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Developing a Theory-Based Intervention to Reduce HIV-Related Stigma in a Community in Northern Thailand

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Abstract

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By Yuthana Sriprapha

HIV-related stigma is a complex phenomenon that affects different stakeholders in different ways and at different levels. Both people living with HIV/AIDS (PLWHA) and the community are affected by stigma, albeit in different ways. In Thailand, instrumental stigma, i.e. fear of infection, is more common than symbolic stigma, i.e. negative attitudes toward PLWHA, because behaviors associated with HIV are not stigmatized behaviors in Thailand. Social status is likely to influence susceptibility to instrumental stigma in Thailand. In terms of socioeconomic status, less powerful individuals seem to be more vulnerable to stigma and its consequences than the more powerful. Instrumental HIV-related stigma in Thailand can also be present in the form of resource-based stigma especially in communities with limited resources. In summary, HIV-related stigma in Thailand can be characterized as arising from fear of infection and influenced by socioeconomic power.

A multi-level intervention program is proposed in this special study project to reduce HIV-related stigma and ultimately improve the quality of life of PLWHA. Hope House, a faith-based organization in Northern Thailand, and Wang Tao village, the neighboring community of Hope House, are the chosen site where the program will be implemented. The program aims to reduce internalized stigma in PLWHA residents of Hope House by increasing their self-esteem and to decrease instrumental stigma in the community by means of an education program. By empowering PLWHA residents to the level of self-reliance, it should also lessen the degree of resource-based stigma in PLWHAs and people in the community. An HIV/AIDS education program that increases the opportunity for community members to interact with PLWHAs is also envisaged to reduce instrumental stigma. Activities that encourage communication between people in the community and PLWHA residents should reduce stigma in both groups and thus improve the quality of life in PLWHA residents of Hope House.

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CHAPTER 1: INTRODUCTION

1.1 Introduction and Rationale

In the past three decades, HIV infection has undoubtedly led to more political and scientific mobilization than any other disease. The latest data from the World Health Organization reveal that 33.4 million people live with the HIV virus worldwide, with almost 90% of those infected living in developing countries (WHO, 2009). The increasing number of people living with HIV/AIDS (PLWHA) and their need for treatment and care place a heavy burden on healthcare and social systems and produce significant socioeconomic impacts on individuals, households and communities (Barnett *et al.*,2001; WHO, 2003). Despite medical advances and the increasingly widespread availability of medication, HIV/AIDS remains a significant public health issue. In 2005-2006, country and regional consultations on universal access to HIV prevention, treatment, care and support showed that stigma and discrimination against PLWHA were major barriers to universal access and undermined the effectiveness of national responses to HIV (MacQuarrie *et al.*, 2009).

Thailand is one of the countries that has experienced a decline in HIV infection as a result of successful HIV/AIDS prevention programs, reducing the estimated number of new HIV infections from 142,819 in 1991 to 19,500 in 2004 (Thailand Ministry of Public Health, 2005). Advanced HIV treatments have allowed PLWHA to live longer and they have reduced AIDS to a chronic, manageable condition. In 2004, it was estimated that there were 600,000 PLWHA in Thailand (Ruxrungtham *et al.*, 2004). The stigma associated with HIV/AIDS is so strong that it may discourage persons who are HIV

positive from disclosing their status to their sex partners. Therefore, the probability of increasing HIV transmission is more likely (Tunthanathip *et al.*, 2009). Moreover, stigma also negatively affects psychological well-being (Li *et al.*, 2009) influencing the quality of life of PLWHA (Khumsaen *et al.*, 2012).

Like HIV/AIDS, this stigma and discrimination is not distributed evenly throughout Thailand (Apinundecha et al., 2007). The Northern region of Thailand, bordering China, Laos, Myanmar, and Vietnam along the upper Mekong River, and populated by ethnic minorities referred to as "hill tribes" in Thailand, including the Akha, Hmong, Kachin, Karen, Lahu, Lisu, Shan and Yao, has been particularly affected by the epidemic, especially the upper north (MOPH, 2005). A UNESCO report notes that the Upper Mekong region, whose trade and migration routes remain in use, has long been characterized by ethnic diversity, cultural pluralism and linguistic complexity forming a coherent cultural, ecological and economic zone. Recently, however, as a result of the opening of borders to tourism and trade, there has been an increase in population movement across borders for purposes of trade, both legal and illegal, and employment. Particularly during the past 30 years, the "hill tribes" have been subject to both social stigmatization and legal discrimination resulting from restrictions on farming and degradation in their environment. When coupled with a breakdown in traditional social safety nets, this has increased their vulnerability to HIV/AIDS and produced major implications for the epidemiology and prevention of HIV/AIDS. According to UNESCO:

> "Many villages have experienced a rise in injection drug use, and are seeing more girls and women being drawn into the commercial sex trade. Girls and women

> from the highlands are a minority among sex workers in Thailand, but they disproportionately represent the lowest, most exploited strata of the sex industry. A lack of knowledge of HIV/AIDS and inadequate access to services in their own languages make it more difficult for highland women to negotiate condom use with clients. Moreover, increased poverty and the weakened social fabric of traditional communities have reduced their capacity to cope with the burdens imposed by the AIDS epidemic." *(Thailand's Response to HIV/AIDS: Progress and Challenges, P. 60, UNDP 2004).*

These factors mean that the Highland peoples face serious challenges, including HIV-related stigma, lack of social support, and mental health issues such as depression (Li *et al.*, 2009)

The majority of the Thai population is Buddhist, and Buddhism has a great deal of influence on their mindset, character, way of life, and health, particularly mental health. The teachings and principles of Buddhism were and still are a major component of Thai culture and are inseparable from Thai values and behavior (Disayavanish & Disayavanish, 2007) In the mid-1990s, Buddhist temples provided a source of care for PLWHA as an alternative to the day care centers at district hospitals established by the Thai government to provide medical, psychological, and social care to PLWHA. This suggests an important role for Buddhism in the support of PLWHA in Thailand.

Many organizations in Thailand have been established to help those PLWHA who are rejected by their family and need a place to reside and take care of themselves. "Hope House" is one such organization in the Nan Province in Northern Thailand. It is

surrounded by 'Wang Tao' village. Since the establishment of Hope House, no analysis has ever been conducted on HIV stigma either among PLWHA at Hope House or among people in Wang Tao; however, anecdotal evidence from another study suggests that levels of stigma in Northern Thailand are still high (Vanlandingham *et al.*, 2005). The planned intervention will target PLWHA residents of Hope House and community members of Wang Tao village.

Figure 1.1 The entrance of Hope House's main building

1.2 Hope House: Background

Hope House is a place to help people living with PLWHA who are rejected by their families in Nan Province and its vicinity. The house was built in 1990 by Bro. Raymond Frank Taylor a Catholic Religious and he is a member of The Servants of the Poor Order. In 2000, the house was transferred to the Diocese of Chiang Mai, which assigned the Congregation of the Most Holy Redeemer (also known as the

Redemptorists) to manage it. The Redemptorists continued Bro. Taylor's work providing a shelter for the poor. Due to the lack of employment and educational opportunities, many people in Nan found themselves working as laborers and were forced to migrate to find work. In October 23, 2000, the Redemptorists launched the "Hope House" as a residential center for PLWHA.

Figure 1.2 Nan and its vicinity.[1]

Nan is a province in the north of Thailand. It remains a largely rural province where traditional northern Thai culture and norms are generally preserved. It is one of the most serene and peaceful province in Thailand.

Hope House is surrounded by forest and mountains. The House consists of a main building and residential buildings for males and females that can accommodate a total of 25 residents. There are two members of the clergy and three lay staff members working in Hope House, and the three staff members are responsible for daily household chores such as cooking, cleaning and doing laundry. Activities for PLWHA residents of Hope House do not take place on a scheduled basis but are instead mostly situation-driven. And the activities are not necessarily aiming at reducing stigma in PLWHA.

[1] http://volunteers.rcnuwc.no/wp-content/uploads/2006/12/ban-joko-thailand.jpg , accessed on April 25, 2010

Wang Tao village is the nearest community to Hope House which is approximately 5 kilometers from Hope House. The village consists of around 200 households. The major occupation of the villagers is agriculture.

1.3 Problem Statement

While there is a growing body of theory seeking to understand and conceptualize HIV stigma, there is limited evidence of interventions designed to reduce stigma leading to sustained effects (Mahajan *et al.*, 2008). This may be because stigma theory is not being applied in intervention design. Effective intervention to reduce HIV-related stigma relies not only on theory, but on the integration of theory and evidence (Bos *et al.*, 2008). It is widely accepted that the content and intensity of stigmatizing beliefs are influenced by epidemiological, sociocultural and political contexts. It has been found that the level and pattern of HIV-related stigma in Thailand is different from what is found in Africa (Genberg *et al.*, 2008) or America (Herek and Capitanio, 1993). This points to the pressing need for the development of locally-appropriate theory-based intervention programs to reduce HIV stigma.

1.4 Purpose Statement

This special studies project aims to design an intervention to reduce stigma experienced by PLWHA residing in a faith-based residential program for PLWHA in Northern Thailand. The goal is to improve residents' quality of life by reducing HIV-related discrimination from the community and reducing their own internalized stigma.

1.5 Research Question

How can theories around HIV stigma, information about the socio-cultural context, and existing literature on stigma reduction interventions inform the development of an intervention to reduce HIV stigma in the Northern Thai community, of Wang Tao village?

The intervention will have the following objectives:

1. To reduce HIV-related stigma in the community (Wang Tao village).

2. To reduce the internalized stigma of PLWHA residents of Hope House.

3. To improve the quality of life of PLWHA residents of Hope House.

1.6 Significance Statement

Community level stigma and discrimination towards people living with HIV/AIDS is found all over the world. Since social support has found to positively affect psychological well-being of PLWHA, reducing community stigma should help improve the mental health of PLWHA by promoting more social support from the community. This support will reduce internalized shame and perceived stigma in PLWHA, and also will help other activities in the program to be more effective. The project will use knowledge from research to inform the development of a theory-based locally-appropriate intervention to help reduce HIV stigma in the community. The intervention research design process and conceptual framework have relevance for the development of similar projects in other communities around the world.

1.7 Methodology

This special study project started from reviewing the literature to understand HIV/AIDS stigma from a theoretical perspective. Then stigma reduction interventions that are suitable to the Thai socio-cultural context were reviewed in order to design an appropriate HIV/AIDS stigma reduction intervention program for PLWHA residents of Hope House and community members of Wang Tao village. No institutional IRB approval was needed for this special study project.

1.8 Definition of Terms[2]

People living with HIV/AIDS (PLWHA) refers to people who are infected with HIV and either progress to the state of AIDS or remain infected as the result of antiviral therapy (ART).

Internalized or Self-Stigma – self-hatred, shame, blame etc. Self-stigma refers to the process whereby people living with HIV react to and begin to accept the negative judgments of society and impose feelings of difference, inferiority and unworthiness on themselves. This may lead them to isolate themselves from their families and communities.

Normative stigma is the perceptions or feelings towards a group, such as people living with HIV, who are different in some respect. This stigma can be blatant or subtle, but it is always value-laden and compromises the human rights of those affected. Stigma is characterized by denial, ignorance and fear.

[2] http://www.iiep.unesco.org/fileadmin/user_upload/Cap_Dev_Training/pdf/1_4.pdf , accessed on January 15,2012

Felt or Perceived Stigma According to (Brown et al., 2003) "Felt stigma refers to real or imagined fear of societal attitudes and potential discrimination arising from a particular undesirable attribute, disease (such as HIV), or association with a particular group or behavior (e.g., homosexuality and promiscuity). For example, an individual many deny his/her risk of HIV or refuse to disclose HIV status for fear of the possible negative reactions of family, friends, and community."

Enacted stigmas are actions fuelled by stigma and which are commonly referred to as discrimination towards PLWHA. The effects of stigma are wide-ranging and may include actions taken by the person concerned in response to the stigma, and actions taken against the person concerned, which are discriminatory.

Instrumental stigma is expressed through an individual's concern about his or her risks of contracting HIV through casual contact with PLWHA.

Symbolic stigma is a vehicle for expressing religious, political, or other attitudes and values through one's perception of PLWHA.

Resource-based stigma can be described as a form of instrumental stigma and/or symbolic stigma (Holmes and Winskell, 2012). In term of instrumental stigma, it is the perception that investment of resources in PLWHA is wasted, due to the fact that AIDS is both an incurable and deadly disease, expressing as withdrawal of financial support to PLWHA and/or the purposeful neglect of PLWHA by household members (Donahue *et al*., 2001; Patient and Orr, 2003; Bond, 2006; Hilhorst *et al*., 2006; Kohi *et al*., 2006; Datta and Njuguna, 2008; Maman *et al*., 2009). In term of symbolic stigma, resource-based stigma can be viewed as the spoiled identity and stigmatization of PLWHA due to

economic dependence caused by poor health that blemish PLWHA's moral character (Moon *et al*., 2002).

CHAPTER 2: LITERATURE REVIEW

2.1 Status of HIV/AIDS Epidemics in Thailand

The first case of HIV/AIDS was reported in 1984, and the incidence of HIV/AIDS infection increased steadily in Thailand until the 1990s, when a massive HIV control program was implemented. Visits to commercial sex workers decreased by half and condom usage rose; thus the prevalence of sexually transmitted diseases (STDs) decreased dramatically and eventually a substantial reduction in new HIV infections was achieved. Thailand's successful efforts to slow the spread of HIV included a 100 percent condom use policy, which brothel owners were encouraged to enforce.

In some provinces, the spread of HIV continues to be severe, particularly in provinces that receive a large number of tourists and those along the eastern seaboard and Gulf of Thailand. HIV prevalence remained stable from 2003 to 2007 (1.4 percent), while access to antiretroviral therapy (ART) increased. There are very few developing countries where public policy has been effective in preventing the spread of HIV and AIDS on a national scale, but Thailand is an exception. It is a well-funded, politically supported and comprehensive prevention program that has saved millions of lives, reducing the number of new HIV infections from 143,000 in 1991 to 19,000 in 2003 (UNDP, 2004). Nonetheless, over a half a million people in Thailand are living with HIV.

Unless past efforts are sustained and new sources of infection are addressed, the striking achievements made in controlling the epidemic could now be put at risk. Factors

such as an increase in risky sexual behavior among young people and a rising number of STI cases (National AIDS Prevention and Alleviation Committee, 2010) have led to concerns that Thailand could face a resurgence of HIV and AIDS in coming years. A trend of increasing spread of HIV has been noted in the adolescent population, and HIV prevalence remains high in the traditionally higher-risk populations and shows no indications of declining any time soon. These patterns present a challenge for reducing the incidence of HIV by half in 2010 as targeted in the multi-national agreement on Universal Access, and according to the targets specified in the NAP (National AIDS Program) plan for 2007-2011. The report also points out that the highest prevalence of HIV still exists in the northern part of Thailand as in the early days of the epidemic.

The majority of Thailand's HIV infections occur through heterosexual sex (National AIDS Prevention and Alleviation Committee, 2010). Approximately five times as many indirect and street-based sex workers experienced new HIV and STI infections as brothel-based sex workers. This is especially worrisome because, proportionally, more indirect sex workers are outside formal HIV prevention programs than direct sex workers, and may not be receiving the same level of care and information about the prevention of HIV and STIs. HIV infection among men who have sex with men (MSM) remains high and does not show any indication of declining. HIV among MSM is highest in large urban centers and important tourist locations (UNGASS, 2009).

The Thai situation, while unique in many ways, has much in common with many of the other medium to high prevalence countries of the developing world:

1. The epidemic is spread primarily by behaviors that are quite normative.

2. In the absence of ART, rapid decline and death usually occur soon after the onset of symptoms (World Bank, 2000).

3. Intensive care giving is provided to PLWHA by their families, especially their parents, who live in tight-knit communities in close proximity to other families, and where information travels quickly and easily (Vanlandingham *et al.*, 2005).

4. Many Thais know individuals who are suffering from or who have died from AIDS (Im-em et al., 2002).

2.2 HIV/AIDS Stigma

The review of the theoretical background of HIV/AIDS stigma led to the development of the conceptual framework in Figure 2.1.

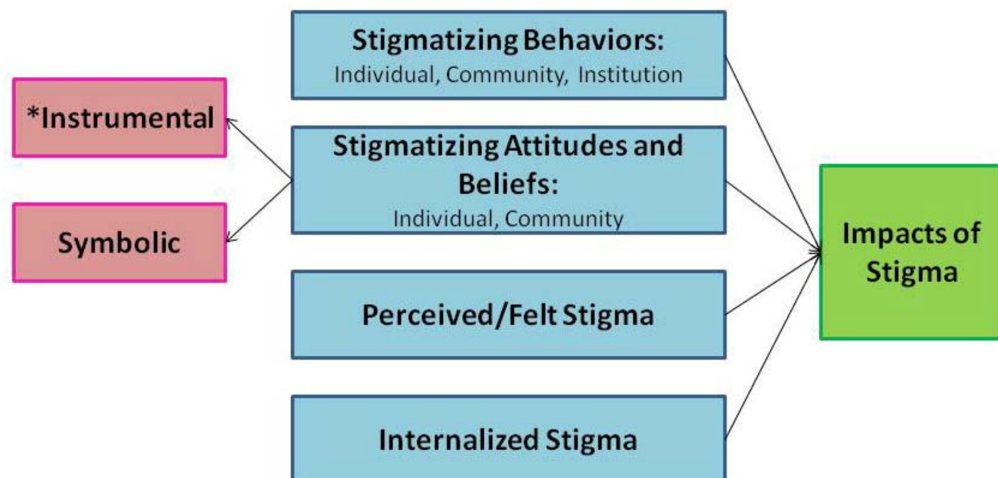

Figure 2.1 Conceptual framework of HIV/AIDS stigma theoretical background

Stigma is a complex phenomenon and various definitions have been proposed. UNAIDS (2002) defines stigma as an attribute or quality that “significantly discredits” an individual in the eyes of others. Stigma is a process and occurs within a particular culture

or setting—certain attributes are seized upon and defined by others as discreditable or unworthy. This definition draws heavily on Goffman (1963) who defined it as an attribute that, according to prevailing societal attitudes (from stigmatizers), is deeply discrediting and reduces a person (the stigmatized) to one who is in some way tainted and can therefore be denigrated. The stigmatized person is, therefore, seen to possess a spoiled or polluted identity that deviates from social norms and which deserves sanctioning (Goffman, 1963, qtd. In UNAIDS, 2002).

The discrediting attitudes and beliefs towards an individual or a stereotype result in either instrumental or symbolic stigma. Instrumental stigma allows people to distance themselves from the fear of infection, and symbolic stigma is based on socially defined norms of behavior, moral judgments and fear (Herek and Capitanio, 1993, qtd. in Stein *et al.*, 2003; People Living with HIV Stigma Index: Asia Pacific Regional Analysis 2011). Having HIV/AIDS would initiate a high level of stigma (Herek *et al.*, 1999) but it may be of different types.

"Enacted stigma is a discriminatory reaction to the attribute from those in the community, whereas felt stigma is the shame felt by the person with the attribute and the fear of encountering discrimination" (Scambler, 2004). According to Nyblade *et al.* (2006), felt stigma can become internalized so that PLWHA accept their lower status. PLWHA find it difficult to resist feelings of devaluation, making them reluctant to challenge stigma; this has been termed double devaluation by Gilmore and Somerville (1994). Nyblade *et al.* (2006) emphasized that this stigma is complicated by feelings of despair and helplessness aroused by having a life-threatening illness. This stigma may also be felt by family members.

Another interesting aspect of stigma is the social and cultural context of stigma. Less powerful groups or individuals seem to be more vulnerable to stigma and its impacts than the more powerful (Link and Phelan, 2001). Resource-based stigma, a form of instrumental stigma, happens with PLWHA who have limited resources. Resource-based stigma is based on the perception that HIV/AIDS is an incurable disease and there is no prospect of economic returns from this group of PLWHA (Holmes *et al.*, 2010).

2.3 HIV/AIDS Stigma Measures

Earnshaw and Chaudoir (2009) have reviewed the available HIV/AIDS stigma measures as summarized in Table 2.1. Considering that enacted stigma refers to the degree of stigmatizing behaviors PLWHA experience, scale factors used to measure enacted stigma are the most various.

Table 2.1 Scale factors used to measure different type of stigma

Internalized Stigma	Anticipated Stigma	Enacted Stigma	Anticipated Stigma and Internalized Stigma	Anticipated Stigma and Enacted Stigma
• Social isolation • Negative self-image • Self-acceptance	• Disclosure concerns • Concern with public attitudes about PLWHA	• Social rejection • Financial insecurity • Personalized stigma • Verbal abuse • Healthcare neglect • Social isolation • Fear of contagion • Workplace stigma • Stereotypes	• Internalized shame	• Social relationship

Resource: Adapted from Table 1 in Earnshaw and Chaudoir (2009)

2.4 Impacts of HIV/AIDS Stigma

HIV/AIDS is a socioeconomic-psychological phenomenon that affects PLWHA, their family and communities. According to the HIV stigma mechanism model proposed in Earnshaw and Chaudoir (2009) as shown in Figure 2.2, HIV infected and uninfected groups develop different mechanisms that cause different outcomes that affect each other (i.e. infected and uninfected groups). The diagram starts with stigma, which is a devalued attribute resulting from HIV infection. The existence of a devalued attribute impacts people through stigma mechanisms which represent the ways people react to the knowledge that they either possess (HIV infected) or do not possess (HIV uninfected) the devalued attribute. Among HIV uninfected people, the stigma mechanisms are expressed as psychological responses (prejudice, stereotype and discrimination) to the possibility that there are PLWHA who may threaten their health and possess moral blemishes. Outcomes for the uninfected group (i.e. desire for social distancing from PLWHA, failure to get tested, and acceptance of discriminatory social policy toward PLWHA) may lead to negative treatment of PLWHA and result in enacted, anticipated and internalized stigma. The stigma mechanisms experienced by PLWHA affect their mental health, social support and HIV symptoms.

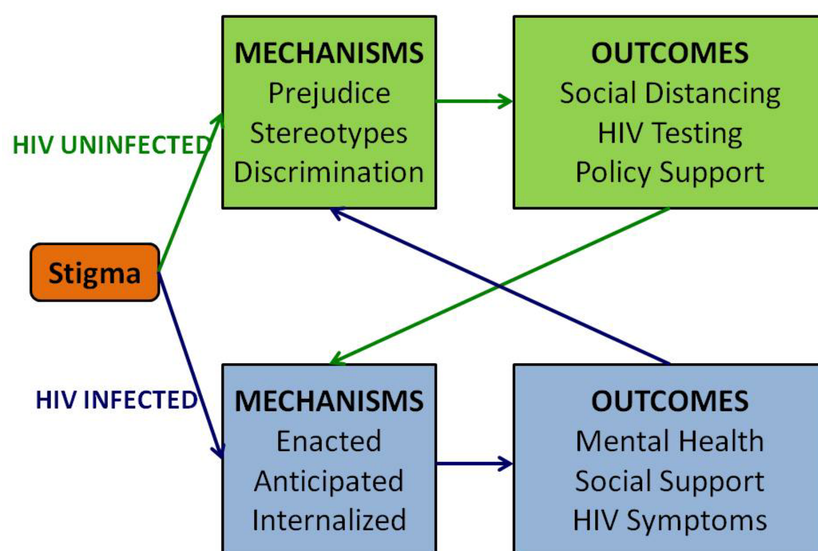

Figure 2.2 A model of HIV stigma mechanism (Earnshaw and Chaudoir, 2009)

2.4.1 Impacts on PLWHA individual

According to Goffman (1963), stigmatized people are socially devalued due to their condition, in this case, infection with HIV/AIDS. With this knowledge, they experience enacted stigma, anticipated stigma and/or internalized stigma. The overall impacts include psychological distress, decreased health and well-being and a decreased likelihood of disclosing their HIV status. It has been suggested that enacted stigma can predict substance use, anticipated stigma can predict depression and internalized stigma can predict sexual risk behavior (Earnshaw and Chaudoir, 2009). In Thailand, discrimination from the community affects PLWHA's quality of life, especially in terms of their mental health (Ichikawa and Natpratanb, 2006).

2.4.2 Impacts on the uninfected, including family and community

A common reaction from the uninfected group is to distance themselves from the infected. Among the uninfected, stigma mechanisms are expressed in three ways, including prejudice, stereotypes and discrimination. Prejudice is experienced as negative emotion and feelings. Stereotype is experienced as cognition or attitude towards a specific group or individuals. Discrimination is experienced as a behavioral expression of prejudice. It has been suggested that stereotypes may be the strongest determinant of the three.

Prejudice, stereotypes and discrimination from the community cause stigma for PLWHA and also cause the community to react in different ways that create stigma for PLWHA. PLWHA's families may be both the stigmatizer towards PLWHA (i.e. when they reject PLWHA from the families), and the stigmatized (when they experience discrimination from the community).

2.4.3 Impact on epidemic control and healthcare

HIV/AIDS stigma impacts HIV/AIDS prevention and care. Fear of discussion, seeking medical help and status disclosure are the major causes. Fear of stigma discourages PLWHA from disclosing their HIV status, especially to their sexual partners, and may increase likelihood of engaging in sexual risk behavior. Seeking medical help and discussing one's HIV/AIDs status is done with caution for fear of the information being revealed to the community, resulting in discrimination. All of these factors affect overall HIV/AIDS epidemic control and health treatment, which is why HIV/AIDS stigma is listed as a factor that needs to be eliminated so that it does not inhibit either epidemic control or health, wellbeing and the enjoyment of human rights.

2.5 Characteristics of HIV/AIDS Stigma in Thailand

Since the HIV/AIDS epidemic in Thailand is not necessarily associated with behaviors that are stigmatized, the characteristics of HIV/AIDS stigma in Thailand are believed to be different from countries like the United States. In Thailand, instrumental stigma is relatively more common than symbolic stigma (Vanlandingham *et al.*, 2005). In Thailand, community reactions to PLWHA are mixed (Apinundecha *et al.*, 2007; Vanlandingham *et al.*, 2005). Many community members show sympathy and acceptance of PLWHA and even assist financially. In contrast, others remain concerned about the risk of HIV infection from incidental contact with PLWHA or their family (Apinundecha *et al.*, 2007). However, the overall community reaction towards PLWHA is more positive than previously assumed. HIV stigma is observed to be the instrumental stigma due to the fear of infection. (Vanlandingham *et al.*, 2005) This may be because the Thai people are very accepting and the nature of stigma there is dynamic – it can change over time.

2.6 Interventions to Help Reduce HIV/AIDS Stigma

General approaches to reduce HIV/AIDS stigma include information-based approaches, skills building, counseling and contact with the affected group. These approaches aim to reduce stigma by 1) increasing the tolerance of PLWHA among the general population, 2) increasing willingness to treat PLWHA among healthcare providers and 3) improving coping strategies for dealing with HIV/AIDS stigma among PLWHA (Brown et al., 2003). As stigma is a multi-layered phenomenon, intervention strategies to reduce stigma can be categorized by level of intervention as shown in Table 2.6.1 (Heijnders and van der Meij, 2006).

Table 2.2 Stigma-reduction strategy

Level	Strategies
Intrapersonal level	Treatment Counseling Cognitive-behavioral therapy Empowerment Group counseling Self-help, advocacy and support group
Interpersonal level	Care and support Home care teams Community-based rehabilitation
Organizational/institutional level	Training programs Patient centered and integrated approaches
Community level	Education Contact Advocacy
Government/structural level	Legal and policy interventions Rights-based approaches

Resource: Adapted from Heijnders and van der Meij (2006)

The stigma reduction strategies range from psychological approaches, which are more individual-based, to group or community approaches. Even though a common source of HIV/AIDS stigma is misperceptions about HIV transmission (Sweat and Levin, 1995), education intervention alone cannot necessarily change attitudes, though it can increase tolerance (Brown *et al.*, 2003). In Thailand, educational interventions with oral health care providers were found not to change attitudes around the risk of infection (Lueveswanji *et al.*, 2000). Multi-intervention or multichannel approaches are common in the studies reviewed in Brown *et al.* (2003). Single-level and single target group

interventions are not enough to make a significant impact on stigma reduction (Heijnders and van der Meij, 2006). The evidence suggests that the effectiveness of stigma reduction interventions relies on multiple approaches rather than one single type of intervention.

Empowerment of PLWHA is an approach to reduce HIV/AIDS stigma at the intrapersonal level. A strategy to empower PLWHA is to have them participate actively by joining in the development and implementation of HIV/AIDS stigma reduction programs (Heijnders and van der Meij, 2006). It has also been reported that economic support to PLWHA can also help reduce internalized stigma (Heijnders and van der Meij, 2006), which could be in the form of microfinance programs to reduce resource-based stigma (Holmes *et al.*, 2010).

Many studies around the world have been conducted to investigate effective interventions to reduce HIV/AIDS stigma. However, a recent review from Sengupta *et al.* (2011), which assessed the internal validity and overall quality of 19 selected studies, found that only 14 of them have shown effectiveness in reducing HIV/AIDS stigma, and only two of the 14 effective studies were considered high quality studies. One was a community participatory study in Thailand conducted by Apinundecha *et al.* (2007) that examined the effectiveness of an HIV/AIDS stigma reduction program in control and intervention villages in Nakhonratchasima, a province in Northeastern of Thailand. The study began with initial surveys of PLWHA, their caregivers and community members to obtain information on their demographic and socioeconomic background, knowledge about HIV/AIDS, experience with PLWHA and PLWHA self-stigma. Two communities were selected based on the comparability of the baseline data. The community participatory intervention was implemented with the study group, utilizing the

LINMODEL, uniquely developed for the study. The LINMODEL consists of eight stages including: 1) leader engagement; 2) information for decision and actions; 3) negotiable planning; 4) management of community resources; 5) operating activities; 6) development for sustainability; 7) evaluation; and 8) forum for learning and sharing experience. Stakeholders in the study included PLWHA and family and community members. Activities generated from participants at stage five included using youth volunteers (HIV/AIDS knowledge), Dharma for releasing suffering, a Dharma courtyard, and community learning center. The effectiveness of the intervention was revealed in the improvement of both HIV/AIDS stigma scores and knowledge scores after the intervention in the study group. Though the authors claim that using youth volunteers as "change agents" was a key factor in the success of the intervention, several other common stigma-reduction strategies were also present in the intervention. These included the multi-level and multi-target approaches and the use of Dharma as a spiritual intervention approach. Active participation of PLWHA and PLWHA's family and community members could be another key factor in the success of the intervention.

2.7 Role of Religions (Buddhism and Christianity) to Help Reduce HIV/AIDS Stigma in Thailand

The majority of the Thai population is Buddhist, and Buddhism has a great deal of influence on their mind, character, way of life, and health, particularly their mental health (Disayavanish and Disayavanish, 2007). The teachings and principles of Buddhism were and still are a major component of Thai culture and are inseparable from Thai values and behavior especially (Kubotani and Engstrom, 2005). Since Buddhism plays a major role

in Thai culture, it must be included when dealing with any societal issue in Thailand such as the reduction of HIV stigma (Michelle Sze wing mah, 2008).

Religious institutions have been trusted as centers of education, health care, and social support in Thai society. Utilizing these deeply embedded forms of civil society to increase HIV/AIDS prevention and care efforts is only logical. Buddhism has had an important role in combating HIV/AIDS in Thailand, due to its holistic methods of treating illness. With over 2,500 years of experience, Buddhism utilizes spiritual belief, support systems, meditation, herbal medication and massage techniques to encourage HIV/AIDS prevention and to bolster the quality of life of people living with HIV/AIDS. These complimentary forms of treatment work in conjunction with modern medication to create a distinctly Thai form of health care.

Buddhism has four central moral virtues: love (metta), compassion (karuna), sympathetic joy (mudita), and equanimity (upekkha) (Dharmasiri, 1989). A loving mind is thought to make one calm and relaxed and results in 11 blessings, which include: comfortable sleep; the absence of evil dreams; an individual's endearment to others; an ability to concentrate mentally; and serenity. This attitude permits one to say, "May all beings be happy." Compassion, as understood in Buddhism, carries with it a "devotion to removing others' suffering" (Dharmasiri, 1989). A compassionate attitude carries with it the thought, "May they be liberated from these sufferings." Compassion is necessary even toward evil persons, as in the Christian faith's idea of "Love your enemy." Compassion does not require that we become sorrowful at others' suffering but, rather, that we wish only for their freedom from such suffering (Dharmasiri, 1989). This concept of compassion has been analogized to Christians' love of God and neighbor. It also

provides an opportunity to emphasize the moral virtues of love and compassion that are central to Buddhism.

Since Buddhism is based on the desire to be free of suffering (Dharmasiri, 1989), it teaches people to live in the spirit of “Metta” and “Karuna,” that is, “kindness” and “compassion.” PLWHA are not just statistics: They are human beings. That is why “compassion and kindness” need to be practiced in a concrete way. It is for these reasons that the value of religions, especially Buddhism, has become a strong source of behavioral change. The involvement of religious persons in the community in helping PLWHA will gradually decrease stigma. The ability to set aside prejudice, judgment and fear is an intrinsic part of modern day religions.

Dane (2000) explored the role of meditation in Thai Buddhist women infected with HIV/AIDS. Interviews were conducted with 26 Thai women living in the northern part of Thailand known as Chiang Mai. Although the scope of this study is limited and not generalizable, it supports the idea that a spiritual approach to healing, in conjunction with conventional medical treatment, is a source of great comfort to persons living with HIV/AIDS and may influence immune functioning. Therefore, the intervention proposed in this special studies project will emphasize the spiritual approach to improving PLWHA’s quality of life from inside out.

CHAPTER 3: PRODUCT PROJECT

3.1 Current Situation and Need Statement

Both PLWHAs and the community are affected by HIV/AIDS stigma. Several interventions designed to reduce the HIV/AIDS stigma in PLWHA have been reported (Sengupta *et al.*, 2011). It has been suggested that single-approach interventions are not as effective in HIV/AIDS stigma reduction as multi-approach and multi-level interventions, i.e. education or information-based intervention alone is not enough to change the attitudes of people in the community and reduce instrumental stigma (Brown *et al.*, 2003). Education programs that have an impact on the community must be accompanied by other approaches. This special study project has proposed a multi-level intervention program to reduce HIV-related stigma, targeting both PLWHA and the neighboring community.

Most of the available community HIV/AIDS programs in Thailand are information-based aiming to prevent the disease in the community and paying minimal attention to stigma. As previously stated, the community stigma that finds expression in discrimination towards PLWHAs could make PLWHA fear discrimination and refuse to disclose their HIV status to their sexual partners, causing new HIV infection in Thailand, (Thanprasertsuk *et al.*, 2006) or avoid testing and treatment services, leading to increased morbidity and mortality. This provides a further justification of the need for an intervention program aiming at reducing HIV-related stigma in the community. Since studies have suggested community-level HIV-related stigma in Thailand is primarily due to fear of infection (Vanlandingham *et al.*, 2005), an HIV/AIDS community education

program is necessary to reduce instrumental stigma though it has to be done in combination with other approaches.

On the PLWHA side, many organizations have been established to provide essential care to PLWHAs especially those who are underprivileged, rejected by family or community. The care provided focuses on physical and emotional well-being without targeting at the presence of stigma which is a psycho-social phenomenon, involving people in the community not just individuals with HIV/AIDS. The intervention program proposed in this study will be conducted at "Hope House" which is a faith-based organization in the Nan province in Northern Thailand. Hope House accepts PLWHAs who need assistance from any geographical location, and is not restricted to those from the neighboring community, Wang Tao village, where the community stigma education program will be implemented. Even though no analysis has been conducted on HIV-related stigma either among PLWHA residents of Hope House or people in the community (Wang Tao village), anecdotal evidence of discrimination experienced by PLWHA residents of Hope House points to the existence of stigma in both PLWHAs and people in the community.

The environment of Hope House provides a sanctuary for the residents which is fundamental to improving their quality of life. Residents can feel safe, secure and comfortable living in a serene and peaceful environment. However, due to the lack of an activities plan and staff, most activities are conducted on a situation-driven basis. Also, no direct stigma reduction program or activity is available, although some existing activity may nurture self-esteem, which is undermined by internalized stigma (Lee *et al.*, 2002). For example, the planting of papayas and passion fruits is a meaningful activity

and source of income, but it cannot build capacity to the level of self-reliance, which is the level that is believed necessary to promote self-esteem. This results in low self-esteem and depression in some cases which is consistent with the results of a study of the quality of life in PLWHA in northern Thailand (Ichikawa and Natpratan, 2004). Due to limited number of staff, the project for Hope House residents should be self-sustaining and require minimum guidance and care from the priest who is responsible for the House.

3.2 Conceptual Framework

The key success factors gathered from the literature review in Chapter 2 include 1) multi-level and multi-approach intervention, 2) accurate information, 3) contact with PLWHA, 4) involvement of participants, 5) resource assistance and 6) spiritual well-being of PLWHA. In terms of activities plan, activities for people in Wang Tao village community are 1) to provide them with useful HIV information and 2) to encourage communication and contact with PLWHA residents of Hope House. For PLWHA residents of Hope House, activities are designed to: 1) encourage networking with other health care programs for PLWHA, 2) promote self-esteem and strengthen individual capacity, 3) provide spiritual support, and 4) promote community connection (Anderson, Scrimshaw, Fullilove & Fielding, 2003). A Logframe for the project is provided in (Appendix A).

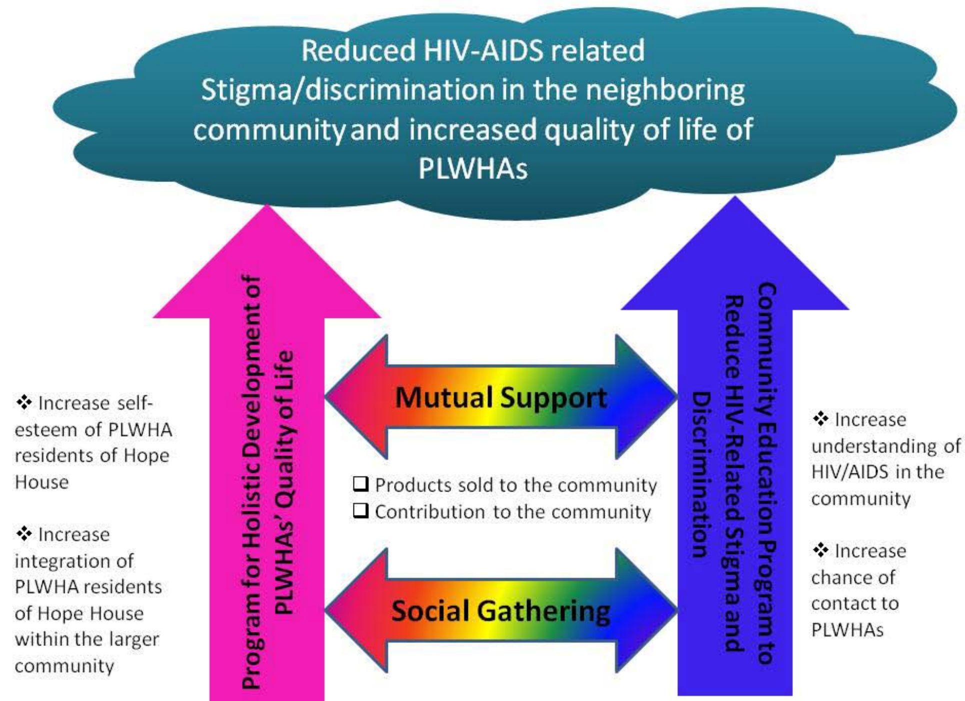

Figure 3.1 Conceptual framework

Most of the activities for PLWHAs at Hope House can be undertaken with minimal guidance and can be self-running. The House leader will be assigned as an informal project manager who will lead a house meeting once a week. (See Appendix B for an example of the weekly schedule). Details of different activities for Hope House residents are shown in Section 3.3.

3.3 Activities for PLWHA Residents of Hope House

3.3.1 Activities to encourage networking with other care programs for PLWHA

The primary driver for networking is the lack of health care professionals in Hope House. This makes it necessary to participate and seek networking with other care programs for PLWHA in order to promote the physical well-being of PLWHA residents,

leading to the improved quality of life in its physical aspect. Nan Hospital has a funded project called 'Puen Wan Jun' (Monday Friends)[3] which provides capacity building workshops and support for PLWHA every Monday. The workshops and one-on-one support and guidance are provided by professional health care staff and also Buddhist monks. This is a good networking opportunity for a small FBO (Faith based Organization) like Hope House to outsource the health care services. This activity is listed in number 4.1.4 in the log frame (Appendix A).

3.3.2 Activities to promote self-esteem and strengthen individual capacity

Realizing values in yourself and being able to give yourself to others are generally known to increase one's self-esteem. These activities must closely resemble a real job that makes the residents of Hope House feel like they are meaningfully employed. However, depending on their state of health, it must not be so difficult that it undermines their physical and mental well-being. Activities that can contribute to others are also useful. Active involvement of PLWHA residents of Hope House in determining and designing these income-generating activities is essential. In the interests of feasibility, the activities must initially be based on existing activities. New activities will then gradually be added as determined by Hope House residents. Three activities have been envisaged that meet these criteria—*planting chrysanthemums, knitting and handicrafts.*

[3] http://www.coreinitiative.org/Grants/cigrants/small_grants.php, accessed on April 27,2010

Chrysanthemums (Figure 3.2 A) are easy to grow and bloom frequently which will consistently generate a decent amount of money. Planting Chrysanthemums was added to the existing activities of planting papaya and grapefruits, which are are not very financially profitable. A potential market is the farmer's market in Wang Tao village. This will provide an activity to promote communication and contact with the community which would contribute to the achievement of purpose 2.1.1 in the log frame (Appendix A). This income-generating activity is basically a job for the residents. In terms of stigma reduction, this activity aims not only to increase PLWHA's self-esteem but also decrease instrumental stigma in the form of resource-based stigma in the community.

A.[4] **B.**[5] **C.**[6]

Figure 3.2 Activities to promote self-esteem and strengthen individual capacity **A.** chrysanthemum planting, **B.** handcrafting and **C.** knitting for Buddhist monks and the needy on the mountains.

Rajamangala University of Technology Lanna usually provides the free training for flower planting as a career. Hope House may invite specialists from the university to give the residents training and consultation on chrysanthemum planting. This little outsourcing strategy is necessary for organizations with limited staff like Hope House.

[4] http://okfloristevents.com/blog/wp-content/uploads/2009/09/chrysanthemum-morifolii2.jpg , accessed on April 25, 2010
[5] http://gotoknow.org/blog/localwisdomkm/166648 , accessed on April 25, 2010
[6] http://topicstock.pantip.com/jatujak/topicstock/2007/09/J5797724/J5797724-3.jpg , accessed on April 25, 2010

PLWHA residents may elect a leader to lead this project to work with the project team and Hope House staff in monitoring the planting project and looking for new possible markets.

A hobby that can motivate good will and generosity is also encouraged. Knitting (Figure 3.2 C) and hand-crafting (Figure 3.2 B) will be proposed to the residents for their feedback. Hand-crafting is an existing income-generating activity which was initiated by PLWHA residents of Hope House. However, the financial returns are much lower than for chrysanthemums: a handcrafting product which takes one week to make is sold for less tan $1, the same amount they will be able to make daily through the sale of two chrysanthemums. This self-initiated activity shows their interest in making some money and bodes well for the introduction of additional income-generating activities. This will allow the hand-crafting activity (log frame number 4.1.2) to become a hobby. Knitting is another hobby that will be proposed to those who are not interested in handcrafting. Knitting and handcrafting can motivate good will towards PLWHA residents when they donate the products they made to people in need. These items can also be sold to add value to the chrysanthemum (e.g. a handcrafted vase for chrysanthemums). This knitting and handcrafting hobby activity can also encourage communication and relationship among PLWHA residents of Hope House where they can spend time together doing something meaningful.

3.3.3 Activities to provide spiritual support and encourage spiritual well-being

The spirituality dimension is also integrated into chrysanthemum planting activities. The residents will experience the cyle of life through the growing and the

blooming of the flowers. A ‘Meditation of Flowers’ (log frame number 4.1.3) class will be provided by the priest to help them grow in spirit (Hanh, 2009). Knitting and handcrafting products that are donated to the poor or offered to the monks in the rural area can also increase the value of the hobby from the level of leisure to the level of spiritual fulfillment.

The other important service and activity offered by the priest who works in Hope House to people living with HIV/AIDS is pastoral counseling. People are supported as they grow, develop and understand their own lives through the Bible and Buddhist Bible. Pastoral counseling helps in the restoration of hope, reconciliation and the discovery of a purpose in life. The spiritual support offered is intended to provide them a great source of comfort and strength, especially in dealing with feelings of guilt and fear. The ultimate goal of pastoral counseling is to help PLWHA residents maintain a spiritual life, providing training in meditation and organizing daily or weekly meditation retreats. Since most of the residents are Buddhists, the Eucharistic Mass is merely the sharing of the sacred and spiritual gifts, not the obligation or intention to convert. The priest also guides them in Buddhist meditation. The meditation is included in this multi-approach intervention as it has been found that meditation can improve the spiritual well-being of Buddhists in Thailand and spiritual well-being has been found to correlate with the quality of life in PLWHA (Khumsaen *et al.*, 2012).

3.3.4 Activities to promote community connection

Nan is an enchanting province that has interesting festivals throughout the year. The Chompoo-Pooka blossom festival in February-March (Figure 3.4 A) will be an

extension of the flower meditation activity. After the weekly meditation, the residents should appreciate the beauty of the Chompoo-Pooka with the inner eyes or at least just enjoy the blossom which will refresh their minds. For Pansa Candle parade in July (Figure 3.4 B), after the residents offer their knitting hats to the Buddhist monks in the morning, they can enjoy the beautiful parade in the afternoon. In November, the residents will attend the annual traditional boat race (Figure 3.4 C). This festival provides an opportunity for them to rent a kiosk and sell their flowers before enjoying the race. Selling their own products in the festival will give them confidence in what they are doing and an opportunity to connect with people in the community. This occasional community participation activity can be considered an extension of Chrysanthemums planting activity (number 4.1.1 in log frame) in terms of product marketing which can serve purpose 2.1.1 (To increase integration of PLWHA residents of Hope House within the larger community).

A.[7] **B.**[8] **C.**[9]

Figure 3.3 Activities to promote community connection **A.** Chompoo-Pooka blossom festival in Feb-March of each year. **B.** Pansa Candle parade held annually the day before Pansa season (Buddhist Lenten season) in July. These beautifully carved candles will be

[7] http://www.oknation.net/blog/ariya2009/2010/02/15/entry-1 , accessed on April 25, 2010, "Chompoo-Pooka" (Bretschneidera sinensis Hemsl, scientific name) is the flower plant rarely found in the world.
[8] http://www.nan2day.com/forum/index.php?topic=2804.0 , accessed on April 25, 2010
[9] http://www.1stopchiangmai.com/images/north/gen6023.jpg , accessed on April 25, 2010

an offering to the temples to light throughout Pansa **C.** Annual Traditional Boat Race in November

3.4 Activities for Wang Tao Village Community

3.4.1 Activity to provide HIV information to the community

As stated earlier, limited staff is available at Hope House. The community HIV education program therefore has to be outsourced. It will be necessary to network with local public health organizations in order to get the education program into the community. Hope House will cooperate with a local public health organization. The local public health organization will give community members of Wang Tao village accurate HIV/AIDS information while also raising awareness of HIV-related stigma. Active participation of the community can be encouraged through active classroom learning. This activity is listed in number 4.1.5 in the log frame. This will serve the purpose of increasing the understanding of HIV/AIDS in the community (number 2.1.2 in the log frame).

Community relationships should be built prior to the education program to generate trust. Hope House staff and the staff from the local public health organization (community education staff) should contact the community leader and make sufficient house visits to get to know people in the village and gather some initial information about HIV/AIDS knowledge and pre-existing stigma.

3.4.2 Activity to promote communication and contact with PLWHAs

Maintaining good relationship with the community is important. Whenever appropriate, people in the Wang Tao village community should be invited to join

recreation activities at Hope House. The idea is to include those who exclude us. PLWHA are usually excluded from the community. PLWHAs will actively include those who have excluded them.

Another activity that encourages more contacts with PLWHAs is to have PLWHAs participate in the HIV/AIDS education class. They can act as instructors, share their story if they are comfortable doing so or can just be present in the class. Alternatively, they might choose to give a presentation to the class about their projects (i.e. planting, handcrafting and knitting) and bring their produced items to sell in the class. Increasing the opportunity of the community to interact with PLWHA will help improve the effectiveness of the education intervention (number 2.1.2 in the log frame) and also help PLWHA residents to be included within the community (number 2.1.1 in the log frame).

3.5 Impact of Activities

The major impact of this project is directed toward the improvement of the quality of life of the residents of Hope House by means of improving their self-esteem. Chrysanthemums planting generates income which should improve their self-esteem and lessen resource-based stigma. Handcrafting and knitting hobbies fill their free time with meaningful activity and opportunities for group sharing among the residents. Meditation of the flowers as well as other spiritual support provided to the residents nurtures their spiritual well-being which is related to quality of life. These impacts will eventually improve self-esteem and reduce the internalized stigma of PLWHA residents of Hope House.

This multi-level program, targeting both PLWHA residents of Hope House and people in the community, can benefit both sides in terms of stigma reduction. When PLWHA residents have improved their self-esteem and reduced their internalized stigma, this should make it easier for PLWHA to connect themselves to the community. Through the education program, HIV/AIDS information should reduce the instrumental stigma of people in the community. Activities that encourage personal contact with PLWHAs, such as the opportunity to talk with PLWHAs and buying items produced by PLWHA residents of Hope House, should help reduce resource-based stigma in the community. And when the stigma in the neighboring community is reduced, the perceived discrimination and stigma in PLWHA residents of Hope House should be reduced as well. And therefore, the quality of life of PLWHA residents of Hope House should be improved.

3.6 Evaluation

Different survey, interview, project accounts and records will be the primary means of project evaluation. The quality of life and self-esteem of PLWHA residents of Hope House will be evaluated using, respectively, the quality of life scale (Ichikawa *et al.*, 2004; Oberdorf *et al.*, 2008) and Rosenberg self-esteem scale (Piyavhatkul *et al.*, 2011) previously used in Thailand. For the community, the instrumental stigma scale (Vanlandigham *et al.*, 2005) will be used to evaluate instrumental stigma. The results of these assessments will indicate the PLWHA perception of quality of life, level of instrumental stigma in the community and self-esteem of PLWHA after the intervention. Also, the survey of HIV/AIDS knowledge will be applied to the community to assess the effectiveness of the education program. In addition, increased number of visits both to

and from the community and number of produced items sold to the community indicate the integration of PLWHA residents within the larger community. Increased number of visits directly suggests more tolerance of PLWHA of people in the community and therefore less instrumental stigma. Increased number of items sold suggests more PLWHA acceptance of community members and resource-based stigma. Project records that keep track of these data provide quantitative information for project monitoring and evaluation.

CHAPTER 4: DISCUSSION AND CONCLUSION

This special study project has proposed a multi-level intervention program to reduce HIV stigma in a Northern Thai community, Wang Tao village, located near Hope House, a faith-based organization for PLWHA who are rejected by their family. The ultimate goal of the project is to improve the quality of life of PLWHA residents of Hope House by reducing HIV/AIDS stigma in the community. The process of intervention design started from reviewing related literature to explore the theory around HIV stigma, characteristics of HIV stigma especially in Thailand, and previous stigma reduction interventions. Finally, the intervention program was designed based on HIV stigma theory, previously successful intervention, and the socio-economic and cultural contexts of the local community.

HIV stigma is not well-understood. So far, stigma is known as a complex psychosocial phenomenon involving multi-layered mechanisms and influenced by differential levels of social and socio-economic power. Intervention programs to reduce stigma are important because stigma not only affects the social functioning and quality of

life of PLWHA but also the prevention and epidemic control of the disease. In Thailand, HIV/AIDS stigma can be characterized as instrumental stigma due to fear of infection. It is also influenced by levels of socioeconomic power. As stigma is multi-layered, successful stigma reduction must rely on multi-level and multi-target interventions. Education interventions to reduce fear of infection among community members or interventions to reduce resource constraints faced by PLWHA alone may not be enough to make the program effective. On the contrary, a range of approaches must be utilized, translating into a range of intervention activities. For organizations with limited staff like Hope House, networking and outsourcing are keys to the implementation of a project with multiple activities.

Not all activities of the program are direct stigma reduction activity. For example, what is distinctive about the proposed intervention program is the intention to reduce resource-based stigma through capacity-building activities for PLWHA and the inclusion of activities that nurture spiritual well-being. The capacity-building intervention was designed in recognition of the role played by power in stigma mechanisms. Even though no studies document a correlation between spiritual well-being and stigma, spiritual well-being is directly related to the quality of life of PLWHA, which is the ultimate goal of this project.

Quality of life of PLWHA may be a sufficient goal for a faith-based organization but may be perceived as limited for a public health intervention. It is nonetheless important to consider that HIV stigma has major public health impacts, including delays in seeking medical treatment and failure to disclose HIV status to sexual partners, which hinder HIV epidemic prevention and control. It is necessary to evaluate the public health

impacts of the HIV stigma reduction intervention in order to achieve the direct public health goals. It is a limitation of this special study project that it does not include any direct public health impact measures. It is nonetheless anticipated that improved the quality of life of PLWHA would result in positive public health impacts.

This special study project is the design of an HIV stigma reduction intervention for a small faith-based organization in Thailand. Even though the project aims to reduce HIV stigma and increase the quality of life of PLWHA residents, this multi-level approach and multi-target project also includes activities that are basic public health interventions found in typical HIV intervention programs, such as HIV education and an HIV support group. While the proposed intervention is specific to the small community in Northern Thailand for which it was designed, it has broader implications. It is recommended here that all HIV intervention programs should be aware of HIV-related stigma and include in their programs interventions to reduce it. This may or may not make the program more effective in achieving its immediate goals, but it will certainly contribute to the long-term goals of HIV prevention, treatment and mitigation, while improving the lives of those living with HIV.

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APPENDIX A: Log frame

Project Description	Performance Indicators	Means of Verification	Assumptions
1.1 Goal: To improve the quality of life of PLWHA residents of Hope House by reducing HIV-related stigma and discrimination in the neighboring community and internalized stigma in the PLWHA.	**1.2.1** PLWHA perception of improved quality of life **1.2.2.**Decreased instrumental stigma in the community **1.2.3** Increased PLWHA self-esteem	**1.3.1** Self-assessment in qualitative interviews and using quality of life scale **1.3.2** Assessment using instrumental stigma scale previously used in Thailand **1.3.3** Self-assessment in qualitative interviews and using Rosenberg self-esteem scale (Thai Translation)	

2.1 Purpose: **2.1.1** To increase integration of PLWHA residents of Hope House within the larger community **2.1.2** To increase understanding of HIV/AIDS in the community	**2.2.1** Increased number of visits by residents of Hope House to village **2.2.2** Increased number of people in the community accepting invitations to come to the social gatherings at Hope House **2.2.3** Increased HIV-related knowledge in the community	**2.3.1** Record of number of visits made by residents of Hope House to the community and community members to Hope House **2.3.2** Pre- and post-survey to assess HIV-related knowledge in the community	**2.4.1** Decreased isolation of PLWHA and increased understanding of HIV/AIDS in the community leads to reduced HIV-related stigma and discrimination in the community and reduced internalized stigma among Hope House residents.
3.1 Outputs: **3.1.1** Increased production of saleable items by residents of Hope House **3.1.2** Increased demand for products from Hope House within the community **3.1.3** Increased community access to quality education about HIV/AIDS	**3.2.1** Number of items produced and sold to the community **3.2.2** Number of hours of quality HIV education provided; number of community members reached	**3.3.1** Project accounts **3.3.2** Project records	**3.4.1** Production and sale of items by PLWHA residents of Hope House increases their self-esteem. **3.4.2** Purchase of items by community members, combined with education classes, reduces HIV-related stigma **3.4.3** Increased access to quality education increases understanding of HIV in the

			community
4.1 Activities: **4.1.1** Chrysanthemum planting **4.1.2** Handcrafting/Knitting hobby **4.1.3** Meditation of flowers **4.1.4** Networking with other health care program **4.1.5** Community education sessions to increase HIV/AIDS understanding and awareness of HIV-related stigma	**4.2 Inputs:** **4.2.1** Hope House facilities including residential area and activity space **4.2.2** PLWHA residents of Hope House and people in the community **4.2..3** Community education staff and necessary classroom materials	**4.3.1** Project records	**4.4.1** PLWHA residents are in good physical health and able to participate in the activities. **4.4.2** PLWHA residents decide and are motivated to do the activities. **4.4.3** Funding, resources and educators are available.

APPENDIX B: Example of weekly schedule for PLWHA residents of Hope House

Day	Morning		Afternoon	
	8:00-10:00	10:00-12:00	1:00-3:00	3:00-5:00
Monday	Garden Work/Visit	Planting Class/ Guest Speaker	“Puen Wan Jun” at Nan Hospital	FREE
Tuesday	Garden Work/Visit	Discussion/ Sharing		Flower Meditation
Wednesday	Garden Work/Visit	Mass and Catechism		Counseling
Thursday	Garden Work/Visit	House Meeting	Flower Meditation	
Friday	Garden Work/Visit	Product selling at the Farmer’s Market in the village		
Saturday	Garden Work/Visit	FREE	Music or other recreation activities with students at Wangtao	
Sunday	Garden Visit	FREE	FREE	

Note: *The blank spaces are reserved for doctor appointment, hobbies (knitting and handcrafting) or community HIV/AIDS class schedule.*