (7% versus 30%). While the overall proportion of key population participants was higher than the minimum requirement, the number of transgender people participants in particular (n=120) was smaller than other groups. The number of migrant worker participants (n=95) was also lower than planned. This was a result of difficulties in reaching specific participant groups.

Question 48m was later discovered to have been incorrectly translated into Thai. The original English version read: “My partner(s) prevented me from accessing (public/private/community-led) health services.” The Thai version read: “My partner(s) could not access (public/private/community-led) health services.” The answer to this question must be interpreted according to the question asked. To prevent this error in the future, at least two separate reviews of the translation’s accuracy may be required.

For the qualitative study, some groups could not reach the targeted sample size of 30. However, the information acquired was rich enough to allow the drawing of conclusions. For studies in the future, better strategies and monitoring of participant recruiting are required to avoid this limitation.

6. Recommendations

Addressing stigma is not a simple process. The following recommendations have emerged from community-led consultations in response to the research findings. Where possible, specific stakeholders have been identified. However, often more than one actor is needed to achieve meaningful and sustained change in these most pressing areas.

Improve public communication, family and social engagement

Raising public awareness that HIV is a chronic, manageable condition and correcting public communication to normalize perceptions about HIV is important – making it clear that there is no need to fear or stigmatize it, as was common during the early years of the HIV epidemic in Thailand. The government, through all relevant ministries, should allocate a budget to continuously and regularly campaign to educate the public correctly, utilizing the latest information on HIV care. For example, the Ministry of Education should revise HIV-related content in the curriculum, discontinuing fear-based teaching methods that use late-stage symptoms as examples. The curriculum should be updated in

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186-193.

collaboration with the Ministry of Social Development and Human Security to promote gender equality and human rights and address issues such as intimate partner violence, which increases women's vulnerability to HIV through abuse or sexual violence.

Each ministry should create measurable indicators to assess the effectiveness of HIV prevention and intervention efforts. Performance evaluations should reward or sanction agencies based on whether they meet the targets set by these indicators.

The government, specifically the Ministry of Public Health, should allocate budgets from both the public and private sectors to support the creation of appropriate media and campaigns to raise awareness about HIV prevention, particularly among vulnerable groups. These groups include those who do not receive sufficient support or funding for HIV prevention and strengthening resilience, such as young women, youth of diverse sexual orientations, women living with HIV, people with disabilities, ethnic minorities, and Muslim populations in the three southern border provinces.

The government, specifically the Ministry of Public Health in collaboration with other relevant ministries, must publicly promote laws and policies that support sexual rights and reproductive health rights, such as the newly amended abortion law and marriage equality law. The National Health Security Office (NHSO) must promote the package of benefits related to disease prevention and health promotion, including safe abortion services. Reproductive health services must also be extended to cover migrant workers who purchase health insurance cards, enabling them to access safe abortion services at no cost.

To achieve this, national and regional departments of health should:

- Enhance general knowledge about HIV, route of transmission, preventive measures, and vulnerability of key population groups to everyone, for example, by highlighting the difficulty of transmission of HIV through ordinary contact and explaining why people turn to the use of substances that could create dependency.
- Collaborate across sectors and industries to provide knowledge in various workplaces. Establish service standards, such as those of the Ministry of Public Health, that are free from stigma and discrimination. Disseminate these standards across all affiliated healthcare units.
- Develop a nationwide awareness campaign about HIV-related stigma and discrimination that covers all population groups.
- Engage in collaborative efforts with other social services to mitigate the stigma and discrimination that exist in families and communities, as these factors increase the likelihood of HIV acquisition and transmission. These issues are exacerbated by violence against people with diverse gender identities and violations of their rights.
- Ensure access to viral load testing and amplify the message that "undetectable = untransmittable". This is a strong evidence-informed public health message that can reduce stigma and empower people living with HIV to overcome internalized stigma.

Common principles of engagement should include enabling community leadership and involving adolescents and young people living with HIV to help foster a new perspective on HIV and necessitate changes in laws, policies and practices that are fit for the future (and not stuck in the past).

Related government bodies, such as the Department of Disease Control and Department of Local

Administration, and communities, can advocate to ensure that the messaging is supportive and inclusive of diverse communities and hold national and regional governments to account if progress on these recommendations is not made.

Strengthen the capacity of the healthcare workforce

Healthcare personnel, both HIV-related care providers and providers of other health services, should receive training during formative and in-service professional development on updated HIV care and treatment as well as knowledge on human rights, sexual health rights, harm reduction, and client-centred mental healthcare.

Healthcare workers have the responsibility to maintain their skills and competencies and should be encouraged to seek out opportunities to bolster the quality of the services they provide and enhance knowledge and practices in relation to addressing bias and stigma and ensuring inclusivity in healthcare settings.

For students and early-career healthcare workers, awareness of diversity, equity, and inclusion within informative medical education should be strengthened. For example, universities and institutes and vocational training should promote up-to-date awareness about HIV and dispel myths, misconceptions, and misunderstandings about sexual orientation and gender diversity before healthcare workers graduate and start providing services.

Curriculums should be established that promote accurate comprehension of: the rights of people living with HIV; sexual health rights; fertility health; the rights of people with diverse sexual identities and groups of persons who are vulnerable to HIV; and laws relating to the promotion of rights to medical students, nurses, and other health professionals who are going to graduate and provide services in healthcare settings. These curriculums would reduce stigma and discrimination introduced by healthcare personnel.

In-service capacity development opportunities should be accredited and provided by public and private institutions to ensure that healthcare services are provided with understanding and take a person-centred approach. Capacity development opportunities should:

- In order to offer care that respects human rights, healthcare professionals should update their knowledge about HIV prevention and care, as well as work to improve their attitudes toward people living with HIV.
- Increase awareness of healthcare providers about services that may unintentionally lead to HIV status disclosure and strengthen competencies around ensuring privacy and respecting confidentiality.
- Facilitate ongoing education and understanding of human rights for people of all groups and backgrounds, ensuring acceptance and prevention of discrimination based on differences in gender, sexual orientation, gender identity, age, ethnicity, religion, education, or health status.
- Ensure that healthcare workers and persons who have the authority to determine the policies understand and respect the sexual rights, reproductive health rights and rights of people living with HIV in general. Healthcare providers should provide comprehensive information without bias to clients. For example, information about rights and options for family planning to prevent unwanted pregnancy should be provided at the reproductive health clinic. Information

about safe and legalized pregnancy termination should be given to pregnant women newly diagnosed with HIV; information about harm reduction should be provided and information about the effects of drugs on both the mother and unborn child should be given to pregnant women living with HIV who also use drugs.

Improve the quality of healthcare and other services

Health systems policymakers, planners and facility managers have a duty to ensure the best possible quality of care for their clients. Stigma and discrimination experienced in healthcare settings are particularly egregious as they negatively affect people when they are at their most vulnerable and seeking health services. Recommended actions include:

- Tailor healthcare services – and the competencies of healthcare providers – to meet the evolving health needs of diverse people living with HIV. This could be through bespoke standalone services, trusted referrals, and/or the integration of HIV services within other settings. It is important to ensure that, throughout, an inclusive and non-stigmatizing approach, which responds to the needs of the whole person seeking care, is taken.
- Reduce communication gaps between hospitals and client referrals.
- Ensure that non-Thai migrant sex workers have access to clinical care rights and urgent care.
- Enable everyone, including sex workers, to seek assistance without fear of law enforcement in response to experiencing physical and mental violence.
- Prioritize confidentiality and the mental well-being of service recipients, including people who use drugs.
- Develop comprehensive programmes to systematically support mental well-being for people who use drugs and all people living with HIV, tailored to their diverse and evolving needs.
- Ensure that no one is forced to undergo an HIV test before treating unrelated illnesses.
- Expand and/or continue flexible models of care, such as mobile clinics, voluntary HIV testing, pre- and post-test counselling, free infant formula for children of people living with HIV, and health insurance for infants or accompanying dependents (including for migrants under universal health coverage), to reach and engage migrant workers in their HIV care.
- Strengthen “friendly” HIV and other services for young people, including taking an integrated approach to care for adolescents in HIV clinics alongside adolescent health clinics, antenatal care clinics, mental health clinics, and others.
- Monitor progress and quality improvement. Indicators pertaining specifically to HIV services must be included in the monitoring procedure. Healthcare facilities should have measures in place to ensure service quality that is free from discrimination. They should actively promote knowledge and understanding of sensitive issues that could trigger discrimination for different communities and key population groups.
- Disaggregate and analyse data based on sex and gender identity and consider intersecting layers of identity and stigma.

Realize human rights in laws and policies

Thailand is a signatory to various human rights treaties which are also reflected in the country's Constitution. The government of Thailand has a duty to protect the human dignity, rights, liberty, and equality of its people, including non-discrimination and progressive realization of the human right to the highest attainable standard of health.

There are existing laws and policies that need attention to create a more enabling environment for the HIV response in Thailand. The evidence from the findings of this research can help inform civil society efforts to ensure accountability and call for focused reform. It is the responsibility of duty bearers to provide for the rights of its people.

Recommended actions highlighted from the findings of the People Living with HIV Stigma Index 2.0 are:

- Repeal or reform discriminatory policies that require HIV testing in educational institutes, including the Police Cadet Academy, the Royal Military Academy, and nursing schools. HIV testing should be voluntary in all circumstances. There should be no compulsory HIV testing or disclosure of HIV status in any population group in Thailand. Instead, encourage promoting voluntary blood tests for personal health management and providing access to both prevention and ART.
- Strengthen legal mechanisms available to eliminate discriminatory practices and provide protection and remedies in cases of stigma and discrimination against various individuals, including transgender people and members of other key population groups.
- Reduce discrimination and decrease violence in all dimensions against transgender people living with HIV.
- Protect human rights by working to legalize sex work, providing welfare for sex workers, and ensuring equal access to treatment according to their rightful entitlements.
- Ensure that migrants are not forced to disclose their HIV status to their community in communications or in work permits. Advocate to ensure that blood test results for HIV are not disclosed to employers.
- Support the enactment of laws to eliminate discrimination against individuals, including against sex workers living with HIV, and to protect sexual and reproductive health and rights for women living with HIV.
- Amend conditions for membership of the Bank for Agriculture and agricultural cooperatives.

The Thai government should allocate enough and a continuous in-country budget to support HIV prevention and care programmes, particularly for the groups that are not supported by the Global Fund.

The government, including all relevant ministries, should allocate funding to support the HIV activities that are run by community organizations and non-governmental organizations that work on creating knowledge and understanding about HIV transmission, current effective care, and treatment of HIV, which helps people living HIV to be healthy live as equals with all people in society. The budget should be sufficient and continuous and it should be distributed to all target populations, including - but not limited to - key populations.

Respect and empower people living with HIV

Communities of people living with and most affected by HIV, including key population groups, often carry the responsibility of speaking out and challenge stigma, as the people directly experiencing it. As such, the findings reflect the need to support and empower people living with HIV to know their rights and to demand them, for example, by ensuring and advocating for privacy and confidentiality.

Specifically, communities of people living with and most affected by HIV could:

- Increase knowledge, understanding, and awareness within communities about HIV, respect for human rights, and not disclosing others' HIV status.
- Support adolescents and young people to develop communication skills about sexual matters and shared responsibility for HIV prevention with their partners.
- Enable circles of support for people living with HIV from family members, caregivers, non-profit organization staff, welfare institutions, healthcare providers, schools, and other institutions.
- Advocate for continuity of funding and the empowerment process for working with young people and women living with HIV, and encourage inner strength while coping with HIV.

7. Advocacy Plan

2023

IAS 2023 – abstract accepted and poster presented (July)

Community analysis workshop (September)

World AIDS Day – media launch with key messages and community discussion event (December)

2024

Zero Discrimination Day – launch of policy brief focused on implications of the Stigma Index 2.0 findings for young people living with HIV (March)

Report submission (April)

Publication submitted (June)

8 Closing

The Thai Stigma Index 2.0 would not have been possible without the guidance and support of the International Stigma Index Partnership.

In conclusion, the findings and process of conducting the People Living with HIV Stigma Index 2.0 in Thailand highlight the importance of context. Differences are evident in the findings across the regions of Thailand and also between groups and communities. For each individual living with HIV who has experienced stigma or discrimination, the effects can be long-lasting. Therefore, even the findings reported that have been experienced by only a few individuals point to areas of concern and a need to ensure that appropriate services can respond to those experiences. As the recommendations suggest, efforts are needed to address and reduce social and structural determinants of stigma. It is hoped that the evidence presented in this report will be useful for policymakers, service providers, and communities to tailor such efforts in the future.

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10. Appendices and Annexes

10.1 Operational Definition of Gender for this Study

This gender report primarily utilizes descriptive statistics. The findings are presented using percentages and relevant graphical representations to enhance clarity and comprehension.

The operational definitions and classifications of gender identity in this study were designed to reflect the diversity of gender identities based on respondents' self-identification, moving beyond the limitations of a binary gender framework. This approach highlights the diversity of experiences living with HIV across various gender identities and affirms that gender is inherently "pluralistic" rather than "binary". Furthermore, the analysis acknowledges the fluidity of gender identity, which may not conform to socially constructed gender norms. The study underscores that individuals' gender-related experiences are not fixed and can diverge from conventional societal expectations.

To ensure a comprehensive understanding of gender diversity, the study operationalized the definition of gender identity for the sample population by cross-analysing responses to two specific questions: Question 2, which enquired about sex characteristics at birth; and Question 3, which required participants to define their gender identity. These two critical questions are part of the Stigma Index for People Living with HIV Survey (version 2.0). Based on this analysis, the gender identity categories were defined as follows:

Cisgender women (or ciswomen): Individuals who answered "female" for sex at birth in response to Question 2 and "woman" for gender identity in Question 3. There were 1,303 participants in this category.

Cisgender men (or cismen): Individuals who answered "male" for sex at birth in response to Question 2 and "man" for gender identity in Question 3. This category included 921 participants.

Transgender women (or transwomen): Individuals who answered "male" for sex at birth in response to Question 2 and "woman" or "transgender" in Question 3. This category consisted of 182 participants.

Transgender men (or transmen): Individuals who answered "female" for sex at birth in response to Question 2 and "man" or "transgender" in Question 3. There were 15 participants in this category.

Non-binary individuals or those who declined to specify gender: Individuals who did not specify their gender identity or chose not to answer Question 3. This category included 87 participants.

This study seeks to promote acceptance and deepen understanding of the diversity and complexity of gender identities, which shape distinct experiences of HIV-related stigma and discrimination among people living with HIV in Thailand. The data analysis in this report focuses on the gender dimensions and the intersectionality of marginalized or vulnerable identities. Using a binary gender framework would fail to capture this diversity. While the analysis of gender identities by categorizing them into "cisgender" and "transgender" might be criticized for reinforcing the essentialism of a binary gender system, this report emphasizes that distinguishing gender identities into five categories ensures that no identity is overlooked or ignored. It also affirms that gender is inherently pluralistic rather than binary. Furthermore, analysing data with a gender-sensitive framework acknowledges the reality that gender identity experiences for some individuals may be fluid and changeable across different stages of life.

10.2 Additional Tables

Table A.1 Experiences of HIV-related discrimination in HIV-specific health services in the previous 12 months by gender (N=2,503)

	Discriminatory experience in HIV-specific health services during the last 12 months				
	Cisgender women N=1,301 % (n)	Cisgender men N=919 % (n)	Transgender women N=182 % (n)	Transgender men N=15 % (n)	Non-binary/ don't specify gender N=86 % (n)
Denial of health services because of your HIV status	1 (18)	2 (16)	4 (8)	7 (1)	1. (1)
Being advised not to have sex because of your HIV status	5 (62)	5 (42)	7 (13)	0 (0)	5 (4)
Being talked badly about or gossiped about because of your HIV status	3 (40)	2 (22)	3 (6)	7 (1)	2 (2)
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	4 (49)	3 (29)	5 (9)	0 (0)	0 (0)
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	0.3 (4)	0 (0)	0 (0)	0 (0)	0 (0)
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	5 (59)	3 (27)	4 (7)	0 (0)	1 (1)
Telling other people about your HIV status without your consent	2 (24)	2 (20)	3 (6)	0 (0)	1(1)

Table A.2 Experiences of HIV-related discrimination in non-HIV-specific health services in the previous 12 months by gender (N=1,594)

	Discriminatory experience in non-HIV-specific health services during the last 12 months				
	Ciswomen N=880) % (n)	Cismen N=546 % (n)	Transwomen N=106 % (n)	Transmen N=7 % (n)	Non-binary/ don't specify gender N=55 % (n)
Denial of health services because of your HIV status	1 (12)	1 (6)	3 (3)	0 (0)	6 (3)
Denial of dental care because of your HIV status	5 (41)	5 (25)	9 (9)	0 (0)	7 (4)
Being advised not to have sex because of your HIV status	3 (27)	3 (15)	2 (2)	0 (0)	4 (2)
Being talked badly about or gossiped about because of your HIV status	2 (21)	2 (10)	4 (4)	14 (1)	2 (1)
Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	3 (29)	3 (14)	4 (4)	0 (0)	2(1)
Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	0.2 (2)	0 (0)	0 (0)	0 (0)	0 (0)
Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	6 (48)	6 (31)	3 (3)	0 (0)	2 (1)
Telling other people about your HIV status without your consent	2 (20)	2 (9)	1 (1)	0 (0)	0 (0)

Table A-3 Experiences of HIV-related discrimination in HIV-specific and non-HIV-specific health services by women living with HV (N=1,326)

Stigma and discrimination may have experienced because of HIV status in the healthcare setting in the past 12 months	Women living with HIV*			
	18-24 N=82 % (n)	25-49 N=693 % (n)	50+ N=551 % (n)	Total N=1,326 % (n)
Experience of HIV-related discrimination in HIV-specific and non-HIV-specific healthcare setting by cisgender women living with HIV in the past 12 months (GAM indicator)	28 (23)	16 (108)	12 (66)	15 (197)

Note: Women living with HIV = Female at birth (Q2) who living with HIV

Table A.4 Experienced stigma and discrimination in the community by gender identities

Stigma and discrimination may have been experienced because of HIV status in the community in the past 12 months	Gender identities				
	Cisgender women % (n/N)	Cisgender men % (n/N)	Transgender women % (n/N)	Transgender men % (n/N)	Non-binary/ don't specify gender % (n/N)
Have you ever been excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status?	1 (17/1,257)	1 (9/890)	3 (6/178)	8 (1/13)	0 (0/84)
Have you ever been excluded from religious activities or places of worship because of your HIV status?	0.2 (3/1,260)	0.2 (2/894)	2 (3/178)	0 (0/13)	0 (0/84)
Have you ever been excluded from family activities because of your HIV status?	0.6 (8/1,266)	0.8 (7/894)	0.6 (1/178)	0 (0/13)	1 (1/83)
Have you ever been aware of family members making discriminatory remarks or gossiping about you because of your HIV status?	2 (25/1,275)	0.7 (6/899)	1 (2/178)	0 (0/14)	0 (0/82)
Have you ever been aware of other people (other than family members) making discriminatory remarks or gossiping about you because of your HIV status?	3 (32/1,270)	2 (15/889)	2 (4/176)	7 (1/14)	2 (2/84)
Has someone ever verbally harassed you (e.g., yelled, scolded, or was otherwise verbally abusive) because of your HIV status?	0.5 (6/1,269)	0.2 (2/886)	0.6 (1/178)	0 (0/14)	0 (0/80)
Has someone ever blackmailed you because of your HIV status?	0.8 (9/1,174)	1 (10/856)	2 (3/166)	0 (0/14)	0 (0/77)
Experienced stigma and discrimination in the community (at least one of the above)	5 (61/1,279)	4 (40/904)	7 (12/179)	14 (2/14)	4 (3/84)

10.3 The Thai People Living with HIV Stigma Index Task Force Committee

Pongthorn	Chanlearn	The LinQ Foundation
Apiwat	Kwangkeaw	Thai Network of People Living with HIV (TNP+)
Saranya	Boonpeng	Thai Women Living with HIV Foundation (TWLHF)
Nipakorn	Nanta	Thai Women Living with HIV Foundation (TWLHF)
Suphawadee	Kokram	Raks Thai Foundation
Dararat	Ruamsuk	Raks Thai Foundation
Kai	Min Lui	Raks Thai Foundation
Sai Yee Tip Awn	(Hak Maung)	MAP Foundation for the Health and Knowledge of Ethnic Labor
Chaiya	Boontem	Thai Drug User's Network (TDN)
Nacha	Oboon	Little Birds Youth Network Foundation
Satayu	Sittikarn	CAREMAT Foundation
Rathchadej	Reankhomfu	CAREMAT Foundation
Nikorn	Chimkong	Bangkok Rainbow Organization
Thitiwatt	Sirasejtakorn	people living with HIV Youth Activist
Bongkosh	Boonprasarn	Health and Opportunity Network (HON)
Thissadee	Sawangying	Health and Opportunity Network (HON)
Surang	Janyam	Service Workers in Group Foundation (SWING)
Supachai	Sukthongsa	Service Workers in Group Foundation (SWING)
Kanjana	Thalaengkit	Thai NGO Coalition on AIDS
Jedsada	Thongngam	Payoonsritrang Group
Thitiyanan	Nakpor	Sister Foundation
Sulaiporn	Chonwilai	Thai Women Living with HIV Foundation (TWLHF)
Somchai	Phromsombut	The POZ Home Center Foundation

10.4 The Thai Women Living with HIV Foundation: Stigma Index 2.0 Managing Organization

Nipakorn	Nanta	Principal Investigator
Saranya	Boonpeng	Co-investigator
Sirintorn	Juntong	Co-investigator
Kanda	Phoonsong	Co-investigator
Sulaiporn	Chonwilai	Co-investigator

10.5 Field supervisor and data collector for both quantitative and qualitative data collection

Field Supervisor

Serea Jintakanon	Eastern
Sirilak Chuachangkien	Southern
Ratnee Phutthachu	Northeastern
Gulad Dangtong	Central and Western
Piraporn Chantima	Northern
Sarut Moonsam	Bangkok
Somchart Thakaeng	Bangkok

Key populations living with HIV Supervisor

Chaiya Boontem	People who use drug
Thissadee Sawangying	Transgender
Preecha Khanawapee	Sex worker
Titima Kuntason	Youth
Manunchaya Inklai	Migrant worker - Samut Sakorn
Satayu Sittikarn	Men who have sex with men
Sai Yee Tip Awn	Migrant worker – Chiang Mai

Data Collector

Yutthana Arunpiboon	Songkhla Province
Supranee Jankaew	Phatthalung Province
Ratsadaphat Chantrachu	Nakhon Si Thammarat Province
Thawisak Thipgied	Surat Thani Province
Natthanon Montharsawin	Rayong Province
Pattarinee Phoboonprung	Chonburi Province
Narongvit Chanthaphat	Ratchaburi Province
Kunlakan Jintakanon	Nakhon Nayok Province
Sittikom Rungreang	Khon Kaen Province
Radamanee Honin	Ubon Ratchathani Province
Aubon Kongchakkaeo	Chaiyaphum Province
Waeraphon Thongtem	Sisaket Province
Sangwun Sonsombat	Udon Thani Province
Suwanna Wongkaiw	Chachoengsao Province
Puwanart Srijundee	Kanchanaburi Province
Panitan Dangthong	Lopburi Province
Thitapha Phukbua	Phitsanulok Province
Apicbart Pungtong	Nakhon Sawan Province
Praphian Charoensuk	Chiang Mai Province
Ruttanai Soparut	Chiang Rai Province
Atehanon Boontep	Phayao Province
Ans Hla Yone	Chiang Mai Province
Than Tun	Samut Sakhon Province
Arongkot Khosshasarn	Samut Sakhon Province
Sukanya Potipongpaiboon	Samut Sakhon Province
Nantabhop Banjobphudsa	Samut Sakhon Province
Nacha oboon	Bangkok
Adul Sakaran	Nakhon Si Thammarat Province
Ratehayapornthawee Thanawattewakul	Chonburi Province
Surasak Naimtanom	Chiang Mai Province
Rathchadej Reankhomfu	Chiang Mai Province
Pongpat Piancharoen	Bangkok
Patinya Surlwong	Bangkok

10.6 Participants in Stigma Index Workshop: Data for Impact on 19-21 September 2023

Ruttanai	Soparut	Thai Women Living with HIV Foundation (TWLHF)
Saranya	Boonpeng	Thai Women Living with HIV Foundation (TWLHF)
Sirilak	Chuachangkien	Thai Women Living with HIV Foundation (TWLHF)
Ratsadaphat	Chantrachu	Thai Women Living with HIV Foundation (TWLHF)
Supranee	Jankaew	Thai Women Living with HIV Foundation (TWLHF)
Sittikorn	Rungreang	Thai Women Living with HIV Foundation (TWLHF)
Sirintorn	Juntong	Thai Women Living with HIV Foundation (TWLHF)
Radamanee	Honin	Thai Women Living with HIV Foundation (TWLHF)
Wanvimon	Meelaung	Thai Women Living with HIV Foundation (TWLHF)
Nipakorn	Nanta	Thai Women Living with HIV Foundation (TWLHF)
Kanda	Phoonsong	Thai Women Living with HIV Foundation (TWLHF)
Sulaiporn	Chonwilai	Thai Women Living with HIV Foundation (TWLHF)
Saisuni	Buangam	Thai Women Living with HIV Foundation (TWLHF)
Piraporn	Chantima	Thai Women Living with HIV Foundation (TWLHF)
Chaiya	Boontem	Thai Drug User's Network (TDN)
Adul	Skarun	Thai Drug Users's Network (TDN)
Dararat	Ruamsuk	Raks Thai Foundation
Nacha	Oboon	Little Birds Youth Network Foundations
Natat	Teeraphapphongphun	Raks Thai Foundation
Somchai	Phromsombut	The POZ Home Center Foundation
Gulab	Dangthong	Thai Network of People Living with HIV/AIDS (TNP+)
Thitapha	Phukbua	Phitsanulok Network of People Living with HIV
Satayu	Sittikarn	CAREMAT FOUNDATION
Nikorn	Chimkong	Bangkok Rainbow Organization
Danai	Linjongrut	Rainbow Sky Association of Thailand
Veeraphon	Thongthen	Srisaket Network of People Living with HIV
Piraporn	Chantima	Thai Women Living with HIV Foundation (TWLHF)
Yutthana	Arunpiboon	Thai Network of People Living with HIV (TNP+), Songkha
Thitiwatt	Sirasejtakorn	People living with HIV Youth Activist
Dr Sarut	Moonsarn	CPHS, Chulalongkorn University
Manunchaya	Inklai	Proud Association
SAI YEE TIP	AWN	The MAP Foundation for the Health and Knowledge of Ethnic Labor

Pongthorn	Chanlearn	The LinQ Foundation
Surasak	Neanthanom	Service workers in group (SWING)
Preecha	Khanawapee	Service Workers in Group (SWING)
Tanawut	Panyanant	MPLUS FOUNDATION
Primma	Mahayosanan	Research Institute for Health Sciences, Chiang Mai University
Kanjana	Thalaengkit	Thai NGO Coalition on AIDS (TNCA)
Thissadee	Sawangying	Health and Opportunity Network (HON)
Bongkosh	Boonprasarn	Health and Opportunity Network (HON)
Ratchayapornthawee	Thanawattewakual	Health & Opportunity Network (HON)
Natanon	MontharSwin	Camillian Social Center Rayong (CSC Rayong)
Pattarinee	Paoboonprung	Saichon Chonburi Network
Narubet	Rakvijit	Youth Activist
Kunkorn	Trakulsri	Youth Activist
Patchara	Benjarattanaporn	UNAIDS Thailand
Niwat	Suwanphatthana	UNAIDS Thailand
Suchada	Thaweesit	Institute for Population and Social Research, Mahidol University
Pennapa	Saenkla	Institute for Population and Social Research, Mahidol University
Lucy	Stackpool-Moore	Watipa
Darinda	Rosa	Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health
Achara	Pakdipinit	Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health
Thanarat	Teerawantanee	Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health
Theethawat	Sriatsanan	Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health
Nunthawan	Wongtip	Division of Aids and STIs, Department of Disease Control, Ministry of Public Health
Wannarat	Makamnerd	Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health
Bussapakorn	Udomsap	Division of AIDS and STIs, Department of Disease Control, Ministry of Public Health
Pavanpart	Palamart	Institute of HIV Research and Innovation (IHRI)
Kunthida	Khotchip	Rainbow Sky Association of Thailand, Chonburi Provincial Office
Pattaraporn	Soiysungnun	APASS

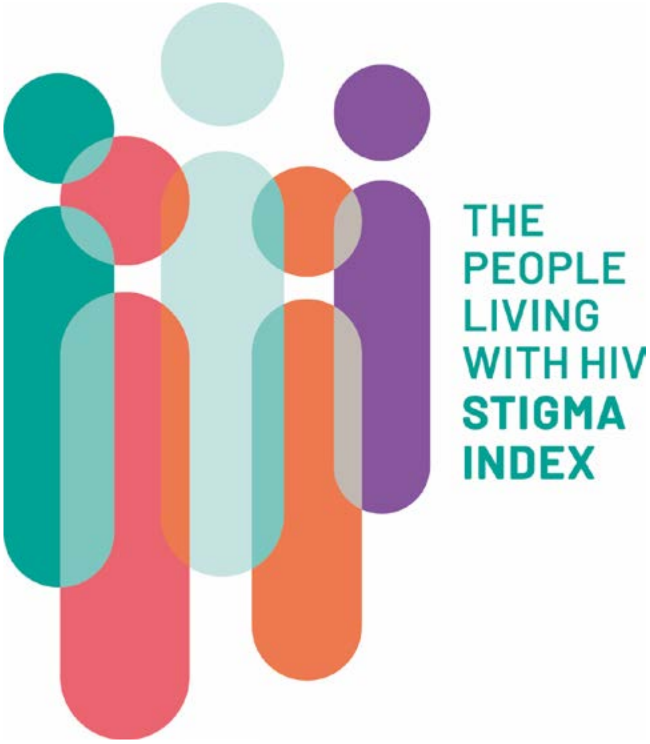
Phonpiphat	Potasin	Sisters Foundation
Nonchaya	Nakchang	World Vision Foundation of Thailand
Linfa	Uppatcha	World Vision Foundation of Thailand
Moemen	Nader	IOM, Thailand
Duangkamol	Ponchamni	UNFPA, Thailand
Waranya	Prasert	Planned Parenthood Association of Thailand (PPAT)
Nuttanicha	Jittreesap	Planned Parenthood Association of Thailand (PPAT)
Srisangwan	Punyapeng	Raks Thai Foundation
Pimpanitta	Saenyakul	USAID, Regional Development Mission, Asia (RDMA)
Hyeyoung	Lim	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Alistair	Shaw	The Global Fund to Fight AIDS, Tuberculosis and Malaria
Cedriann	Martin	UNAIDS Regional Support Team (RST)
Kriengkrai	Srithanaviboonchai	Research Institute for Health Sciences, Chiang Mai University
Arunrat	Tangmunkongvorakul	Research Institute for Health Sciences, Chiang Mai University
Jarun	Chueayen	Research Institute for Health Sciences, Chiang Mai University

10.7 Technical Team

Moemen	Nader	IOM, Thailand
Duangkamol	Ponchamni	UNFPA, Thailand
Thananda	Naiwatanakul	Thai Ministry of Public Health and US Collaboration (TUC)
Pimpanitta	Saenyakul	USAID, Regional Development Mission, Asia (RDMA)
Pennapa	Saenkla	Institute for Population and Social Research, Mahidol University
Suchada	Thaweesit	Institute for Population and Social Research, Mahidol University
Kriengkrai	Srithanaviboonchai	Research Institute for Health Sciences, Chiang Mai University
Arunrat	Tangmunkongvorakul	Research Institute for Health Sciences, Chiang Mai University
Jarun	Chueayen	Research Institute for Health Sciences, Chiang Mai University
Lucy	Stackpool-Moore	Watipa
Niwat	Suwanphatthana	UNAIDS Thailand
Patchara	Benjarattanaporn	UNAIDS Thailand

The People Living with HIV Stigma Index 2.0

Questionnaire



Before the Interview... *[Sheet for the Interviewer]*

Before starting the interview, you must complete the following 3 actions. Please tick the box when completed.

·	Give the interviewee the information sheet and allow him/her time to read through it. If he/she is unable to read, you must read it out to him/her.	☐
·	Read the informed consent form to the interviewee. If he/she agrees to participate in the study, complete two copies of the form. After both forms have been signed, give one to the interviewee for him/her to keep and you keep the other one.	☐
·	Create a unique identifying code:	☐

Country code	Interviewer code	Interviewee code	Date of the interview (dd/mm/yy)

NOTE:
○ = Select one
☐ = Multiple selections possible

Section A.
ABOUT YOU

1.	**How old are you?**
	_______ years
2.	**What sex were you assigned at birth, on your birth certificate?**
	○ Female ○ Male
3.	**For some people, their gender identity differs from the sex they were assigned at birth. How you do describe yourself?**
	○ Female ○ Male ○ Transgender ○ I do not identify as female, male, or transgender ○ I prefer not to answer
4.	**How long have you known your HIV-positive status?**
	_______ years (If less than 1 year, enter “0”. If respondent cannot remember, enter “99”.)
5.	**Are you currently in an intimate/sexual relationship (whether married or unmarried)?**
	○ Yes ○ No [Skip to Q7]

6. **Is your partner also living with HIV? If you have more than one partner, are any of your partners living with HIV?**

○ Yes, my partner(s) is also HIV-positive
○ No, my partner(s) is not HIV-positive
○ I am unsure about the HIV status of my partner(s)

7. **How many children live in your household that you take care of?**

children

8. **Are you currently following any type of formal education?**

○ Yes
○ No

9. **What is the highest level of formal education you have completed?**

○ No formal education
○ Primary/elementary/local equivalent
○ Secondary/high school/local equivalent
○ Trade/vocational school
○ University/tertiary education

10. **Which one of these statements best describes your current work status?**

○ In full-time work (as an employee)
○ In part-time work (as an employee)
○ Working full-time, but not as an employee (self-employed or business owner)
○ Doing casual or informal part-time work (self-employed or paid work for others)
○ Retired/on pension
○ Unemployed

11. **In the last 12 months, how often have you been unable to meet basic needs (e.g., food, shelter, or clothing?**

○ Never
○ Some of the time
○ Most of the time

12. **Please indicate if you currently belong to or have been a member of any of the following groups (tick “Yes”, “No” or “Prefer not to answer” for each).**

	Yes	No	Prefer not to answer
a. Member of a racial, ethnic, or religious minority	○	○	○
b. Member of an indigenous/aboriginal group	○	○	○
c. Living with a disability (vision, hearing, mobility, intellectual/ developmental) of any kind (other than HIV)	○	○	○
d. Refugee or asylum seeker	○	○	○
e. Migrant worker	○	○	○
f. Internally displaced person	○	○	○
g. Incarcerated/in prison	○	○	○

13. **Are you a member of a network or support group of people living with HIV?**

○ Yes
○ No

Section B.
DISCLOSURE

14.	**Do the following people or groups of people know your HIV-status? (Please select "Yes", "No" or "N/A" for each person/group below. If "Yes", tick if your status was ever disclosed to at least one person from that group without your consent.)**				
		Yes	If "Yes", was your status ever disclosed to this person/group without your consent?	No	N/A – This group is not relevant for me
	a. Your husband/wife/partner(s)	○	○	○	○
	b. Your children	○	○	○	○
	c. Other family members	○	○	○	○
	d. Your friends	○	○	○	○
	e. Your neighbors	○	○	○	○
	f. Your employer(s)	○	○	○	○
	g. Your co-workers	○	○	○	○
	h. Your teacher(s)/school administrator(s)	○	○	○	○
	i. Your classmates	○	○	○	○
	j. Local leaders	○	○	○	○
	k. Authority figures (e.g., police, judges, law enforcement, etc.)	○	○	○	○

15.	**Please tell me if you "Agree", "Somewhat agree" or "Disagree" with each of the following statements about your experiences when disclosing your status. (Please select one response for each item below.)**				
		Agree	Somewhat agree	Disagree	N/A
	a. In general, disclosing your HIV status to <u>people you are close to</u> (e.g., partner, family, close friends) has been a positive experience.	○	○	○	○
	b. In general, <u>people you are close to</u> were supportive when they first learned about your HIV status.	○	○	○	○
	c. In general, disclosing your HIV status to <u>people you don't know very well</u> has been a positive experience.	○	○	○	○
	d. In general, <u>people you don't know very well</u> were supportive when they first learned about your HIV status.	○	○	○	○
	e. In general, disclosing your HIV status has become easier over time.	○	○	○	○

Section C.
YOUR EXPERIENCE OF STIGMA AND DISCRIMINATION

16.	**In this section, I will be asking you about stigma and discrimination you may have experienced because of your HIV status. (Please select one response for each question below.)**	Yes, within the last 12 months	Yes, but not in the last 12 months	No	N/A
a.	Have you ever been excluded from social gatherings or activities (e.g., weddings, funerals, parties, clubs) because of your HIV status?	○	○	○	○
b.	Have you ever been excluded from religious activities or places of worship because of your HIV status?	○	○	○	○
c.	Have you ever been excluded from family activities because of your HIV status?	○	○	○	○
d.	Have you ever been aware of family members making discriminatory remarks or gossiping about you because of your HIV status?	○	○	○	○
e.	Have you ever been aware of other people (other than family members) making discriminatory remarks or gossiping about you because of your HIV status?	○	○	○	○
f.	Has someone ever verbally harassed you (e.g., yelled, scolded, or was otherwise verbally abusive) because of your HIV status?	○	○	○	○
g.	Has someone ever blackmailed you because of your HIV status?	○	○	○	○
h.	Has someone every physically harassed or hurt you (e.g., pushed, hit, or was otherwise physically abusive) because of your HIV status?	○	○	○	○
i.	Have you ever been refused employment or lost a source of income or job because of your HIV status?	○	○	○	○
j.	Has your job description or the nature of your job ever been changed, or have you ever been denied a promotion, because of your HIV status?	○	○	○	○
k.	Has your wife/husband, partner(s) or child(ren) ever experienced discrimination because of your HIV status?	○	○	○	○

Section D.

INTERNALISED STIGMA (THE WAY YOU FEEL ABOUT YOURSELF) AND RESILIENCE

17. **Please answer whether your ability to meet the following needs over the past 12 months has been positively affected, not affected, or negatively affected by your HIV status. (Please select one response for each item below.)**

		Has been positively affected by my HIV status	Has not been affected by my HIV status	Has been negatively affected by my HIV status	N/A
a.	My self-confidence	○	○	○	○
b.	My self-respect	○	○	○	○
c.	My ability to respect others	○	○	○	○
d.	My ability to cope with stress	○	○	○	○
e.	My ability to have close and secure relationships with others	○	○	○	○
f.	My ability to find love	○	○	○	○
g.	My desire to have children	○	○	○	○
h.	My ability to achieve personal and/or professional goals	○	○	○	○
i.	My ability to contribute to my community	○	○	○	○
j.	My ability to practice a religion/ faith as I want to	○	○	○	○

18. **What about before 12 months ago? In general, was the effect of your HIV status on your ability to meet the needs described in Q17 better, about the same, or worse?**

○ Better
○ About the same
○ Worse
○ N/A, because I was diagnosed with HIV within the last 12 months

19. **In the past 12 months, have you ever done any of the following things because of your HIV status? (Please select one response for each item below.)**

		Yes	No	N/A (category not relevant for me)
a.	I have chosen not to attend social gatherings	○	○	○
b.	I avoided going to a clinic or hospital when I needed to	○	○	○
c.	I have chosen not to apply for a job(s)	○	○	○
d.	I have chosen not to seek social support	○	○	○
e.	I have isolated myself from family and/or friends	○	○	○
f.	I decided not to have sex	○	○	○

20. **Please tell me if, in general, you agree or disagree with the following statements.**

		Agree/Yes	Disagree/No
a.	It is difficult to tell people that I am HIV positive	○	○
b.	Being HIV positive makes me feel dirty	○	○
c.	I feel guilty that I am HIV positive	○	○
d.	I am ashamed that I am HIV positive	○	○
e.	I sometimes feel worthless because I am HIV positive	○	○
f.	I hide my HIV status from others	○	○

Section E.
INTERACTIONS WITH HEALTHCARE SERVICES

HIV Testing, Care, and Treatment

21. **Was it your choice to be tested for HIV?**

○ Yes, it was my choice
○ Yes, but I was pressured by others
○ No, I was tested without my knowledge and only found out after the test had been done [Skip to Q25]
○ No, I was forced to take an HIV test without my consent [Skip to Q25]
○ No, I was born with HIV or acquired HIV in infancy/childhood and was not aware I had been tested [Skip to Q25]

22. **What was the MAIN reason you were tested for HIV?**

○ A provider recommended it, or as part of other health care (e.g., antenatal, medical male circumcision, STI testing/treatment, PrEP)
○ I believed I was at risk for HIV
○ I felt sick and I/someone close to me thought it might be HIV related
○ As part of or because of a community-based program
○ It was mandatory (e.g., for employment, visa/citizenship, incarceration, marriage, to access antenatal care)
○ I just wanted to know
○ Other reasons (please specify) ______________________________

23. **About how long was the time between when you first thought you should get an HIV test and the time you first took an HIV test?**

INSTRUCTION TO INTERVIEWER: DO NOT READ THE RESPONSE OPTIONS – ASK RESPONDENT THE QUESTION AND, BASED ON THE RESPONSE, TICK THE APPROPRIATE BOX.
○ 6 months or less
○ More than 6 months to 2 years
○ More than 2 years
○ I don't know/can't remember

24. **Did fears about how other people (e.g., your family, friends, employer, or community) would respond if you tested positive make you hesitate to get tested for HIV?**

○ Yes
○ No

25. **Are you currently or have you ever been on HIV treatment?**

○ Yes
○ No [Continue with Q26, then skip to Q34]

26. **Did any of the following make you hesitate, delay, or prevent you from initiating care or treatment for HIV? (Tick "Yes" or "No" for each item below.)**

	Yes	No
a. I was worried that my partner, family or friends would find out my status	○	○
b. I was worried other people (not family or friends) would find out my status	○	○
c. I was not ready to deal with my HIV infection	○	○
d. I was afraid health workers (doctors, nurses, staff) would treat me badly or disclose my status without my consent	○	○
e. I had a bad experience with a health worker previously	○	○

27. **Was it your choice to start taking HIV (antiretroviral) treatment or were you pressured or forced by anyone to start HIV treatment?**

○ I was told the benefits and chose to start as soon as it was offered to me
○ When treatment was offered to me, I took the decision to wait and started at a later time
○ I felt pressured or forced to start by health care staff
○ Other reasons (please specify): ______________________

28. **After being diagnosed with HIV, how long was it before you began taking HIV (antiretroviral) treatment?**

INSTRUCTION TO INTERVIEWER: DO NOT READ THE RESPONSE OPTIONS – ASK RESPONDENT THE QUESTION AND, BASED ON THE RESPONSE, TICK THE APPROPRIATE BOX.
○ Immediately – or the same day I was diagnosed
○ >1 day to 1 month (30 days) after being diagnosed
○ >1 month to 6 months after being diagnosed
○ >6 months to 2 years after being diagnosed
○ >2 years after being diagnosed
○ I can't remember

29. **In the past 12 months, did fears about someone learning your HIV status lead you to miss a dose of your HIV (antiretroviral) treatment?**

○ Yes
○ No

30. **Did your most recent viral load test in the last 12 months show you have an undetectable viral load?**

○ Yes
○ No – I have not had a viral load test in the last 12 months
○ No – I had a viral load test and am waiting for the results
○ No – The virus was detectable/I am not virally suppressed
○ No – I have never had a viral load test
○ I don't know what viral load or viral suppression are
○ Cannot remember

Treatment Interruptions

31. **Have you ever interrupted or stopped your HIV (antiretroviral) treatment?**

○ Yes
○ No [Skip to Q35]
○ I don't know/can't remember [Skip to Q35]

32. **If you have ever stopped taking HIV (antiretroviral) treatment for any period of time in the last 12 months, was that for any of the following stigma-related reasons?**

○ I am worried that someone would find out my HIV status
○ I am not ready to deal with my HIV infection
○ I am worried the healthcare workers would treat me badly or disclose my HIV status without my consent
○ I was denied HIV treatment due to currently using drugs
○ N/A – I have not been taking HIV (antiretroviral) treatment in the last 12 months or I have not stopped taking HIV (antiretroviral) treatment in the last 12 months
○ Other reason (please specify): ____________________

33. **If you have ever stopped care or treatment for HIV, did any of the following make you hesitate, delay, or prevent you from restarting care or treatment for HIV? (Tick "Yes" or "No" for each item below.)**

		Yes	No
a.	I was worried that my partner, family or friends would find out my status	○	○
b.	I was worried other people (not family or friends) would find out my status	○	○
c.	I was not ready to deal with my HIV infection	○	○
d.	I was afraid health workers (doctors, nurses, staff) would treat me badly or disclose my status without my consent	○	○
e.	I had a bad experience with a health worker previously	○	○

34. **What is the main non-stigma related reason you are not currently taking HIV (antiretroviral) treatment or ever stopped it?**

○ Medication is not available at the clinic (based on policy or stock outs)
○ Medication is not affordable to me
○ I am unable to collect medications at the clinic or pharmacy
○ I cannot tolerate medication side effects
○ I do not feel treatment is needed
○ I do not qualify for treatment because of my CD4s or viral load count
○ I was in prison or detention and treatment was not available
○ N/A – I have stopped treatment, but not in the last 12 months
○ Other reasons (please specify) ________________________

General Health Status

35. **In general, how would you describe your health at the moment?**

○ Good
○ Fair
○ Poor

36.	**In the last 12 months, have you been diagnosed with any of the following? (Tick "Yes" or "No" for each item below.)**	Yes	No
a.	Tuberculosis (TB)	○	○
b.	Viral hepatitis	○	○
c.	Sexually transmitted infection(s)/"STD" (e.g., herpes, gonorrhea, chlamydia, syphilis)	○	○
d.	Mental health condition (e.g., anxiety, depression, insomnia, post-traumatic stress)	○	○
e.	Noncommunicable disease(s) (NCDs)	○	○
f.	Opportunistic infection(s)	○	○
g.	Alcohol/drug dependency syndrome(s)	○	○

37. **In the past 12 months, have you been offered treatment for all of the conditions you have listed to be diagnosed with in Q36?**

○ Yes
○ No
○ N/A – I have not been diagnosed with any of these conditions in the last 12 months

Service Delivery Experiences

38. **Where do you usually receive your regular HIV care and treatment?**

○ Government or public clinic or facility
○ Private clinic, hospital or doctor
○ Non-governmental (NGO) clinic or facility
○ Community-led care (e.g., drop-in centers run by key population groups)
○ Multiple places
○ N/A – I am not currently receiving HIV care or treatment [Skip to Q42]

39. **Do you know if there is a clinic providing HIV-related services that is community-led, that you can access?**

○ Yes, there is, but I don't access my HIV care there
○ Yes, there is, and I access my HIV care there
○ No, there is not [Skip to Q41]
○ I don't know [Skip to 41]

40. **Which of the following HIV-related services can you access in the community-led facility? (Please tick all appropriate boxes.)**

○ HIV information
○ Peer support (groups)
○ Adherence counseling
○ Prevention services and commodities
○ HIV treatment services
○ Case management
○ HIV care and testing services

41. **In the past 12 months, when seeking HIV specific health care, have you experienced any of the following from health facility staff working in the place you receive your HIV care? (Tick “Yes” or “No” for each item below.)**

		Yes	No
a.	Denial of health services because of your HIV status	○	○
b.	Being advised not to have sex because of your HIV status	○	○
c.	Being talked badly about or gossiped about because of your HIV status	○	○
d.	Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	○	○
e.	Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	○	○
f.	Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	○	○
g.	Telling other people about your HIV status without your consent	○	○

42. **In the past 12 months, have you sought healthcare for non-HIV related health needs (e.g., malaria, flu, dental services, vaccinations, injuries, etc.)?**

○ Yes
○ No [Skip to Q44]

43. **In the past 12 months, when seeking care for non-HIV related health needs, have you experienced any of the following treatment by health facility staff? (Tick “Yes” or “No” for each item below.)**

		Yes	No
a.	Denial of health services because of your HIV status	○	○
b.	Denial of dental care because of your HIV status	○	○
c.	Being advised not to have sex because of your HIV status	○	○
d.	Being talked badly about or gossiped about because of your HIV status	○	○
e.	Verbal abuse (yelling, scolding, name calling, or being otherwise verbally abused) because of your HIV status	○	○
f.	Physical abuse (pushing, hitting, or being otherwise physically abused) because of your HIV status	○	○
g.	Avoidance of physical contact with you/taking extra precautions (e.g., wearing double gloves) because of your HIV status	○	○
h.	Telling other people about your HIV status without your consent	○	○

44. **When you go outside the HIV clinic for general (non-HIV related) health services, do you usually disclose that you are living with HIV?**

○ Yes
○ No

45. **Do you think your medical records relating to your HIV status are kept confidential?**

○ I am sure that my medical records will be kept confidential and will not be shared without my written informed consent
○ I don’t know if my medical records are kept confidential
○ It is clear to me that my medical records are not being kept confidential

Sexual and Reproductive Health

46. **In the last 12 months, has a healthcare professional done any of the following, solely because of your HIV status? (Select one response for each item below.)**

		Yes [If "Yes", please answer #a and #b]	#a In which district/ county did this occur? (Please do not list facility name.)	#b Did you tell anyone about this and, if so, who (please explain)?	No	N/A	Prefer not to answer
a.	Advised you not to mother/father a child	○	________	________	○	○	○
b.	Pressured or incentivized you to get sterilized	○	________	________	○	○	○
c.	Sterilized you without your knowledge or consent	○	________	________	○	○	○
d.	Denied your contraception/family planning services	○	________	________	○	○	○
e.	Told you that you had to use (a specific method of) contraception in order to get your HIV (antiretroviral) treatment	○	________	________	○	○	○

The following question (Q47) is only for people who were assigned FEMALE on their birth certificate.

47. **Has a healthcare professional done any of the following, solely because of your HIV status? (Select one response for each item below.)**

		Yes, within the last 12 months	Yes, but not within the last 12 months	No	N/A	Prefer not to answer
a.	Advised you to terminate a pregnancy	○	○	○	○	○
b.	Pressured you to use a specific type of contraceptive method	○	○	○	○	○
c.	Pressured you to use a particular method of giving birth/delivery option	○	○	○	○	○
d.	Pressured you to use a particular infant feeding practice	○	○	○	○	○
e.	Pressured you to take HIV (antiretroviral) treatment during pregnancy	○	○	○	○	○

Section F.
HUMAN RIGHTS AND EFFECTING CHANGE

48. **Have you experienced any of the following abuses of your rights? (Please select one response for each item below.)**

		Yes, within the last 12 months	Yes, but not within the last 12 months	No	Prefer not to answer
I was forced to get tested for HIV or disclose my status in order to...					
a.	...obtain a visa or to apply for residency/citizenship in a country	○	○	○	○
b.	...apply for a job or get a pension plan	○	○	○	○
c.	...attend an educational institution or get a scholarship	○	○	○	○
d.	...get health care services	○	○	○	○
e.	...get medical insurance	○	○	○	○
In addition, have you ever experienced any of the following abuses of your rights?					
f.	I was arrested or taken to court on a charge related to my HIV status	○	○	○	○
g.	I was detained or quarantined because of my HIV status	○	○	○	○
h.	I was denied a visa or permission to **enter** another country because of my HIV status	○	○	○	○
i.	I was denied residency or permission to **stay** in another country because of my HIV status	○	○	○	○
j.	I was forced to disclose my HIV status publicly or my status was publicly disclosed without my consent	○	○	○	○
k.	I was forced to have sex when I did not want to	○	○	○	○
l.	I was denied access to a domestic violence shelter	○	○	○	○
m.	My partner(s) prevented me from accessing (public/private/community-led) health services	○	○	○	○

49a. **If any of these rights abuses (in Q48) happened to you in the last 12 months, did you try to do anything about the matter?**

○ Yes [Answer Q49b and Q49c; skip Q49d]
○ No [Skip to Q49d]
○ N/A – I have not experienced any of the rights abuses mentioned in Q48 in the last 12 months [Skip to Q50]

49b. **If yes, what did you try to do about the matter?**

- ○ Filed a complaint
- ○ Contacted a lawyer
- ○ Contacted a government official or politician
- ○ Spoke out publicly
- ○ Contacted a community organization/network of persons living with HIV for support
- ○ Other (please specify): ______________

49c. **If yes, what was the result?**

- ○ The matter has been dealt with
- ○ The matter is still in the process of being dealt with
- ○ Nothing happened/the matter was not dealt with

49d. **If no, what was the main reason for not trying to do something about the matter?**

- ○ I did not know where to go/how to take action
- ○ I had insufficient financial resources to take action
- ○ The process of addressing the problem appeared too complicated
- ○ I felt intimidated or scared to take action
- ○ I was worried taking action might lead people to learn about my HIV status
- ○ I was worried taking action might lead people to learn that I am a man having sex with men/transgender person/person who sells sex/person who uses drugs
- ○ I was advised against taking action by someone else
- ○ I had no/little confidence that the outcome would be successful
- ○ There was a lack of evidence of the abuse
- ○ Other (please specify): _________________

50. **Do you know if there are any laws in your country to protect people living with HIV from discrimination?**

- ○ Yes, there are laws
- ○ No, there are no laws
- ○ I don't know if there are laws

51. **Have you done any of the following? (Please select one response for each item below.)**

		Yes, within the last 12 months	Yes, but not within the last 12 months	No
a.	Challenged or educated someone who was engaging in stigma or discrimination against you	○	○	○
b.	Challenged or educated someone who was engaging in stigma or discrimination against other people living with HIV	○	○	○
c.	Provided emotional, financial, or other support to help someone living with HIV deal with stigma and/or discrimination	○	○	○
d.	Participated in an organization or educational campaign working to address stigma and discrimination against people living with HIV	○	○	○
e.	Encouraged a community leader to take action about issues of stigma and discrimination against people living with HIV	○	○	○
f.	Encouraged a government leader or a politician to take action about issues of stigma and discrimination against people living with HIV	○	○	○
g.	Spoke to the media about issues of stigma and discrimination against people living with HIV	○	○	○

Section G.

STIGMA AND DISCRIMINATION EXPERIENCED FOR REASONS OTHER THAN HIV STATUS

This section addresses stigma and discrimination you may have experienced because of groups you belong to, ways you self-identify, or things that you do. Remember, you can refuse to answer any question that makes you feel uncomfortable.

Continue on to Q52 if the participant:
- Identified as transgender in Q3;
- Answered male in Q2, but not in Q3;
- Answered female in Q2, but not in Q3.

Otherwise, go to Q55 and follow the instructions there.

NOTE: These questions are for participants who identify as transgender, non-gender binary, or people who were assigned a gender on their original birth certificate that does not match their current gender identify.

52. **Please select one response for each question below.**

		Yes, within the last 12 months	Yes, but not in the last 12 months	No	Prefer not to answer
a.	Have you ever felt excluded from family activities because of your gender identity?	○	○	○	○
b.	Have you ever felt that family members have made discriminatory remarks or gossiped about you because of your gender identity?	○	○	○	○
c.	Have you ever felt afraid to seek health services because of your gender identity?	○	○	○	○
d.	Have you ever avoided seeking health services because you worried someone may learn of your gender identity?	○	○	○	○
e.	Has someone ever verbally harassed you because of your gender identity?	○	○	○	○
f.	Has someone ever blackmailed you because of your gender identity?	○	○	○	○
g.	Has someone ever physically harassed or hurt you because of your gender identity?	○	○	○	○

53. **In general, do the following people or groups of people know your gender identity? (Tick "Yes" or "No" for each of the following items.)**

		Yes	No
a.	Other transgender people or people whose gender identity differs from the sex they were assigned at birth	○	○
b.	Family or other friends	○	○
c.	Other people in your community	○	○

54. **Do you belong to a network or support group for transgender people or people whose gender identity differs from the sex they were assigned at birth?**

○ Yes
○ No

THIS NEXT SECTION IS ONLY FOR PARTICIPANTS WHO CURRENTLY IDENTIFY AS MALE.

THE QUESTIONS SHOULD BE ASKED OF THOSE WHO ANSWERED "MALE" TO Q3 OR WHO ANSWERED "FEMALE" TO Q2 AND "MALE" OR "TRANSGENDER" TO Q3.

ALL OTHERS, SKIP TO Q60.

55. **Do you currently or have you previously identified as a member of any of the following groups?**

○ Men who have sex with men (MSM) [Skip to Q57]
○ Gay/homosexual [Skip to Q57]
○ Bisexual [Skip to Q65]
○ None of the above [Continue with Q56]

56. **Have you ever had sex with another man?**

○ Yes
○ No
○ Prefer not to answer

The next section is for participants who identify as MSM or gay/homosexual in Q55 or who answered "Yes" to Q56. If participants identify as "None of the above" in Q55 and answered "No" or "Prefer not to answer" in Q56, skip to Q68.

57. **Please select one response for each question below.**

		Yes, within the last 12 months	Yes, but not in the last 12 months	No	Prefer not to answer
a.	Have you ever felt excluded from family activities because you are gay/homosexual/MSM/have sex with men?	○	○	○	○
b.	Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are gay/homosexual/MSM/have sex with men?	○	○	○	○
c.	Have you ever felt afraid to seek health services because you worried someone may learn you are gay/homosexual/MSM/have sex with men?	○	○	○	○
d.	Have you ever avoided seeking health services because you worried someone may learn you are gay/homosexual/MSM/have sex with men?	○	○	○	○
e.	Has someone ever verbally harassed you because you are gay/homosexual/MSM/have sex with men?	○	○	○	○
f.	Has someone ever blackmailed you because you are gay/homosexual/MSM/have sex with men?	○	○	○	○
g.	Has someone ever physically harassed or hurt you because you are gay/homosexual/MSM/have sex with men?	○	○	○	○

58. **In general, do the following people or groups of people know that you are gay/homosexual/MSM/have sex with men? (Tick "Yes" or "No" for each of the following items.)**

		Yes	No
a.	Others who are gay/homosexual/MSMs/have sex with men	○	○
b.	Family or other friends	○	○
c.	Other people in your community	○	○

59. **Do you belong to a network or support group for people who are gay/homosexual/MSM/have sex with men?**

○ Yes
○ No

THIS NEXT SECTION IS ONLY FOR PARTICIPANTS WHO CURRENTLY IDENTIFY AS FEMALE.

THE QUESTIONS SHOULD BE ASKED OF THOSE WHO ANSWERED "FEMALE" TO Q3 OR WHO ANSWERED "MALE" TO Q2 AND "FEMALE" OR "TRANSGENDER" TO Q3.

ALL OTHERS, SKIP TO Q68.

60. **Do you currently or have you previously identified as a member of any of the following groups?**

○ Women who have sex with women [Skip to Q62]
○ Lesbian/gay [Skip to Q62]
○ Bisexual [Skip to Q65]
○ None of the above [Continue with Q61]

61. **Have you ever had sex with another woman?**

○ Yes
○ No
○ Prefer not to answer

This next section is for participants who identify as lesbian/gay/WSW in Q60 or answered "Yes" to Q61. If participants identify as "None of the above" in Q60 and answered "No" or "Prefer not to answer" in Q61, skip to Q68.

62. **Please select one response for each question below.**

		Yes, within the last 12 months	Yes, but not in the last 12 months	No	Prefer not to answer
a.	Have you ever felt excluded from family activities because you are lesbian/gay/have sex with women?	○	○	○	○
b.	Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are lesbian/gay/have sex with women?	○	○	○	○
c.	Have you ever felt afraid to seek health services because you worried someone may learn you are lesbian/gay/have sex with women?	○	○	○	○
d.	Have you ever avoided seeking health services because you worried someone may learn you are lesbian/gay/have sex with women?	○	○	○	○
e.	Has someone ever verbally harassed you because you are lesbian/gay/have sex with women?	○	○	○	○
f.	Has someone ever blackmailed you because you are lesbian/gay/have sex with women?	○	○	○	○
g.	Has someone ever physically harassed or hurt you because you are lesbian/gay/have sex with women?	○	○	○	○

63. **In general, do the following people or groups of people know that you are lesbian/gay/have sex with women? (Tick "Yes" or "No" for each of the following items.)**

		Yes	No
a.	Others who are lesbian/gay/have sex with women	○	○
b.	Family or other friends	○	○
c.	Other people in your community	○	○

64. **Do you belong to a network or support group for people who are lesbian/gay/have sex with women?**

○ Yes
○ No

THIS NEXT SECTION IS ONLY FOR PARTICIPANTS WHO IDENTIFIED AS BISEXUAL IN Q55 OR Q60.

ALL OTHERS, SKIP TO Q68.

65. **Please select one response for each question below.**

		Yes, within the last 12 months	Yes, but not in the last 12 months	No	Prefer not to answer
a.	Have you ever felt excluded from family activities because you are bisexual/have sex with men and women?	○	○	○	○
b.	Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are bisexual/have sex with men and women?	○	○	○	○
c.	Have you ever felt afraid to seek health services because you worried someone may learn you are bisexual/have sex with men and women?	○	○	○	○
d.	Have you ever avoided seeking health services because you worried someone may learn you are bisexual/have sex with men and women?	○	○	○	○
e.	Has someone ever verbally harassed you because you are bisexual/have sex with men and women?	○	○	○	○
f.	Has someone ever blackmailed you because you are bisexual/have sex with men and women?	○	○	○	○
g.	Has someone ever physically harassed or hurt you because you are bisexual/have sex with men and women?	○	○	○	○

66. **In general, do the following people or groups of people know that you are bisexual/have sex with men and women? (Tick "Yes" or "No" for each of the following items.)**

		Yes	No
a.	Others who are bisexual/have sex with men and women	○	○
b.	Family or other friends	○	○
c.	Other people in your community	○	○

67. **Do you belong to a network or support group for people who are bisexual/have sex with men and women?**

○ Yes
○ No

Q68 IS FOR ALL PARTICIPANTS.

68. **Have you ever had sex in exchange for money or goods? (This question is asked of all participants.)**

○ Yes
○ No [Skip to Q73]
○ Prefer not to answer

69. **Do you identify as a sex worker?**

○ Yes
○ No
○ Prefer not to answer

If "Yes" to Q68 or Q69 (or both), continue below. If "No" or "Prefer not to answer" to both, skip to Q73.

70. **Please select one response for each question below.**

		Yes, within the last 12 months	Yes, but not in the last 12 months	No	Prefer not to answer
a.	Have you ever felt excluded from family activities because you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○
b.	Have you ever felt that family members have made discriminatory remarks or gossiped about you because you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○
c.	Have you ever felt afraid to seek health services because you worried someone may learn you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○
d.	Have you ever avoided seeking health services because you worried someone may learn you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○
e.	Has someone ever verbally harassed you because you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○
f.	Has someone ever blackmailed you because you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○
g.	Has someone ever physically harassed or hurt you because you are (or were) a sex worker or sell (or sold) sex?	○	○	○	○

71. **In general, do the following people or groups of people know that you are (or were) a sex worker or sell (or sold) sex? (Tick "Yes" or "No" for each of the following items.)**

		Yes	No
a.	Other sex workers/peers in the sex work community	○	○
b.	Family or other friends	○	○
c.	Other people in your community	○	○

72. **Do you belong to a network or support group for sex workers and/or people who sell sex?**

○ Yes
○ No

Q73 IS FOR ALL PARTICIPANTS.

73. **Have you ever injected or habitually used drugs such as heroin, cocaine, or methamphetamines? (This question is asked of all participants.)**

○ Yes
○ No [Skip to Section H, Q78]
○ Prefer not to answer

74. **Do you identify as a person who uses (or used) drugs?**

○ Yes
○ No [Skip to Section H, Q78]
○ Prefer not to answer

If "Yes" to Q73 or Q74 (or both), continue below. If "No" or "Prefer not to answer" to both, go to Section H, Q78.

75. **Please select one response for each question below.**

		Yes, within the last 12 months	Yes, but not in the last 12 months	No	Prefer not to answer
a.	Have you ever felt excluded from family activities because you use (or used) drugs?	○	○	○	○
b.	Have you ever felt that family members have made discriminatory remarks or gossiped about you because you use (or used) drugs?	○	○	○	○
c.	Have you ever felt afraid to seek health services because you worried someone may learn you use (or used) drugs?	○	○	○	○
d.	Have you ever avoided seeking health services because you worried someone may learn you use (or used) drugs?	○	○	○	○
e.	Has someone ever verbally harassed you because you use (or used) drugs?	○	○	○	○
f.	Has someone ever blackmailed you because you use (or used) drugs?	○	○	○	○
g.	Has someone ever physically harassed or hurt you because you use (or used) drugs?	○	○	○	○

76. **In general, do the following people or groups of people know that you use (or used) drugs? (Tick "Yes" or "No" for each of the following items.)**

		Yes	No
a.	Other people who use drugs	○	○
b.	Family or other friends	○	○
c.	Other people in your community	○	○

77. **Do you belong to a network or support group for people who use drugs?**

○ Yes
○ No

Section H.
PERSONAL EXPERIENCE OF STIGMA AND DISCRIMINATION

78. **We're coming to the end of the interview. Is there anything else you would like to share about your experiences? For example, this can be about stigma related to disclosure, your interactions with healthcare services, your human rights, or your efforts to effect positive change.**

-- END OF THE QUESTIONNAIRE --

Quality Checks

This section is designed to help the interviewer and team leader to check the questionnaire to make sure that it has been properly and fully completed. However, you also need to use your own judgement to make sure that a good job has been done. The team leader should check the interviewer's responses on their return to base/on receiving the completed questionnaire, and before it is passed for data entry. The interviewer should respond to the following points before the closure of the interview, so that the interviewee is able to assist you to complete the responses to these questions. Please circle your responses.

1. **Has the interviewee answered every question in Sections A to F (questions 1 – 51) of the questionnaire?**

○ Yes
○ No ➔ *If "No", please specify which questions have not been answered and give reasons why – other than them being not applicable:*

2. **Do the answers to the questions in Section G appear to be consistent and complete?**

○ Yes
○ No ➔ *If "No", please explain:*

3. **Has Section H, Q78 been completed?**

○ Yes
○ No ➔ *If "No", please explain:*

4. **Has page 2 of the questionnaire, the sheet for the interviewer, been completed?**

○ Yes
○ No ➔ *If "No", then please do so. Note: the last quality check can be completed by the interviewer after the interviewee has left, but before the interviewer leaves the place of the interview.*

5. **Has the unique identifying code been written on page 2?**

○ Yes
○ No

After the interview… *[Sheet for the Interviewer]*

Referrals and Follow-Up

1. **Did the interviewee need a referral?**

○ Yes
○ No [Skip to Q4]

2. **If "Yes", what kind of referral(s)?**
(Note: these categories of referral can be changed for local circumstances.)

☐ Legal
☐ Counseling
☐ Support group
☐ Other (please specify): ______________________________

3. **What steps have you taken to help the interviewee with the above referral(s)?**

☐ I have given sufficient information on the referral(s) already
☐ I will contact the interviewee later and give them the required information
☐ Further follow-up is needed (e.g., the team leader is contacting them)

Please give details of what you promised to do about referral(s) after the interview, if anything:

Case Studies and Keeping in Contact

4a. **Is this interviewee a potential candidate for a case study?**

○ Yes
○ No

4b. **Does the interviewee agree to be contacted again for reasons other than case study (e.g., to be invited to a feedback meeting, being provided a copy of the research, etc.)?**

○ Yes
○ No

4c. **If "Yes" to 4a. or 4b., has contact information been provided?**

Be sure to keep contact information (which may be 4a. or 4b. or both or because of further follow-up under 3c.) separate from this form to protect confidentiality.
○ Yes
○ No

This page has been left blank intentionally for your notes.

The International Partnership of the People Living with HIV Stigma Index consists of: The Joint (UNAIDS), International Community for Women Living with HIV (ICW), and Global Nework of People Living with HIV (GNP+).

This questionnaire is only authorised for use as part of an implementation of the People Living with HIV Stigma Index that is in accordance with the principles of governance as described on www.stigmaindex.org.

Any enquiries about the People Living with HIV Stigma Index should be directed to:
plhivstigmaindex@gnpplus.net.

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As part of a project coordinated by:

Led by the Population Council, Project SOAR is implemented in collaboration with Avenir Health, Elizabeth Glaser Pediatric AIDS Foundation, Johns Hopkins University, Palladium, and The University of North Carolina.

For further information contact the Thai Women Living with HIV Foundation (TWLHF) or UNAIDS Thailand.

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Thai Women Living with HIV Foundation

THE PEOPLE LIVING WITH HIV STIGMA INDEX
GNP+ GLOBAL NETWORK OF PEOPLE LIVING WITH HIV
ICW INTERNATIONAL COMMUNITY OF WOMEN LIVING WITH HIV
RIHES Chiang Mai University
watipa
Mahidol University Institute for Population and Social Research

Health & Opportunity Network
CAREMAT foundation
swing
สมาคมฟ้าสีรุ้ง PROUD ASSOCIATION
MAP FOUNDATION

กรมควบคุมโรค Department of Disease Control
DDC Division of AIDS and STIs
UNFPA The United Nations Population Fund
กองทุนประชากรแห่งสหประชาชาติ
UNAIDS
IOM UN MIGRATION

L'INITIATIVE sida, tuberculose, paludisme
IMPLEMENTED BY EXPERTISE FRANCE GROUPE AFD
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