Promoting Health-Seeking Behaviours and Quality of Care among Men who have Sex with Men and Transgender Women: Evidence from 5 Provinces in Thailand
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<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<td>ARV</td>
<td>Antiretroviral</td>
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<td>CSMBS</td>
<td>Civil Servant Medical Benefit Scheme</td>
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<td>FGD</td>
<td>Focus Group Discussion</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>HSRPO</td>
<td>The Health System Research Promoting Office</td>
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<td>MSM</td>
<td>Men who have Sex with Men</td>
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<td>MSW</td>
<td>Male Sex Worker</td>
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<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
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<td>SHS</td>
<td>Social Security Scheme</td>
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<td>SP</td>
<td>Service Provider</td>
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<td>SRS</td>
<td>Sex Reassignment Surgery</td>
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<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>TG</td>
<td>Transgender</td>
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<td>UCS</td>
<td>Universal Coverage Scheme</td>
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<td>UNAIDS</td>
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<td>UNESCO</td>
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<td>WCS</td>
<td>Worker Compensation Scheme</td>
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This study was commissioned by the HIV Prevention and Health Promotion (HP2) Unit of UNESCO’s Asia-Pacific Regional Bureau for Education.

The Health System Research Promoting Office (HSRPO) Northeast region, Khon Kaen University was contracted to undertake the research, with the research team comprised of Pattara Sanchaisuriya, Thana Pramukkul, Tiptiya Heangson, Surasak Athikamanon, Suthima Sanguansak, Pawana Chucherad and Siriluk Khamsuk. Technical support and guidance were provided by Rapeepun Jommaroeng, Justine Sass, Stephanie Gater, and Kritsiam Arayawongchai in the HP2 Unit.

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Last but certainly not least, UNESCO would like to recognize the 100 participants in this review who provided their time and shared their experience to improve the sexual health and well-being of men who have sex with men and transgender women in Thailand.
EXECUTIVE SUMMARY

Rationale and purpose of the study

Thailand’s response to the national HIV epidemic has been hailed as a success story. New infections dropped from 143,000 in 1991 to 12,000 in 2009, when 1.3 per cent of the adult population (530,000 people) was estimated to be living with HIV (www.aidsdatahub.org, 2011).

However, addressing new infections among men who have sex with men (MSM) and transgender (TG) women has been an area in which similar success has not been attained (United Nations Development Programme/UNDP, 2004). The number of new infections due to male-to-male sex has remained high and was projected in 2005 to become the most common type of new infections by 2009 (Family Health International and Bureau of AIDS, Tuberculosis (TB) and Sexually Transmitted Infections (STIs), Department of Disease Control, Ministry of Public Health, Thailand, 2008).

The estimated overall HIV prevalence among MSM and TG women was 13.5 per cent in 2010, roughly ten times the general adult population prevalence (National AIDS Prevention and Alleviation Committee, 2010).

To address this gap, MSM were included as a specific target group in the National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011 and specific strategies were devised (National AIDS Prevention and Alleviation Committee, 2007). At the end of the implementation period of the plan, the number of provinces with MSM-specific prevention activities (30 out of 77) covered by The Global Fund to Fight AIDS, Tuberculosis and Malaria alone was three times higher than the number of provinces with any MSM-specific prevention activities at the beginning of the plan. Provinces not covered by the Global Fund were eligible for smaller Thai government grants for such activities (personal communication, Danai Linjongrut, Executive Director, Rainbow Sky Association of Thailand, 16 December 2011).

However, worldwide, homophobia and transphobia present significant barriers to STI/HIV prevention and treatment (Global Forum on MSM and HIV, 2010). A recent review of research on stigma and discrimination against sexual/gender minorities has revealed these are also significant problems in Thailand (Ojanen, 2009). Thus, a study was needed to evaluate whether the existing services were meeting the needs of MSM and TG women in the current Thai context, to increase understanding about their health-seeking behaviour, to identify obstacles they had in accessing health care, and to develop recommendations for improving their health-seeking behaviour.

Methodology and limitations

This primarily qualitative study was commissioned by the HIV Prevention and Health Promotion (HP2) Unit of UNESCO’s Asia-Pacific Regional Bureau for Education in the context of the formulation of Thailand’s national strategic AIDS prevention and alleviation plan for the years 2012-2016. The Health System Research Promoting Office (HSRPO) Northeast region, Khon Kaen University was contracted to undertake the research.

A research advisory committee was established in order to guide and facilitate the implementation of the study, comprising representatives from local MSM-focused NGOs, government agencies providing sexual health services to MSM and TG women, as well as other relevant NGOs.

The NGO-based committee members recruited 20 participants in Bangkok, Ratchaburi, Chiang Mai, Phuket and Khon Kaen each (totaling 100), for individual structured interviews and semi-structured focus group discussions (FGDs). The study sites were chosen to represent all major regions of the country plus the capital city. Having well-established local organizations and health services for MSM was a further selection criterion.

Participants had to have Thai nationality, be at least 18 years old, and able to communicate in Thai. Sex workers were not included in this study. In terms of self-identification, 61 self-identifying gay participants, 31 TG women, 4 bisexual men, and 4 participants who described themselves as simply “men” were recruited. Urban areas had higher representation than rural areas. Most participants’ highest educational attainment ranged from senior
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high school to bachelor’s degree. All were covered by some type of public health insurance, most commonly the Universal Coverage Scheme (UCS).

Participation was anonymous, informed verbal consent was obtained, responses were treated confidentially, and participants were given a compensation of 300 baht for travel and their time.

Being a qualitative study, the findings are illustrative rather than generalizable. Only five provinces with established local organizations and MSM-specific health services are directly represented. Non-Thais’, sex workers’, and service providers’ experiences were not covered. All participants had prior connection to local organizations, which may mean they were in general better informed of existing services and more likely to have used them than those without such a connection.

Findings: Health-seeking behaviours, access and perceived quality of care

Stigma and discrimination
The participants’ accounts confirmed that stigma and discrimination not only against MSM and TG women but also against people living with HIV are still a part of the Thai societal mainstream.

Perceptions of illness
Common illnesses were not particularly feared unless interpreted as possible signs of HIV. STIs were stigmatized like HIV, but not particularly feared since they were seen as treatable with contemporary medicine. Transgender participants also talked of the negative health consequences of hormone use, which could be diverse and debilitating.

Health-seeking behaviours
STI diagnosis and treatment was generally sought only when symptomatic, whereas HIV testing was more commonly initiated due to perceived risk, anxiety and only sometimes due to health symptoms that could be construed as possible signs of HIV.

Thirty-five participants reported ever having been tested for HIV, 18 reported they had received counselling and/or advice, and eight stated they had received STI diagnosis and treatment. However, 77 reported having accessed sexual health services through a hospital or clinic, and 47 through a drop-in centre.

Twenty-six participants said they had made no visits to a sexual health facility in the past one year, with almost a half making one to three visits in the past one year. Fifty-eight reported at least one visit to sexual health services at a hospital or clinic in the past one year, and 16 at a drop-in centre. However, in Bangkok, Chiang Mai and Phuket, only 1 participant per site considered they had used sexual health services at a drop-in centre in the past year (possibly because they did not perceive the services provided, such as information, condoms and lubricant, as being sexual health services).

Gay participants had a higher proportion of those accessing sexual health services at a hospital or clinic at least once in the past year (72 per cent, 44 out of 61) than did either TG women (39 per cent, 12 out of 31) or non-gay MSM (25 per cent, 2 out of 8). TG women had the highest proportion of those considering they had accessed sexual health services at a drop-in centre in the past one year (19 per cent, 6 out of 31), followed by gay participants (15 per cent, 9 out of 61) and non-gay MSM (13 per cent, 1 out of 8).

Sources of information for sexual health included drop-in centres for 64 participants, the Internet for 40 participants, hospitals or clinics for 34 participants, and friends for 19. Drop-in centres were also the most popular source of condoms and water-based lubricant, used by 74 participants, followed with hospitals and clinics, used by 39 participants. Supply of condoms was limited and lubricant was unavailable at some hospitals and clinics. Twenty-five participants said they bought condoms and lubricant from convenience stores.

Trustworthiness and credibility were the most common criteria participants reported they used in choosing a sexual health venue, noted by 13 participants. These were commonly linked to confidentiality and privacy in using the services, as well as to having a personal connection (such as
personally knowing a staff member) and being familiar with a venue, both stated by 12 participants. Ten stated convenience of the location of the venue was their reason for choosing a particular venue. Other common criteria were participation in a research project (commonly involving compensation; 9 participants), availability of a group-specific service (8 participants) and services being free of charge (7 participants).

**Constraints and obstacles in accessing sexual health services**

When asked about constraints and obstacles to accessing sexual health services in general, only 28 participants identified any. The most common replies were inconvenient service hours (7 participants), long waiting times (5 participants), and lack of trust in the confidentiality and privacy in the services (5 participants). When asked about second-hand accounts on such constraints and obstacles, the responses were similar, except that 7 participants identified disrespectful service providers, being the second most common reply after long waiting times (8 participants).

When asked about specific aspects of the services, a much higher proportion identified problems with the services, especially with the physical aspects of the venues and the personnel. These are reported below in descending order by the number of participants identifying problems in each aspect of the services.

**Physical venue.** When specifically asked, 57 participants found the physical venue of their sexual health services problematic. By far the most common complaints were that the venue was too cramped (27 participants) and offered little privacy (26 participants). Lack of specific spaces for specific groups (such as separate areas for MSM and TG women) was noted by nine participants. Cluttered or dirty interiors, poor signage and lack of parking space all attracted criticism from five to six participants.

**Personnel.** When specifically asked, 56 participants identified problems with the personnel of their sexual health venue. Staff with inappropriate manners and attitudes were most commonly criticized (reported by 28 participants). These were primarily general comments about impolite or unfriendly service providers, although some gave examples of judgmental attitudes to clients on the basis of their gender identity or sexuality. The worst reaction was observed by a 24-year old gay Bangkokian, who said the service provider “didn’t give me information, was unfriendly, and told me that being gay, I should go receive services elsewhere.” Twenty said they could not trust that the staff would safeguard their confidentiality, and some gave examples of clear violations. Seventeen felt uneasy with the gender or age of staff members, but preferences for these varied. Gay male service providers seemed most acceptable for gay clients, and women (TG or non-TG) most acceptable for TG women clients. Fifteen thought there were simply too few staff, leading to overcrowding and long waiting times. One participant from Bangkok indicated that service providers may not consider appropriate tests for TG women due to their limited understanding of sexuality, saying “…If we’d go see a doctor in certain clinics where they think we just don’t use the ‘front works’ [i.e., penis], they’d just check our ‘backside’ [i.e., anus], and so our ‘little sister’ [i.e., vagina] with gonorrhoea would be left undiagnosed. They wouldn’t check it because they don’t understand our way of life.”

**Location of services.** When specifically asked, 11 participants considered the location of the services problematic. However, both interviews and FGD discussions suggested that location of services could be a significant obstacle to those living outside both the national capital and provincial capitals, where there were no group-specific clinics. Cost of traveling from a rural district to receive services in the provincial capital could exceed the daily salary of a person on a low income. Awareness about the services was also considered low in rural areas. Some Bangkok participants noted clinics were concentrated in the city centre, and traveling in from the city outskirts could be inconvenient, as well.

**Costs.** Costs incurred using the services were generally not a significant obstacle to using the services, since most participants got the services either free of charge or at a cost they thought was manageable. However, travel costs and lack of access to free treatment when outside one’s own province were identified as problematic by some.

**Quality and accessibility of medicine.** Accessibility and quality of medicine were mostly not considered to be problematic by the participants.
**Scope of the services provided.** The participants were also asked several questions about the scope of the services provided – whether it was sufficient, and what they might want to add. With the replies to these questions combined, altogether 58 participants identified shortcomings or made suggestions. Nine participants thought the services were insufficiently publicised. Nine participants thought they received too little sexual health information, and seven said printed information materials were insufficient. Six TG participants expressed a wish to access information and counselling on surgical operations and on the safe use of hormones, or on cosmetic issues. Five participants said counselling was insufficient or not provided at all.

**Discontinuation of service use.** Twenty participants said they had discontinued using their sexual health services for various reasons. The most common reason cited was unfriendly staff, noted by seven participants, followed by long waiting times (4 participants), perceived staff reluctance to provide services (3 participants) and various other reasons only reported by one or two participants. While many of the reasons for discontinuation of service could be common to the general population, some appear to have been linked to the sexuality or gender identity of clients. For example, there were complaints by TG women in both Khon Kaen and Chiang Mai of staff reluctance to provide services to them. In Chiang Mai and Ratchaburi, other participants voiced complaints of staff who “didn’t talk nicely”, were “stigmatising”, and “not welcoming.”

**Conclusions**

While sexual health services are now commonly accessed by MSM and TG women connected with local organisations in the five provinces, stigma and discrimination in society at large hampers utilization of such services, and the existing services also still have limitations, as summarized below:

- The services have insufficient geographic coverage.
- Awareness about HIV and the services remains low among the target groups.
- Staff continue to display inappropriate attitudes and manners, including judgmental attitudes and behaviours toward MSM and TG women clients.
- Privacy and confidentiality are compromised by staff behaviours and cramped, non-private physical venues.
- The existing venues have insufficient staff and limited operating hours.
- There are hardly any TG-specific services at all.
- The existing venues provide an insufficient scope of services – commonly, not all key services are available from the same venue.
- Staff demographics (gender, age) often don’t match client preferences.

**Recommendations**

Overall, inputs are needed in the following areas:

**By community organizations, groups, hospitals and clinics**

- Focus on safeguarding confidentiality and privacy, both in terms of staff behaviour and privacy of the physical venue.
- Network more, within and beyond current geographic coverage. Personal contacts and social networking sites are useful.
- Aim at providing one-stop services, integrating all key services.
- Provide specific services to TG women.
- Adjust operating hours to meet the needs of all client groups.
- Strive to hire staff with gender and sexuality that matches the preferences of the clients, especially gay staff for gay clients, and (TG or non-TG) women staff for TG women.

**By policy-makers and development partners (UN, INGOs, and donors)**

- Channel resources for countering stigma and discrimination about MSM, TG women and people living with HIV through mainstreaming destigmatization messages.
- Channel resources and explore new solutions (such as mobile clinics) to increase the geographic coverage and public awareness of the services.
• Channel resources on establishing specific services for TG women, including services facilitating safer hormone use.
• Ensure free-of-charge access to the services across the country.
• Commission further research on the sexual health needs and service use among populations not covered by this study, particularly sex workers and non-Thai MSM and TG women living in Thailand.
RATIONALE AND PURPOSE OF THE STUDY

Thailand has been credited with reversing a serious HIV epidemic in the first half of the 1990s. At that point, the bulk of new infections resulted from unprotected sex between sex workers and their clients (UNDP, 2004). The nationwide number of new infections dropped from its 1991 peak of 143,000 to 12,000 in 2009, when 1.3 per cent of the adult population (530,000 people) was estimated to be living with HIV (www.aidsdatahub.org, 2011). This reversal of the epidemic has been attributed to a pragmatic, well-funded and committed multi-sectoral response with high-level political involvement (UNDP, 2004).

However, UNDP (2004) also indicated that a similarly pragmatic and well-funded response was not yet underway with certain stigmatized groups, including MSM and male sex workers (MSW). TG women have often been studied as a subgroup of MSM, and the above also applies to them.

MSM, TG women, and MSWs are at an increased risk of HIV infection primarily if they have unprotected penetrative sex. In 2005, 46.7 per cent of MSM, 34.9 per cent of MSW, and 52.3 per cent of TG women sampled in Bangkok, Chiang Mai and Phuket reported recent inconsistent condom use (Chemnasiri et al., 2010).

Globally, transgender people and men who have sex with men often face stigma, discrimination and violence which increases their own risk of HIV infection as well as the risk for their male and female partners (UNAIDS, 2010). A review of recent research on the Thai context concluded that both MSM and TG individuals face stigma and discrimination in Thailand in a variety of contexts, including employment and education, families, the military, religious contexts and health care (Ojanen, 2009). Transgender people are particularly heavily affected in Thailand, as is the case globally (Global Forum on MSM and HIV, 2010).

Furthermore, a large-scale survey of MSM (n = 821) and TG women (n = 474) in Bangkok, Chiang Mai and Phuket found that 19.4 per cent of MSM and 26.4 per cent of TG women had been forced to have sex, and that:

*traditional HIV correlates, such as usually practicing receptive only or practicing receptive and insertive anal sex (versus insertive only),
having ever used drugs; having used drugs in the past 3 months, having had more than one lifetime male intercourse partner (versus one or no partner), and having ever received or given money, gifts, or valuables for sex were all significantly associated with a history of forced sex in bivariate analysis” (Guadamuz et al., 2009).

Data collected in Bangkok among a community sample of MSM (n = 1,121) in 2003 showed an HIV prevalence of 17.3 per cent among this group, demonstrating an epidemic (van Griensven et al., 2005). Biennial prevalence surveillance was conducted in Bangkok, Phuket and Chiang Mai in the following years. In these studies, rising prevalence was found until 2009, when the first drop was observed in Bangkok (see Figure 1). HIV prevalence among MSM was found to be somewhat lower in the more rural provinces of Udon Thani (4.7 per cent) and Phatthalung (5.5 per cent), which were studied in 2008 (National AIDS Prevention and Alleviation Committee, 2010).

Among TG women studied in Bangkok, Chiang Mai and Phuket in 2005, an average HIV prevalence of 13.5 per cent was found, with nonsignificant differences between the cities (Guadamuz et al., 2010). The latest national HIV prevalence estimate for both MSM and TG women was also 13.5 per cent – roughly ten times the national average among the general population (National AIDS Prevention and Alleviation Committee, 2010).

Projections made in 2005 using the Asian Epidemic Model (Family Health International and Bureau of AIDS, TB and STIs, Department of Disease Control, Ministry of Public Health, Thailand, 2008) have suggested that the number of new HIV infections due to male-to-male sex (including sex in which at least one party is a TG woman) would remain high and become the most common type of all new infections, replacing the previously most common type, sexual transmission from husband to wife, by 2009 (Figure 2). This suggests that controlling the HIV epidemic among MSM and TG women is a key element of controlling the epidemic in Thailand in general.

The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011 (National AIDS Prevention and Alleviation Committee, 2007) was the first Thai national strategic plan of its kind in which MSM were included as a specific target group throughout the term of the plan. The National AIDS Prevention and Alleviation Plan 2002-2006 had already been adjusted during its term to incorporate work with MSM, after the first HIV prevalence study among MSM in Bangkok had shown they had high prevalence of HIV (Worasinan and Kiratikan, 2008). The plan for 2007 to 2011 laid out 10 specific measures that would be taken to address HIV and AIDS among MSM. These measures emphasized prevention, through mechanisms such as disseminating information and providing counseling services; facilitating access to condoms and lubricant,
strengthening organizations working with MSM; and shaping a favourable policy context. Stigma and discrimination were to be reduced by building awareness about sexuality. Continuous monitoring of the extent of the epidemic, as well as the provision of testing and treatment of STI and HIV related illness to MSM were also included. Community participation and inputs were called for. While working with men in all-male institutions like prisons, youth detention centres, boys’ schools and the military, specific work with TG women was not specifically mentioned in these measures.

In 2007, the first year of the 2007-2011 plan, only 10 provinces (of Thailand’s 77 provinces) had MSM-specific prevention activities (such as outreach, condom and lubricant distribution, and peer education workshops) and six had MSM-specific clinics. By late 2011, The Global Fund to Fight AIDS, Tuberculosis and Malaria was supporting MSM-specific prevention activities in 30 provinces (personal communication, Danai Linjongrut, Executive Director, Rainbow Sky Association of Thailand, 16 December 2011). Roughly 15 provinces had openly accessible clinics with special provisions for MSM clients (personal communication, Rakthai Saengnunprompong, MSM Project Coordinator - TUC, Ministry of Public Health, 13 February 2012). Groups or organizations working with MSM in provinces not covered by the Global Fund scheme had the option of requesting Thai government funding. However, TG-specific services existed only in the city of Pattaya; in the other contexts, services to TG women were provided as a part of the services to MSM (personal communication, Danai Linjongrut, Executive Director, Rainbow Sky Association of Thailand, 16 December 2011).

Prevention efforts like drop-in centres and outreach have generally been run by NGOs and groups, whereas group-specific clinics have mostly been run by public sector bodies (personal communication, Danai Linjongrut, Executive Director, Rainbow Sky Association of Thailand, 16 December 2011).

A recent international survey (not covering Thailand) demonstrated that worldwide, “homophobia and transphobia create an environment of fear through stigma, discrimination and violence, presenting significant barriers to STI/HIV prevention and treatment services at nearly every step of the care-seeking process” (Global Forum on MSM and HIV, 2010, p. 10). Hence, while there has been significant geographic expansion of HIV-related services to MSM during the implementation of the 2007-2011 plan in Thailand, it has not been clear how well these services meet the needs of MSM and TG clients, and what kinds of barriers hamper their access to such services in Thailand. No previous systematic evaluations of these issues from the (potential) clients’ point of view had been carried out.

To facilitate the creation of evidence-informed strategies in health service planning for MSM and TG women, a qualitative study with 100 MSM and TG women participants was thus conducted in five regions of Thailand to specifically assess these groups’ health-seeking behaviours and factors influencing their decision-making to access health services.

Objectives of the study

The overall goal of this study was to improve understanding of the sexual health-seeking behaviour and factors influencing decision-making to attend health services among MSM and TG women in Thailand.

In particular, the study sought to:

1. Bring together the evidence base on the health-seeking behaviours of MSM and TG women;
2. Identify (perceived and real) obstacles by MSM and TG women in accessing health care;
3. Develop recommendations for how health-seeking behaviour can be improved—including, for example, how to strengthen linkages between outreach and clinical services.
METHODOLOGY AND LIMITATIONS

Health-seeking behaviours, factors influencing decision-making, and perceived quality of care among MSM and TG women were studied in five provinces of Thailand by collating health and health care related experiences and views through individual interviews and focus group discussions (FGDs).

Procedure

The study was commissioned by the HIV Prevention and Health Promotion (HP2) Unit of UNESCO’s Asia-Pacific Regional Bureau for Education in the context of the formulation of Thailand’s national strategic AIDS prevention and alleviation plan for the years 2012-2016. The Health System Research Promoting Office (HSRPO) Northeast region, Khon Kaen University was contracted to undertake the research.

A research advisory committee was established in order to guide and facilitate the implementation of the study. The members of this committee were representatives of local MSM-focused NGOs, public sector bodies providing sexual health services to MSM and TG women, NGOs and international organizations working in this area. The committee members were unpaid but received compensation for their travel expenses. For the full terms of reference under which the committee members were recruited see Annex III; for a list of the committee members, see Annex IV.

The NGO-based advisory committee members were also responsible for recruiting 20 study participants from each of their respective geographic areas. Subsequently, twenty individual interviews and one FGD were arranged in each of the five study sites between June and August, 2011 (except in Ratchaburi, where only interviews were conducted). The participants were informed of the objectives of the study, the voluntary nature of their participation, the compensation they would receive (300 baht), and that their data would be kept confidential. Those who chose to participate gave a verbal consent to participate.

The interview data were recorded in writing on interview guideline forms (Annex I), whereas the FGDs were audio recorded and later transcribed. The interview data from the resulting 100 interview guideline forms were collated in a spreadsheet programme file under headings representing questions in the form.

The FGD transcripts were qualitatively analyzed by assigning codes (roughly corresponding to types of data expected to be gained through the study) to the data using the qualitative analysis software package ATLAS.ti 5.0. The collated interview data were qualitatively analyzed within the spreadsheet programme by categorizing replies in each column (or sometimes combining data from several columns) into types of replies and in most cases, quantifying this data to reflect relative commonalities, and explicating it with quotes from the interview forms and related comments made in the FGDs.
Instruments

An interview guideline (Annex I) was used to structure the individual interviews. The guideline questions covered health-seeking behaviours, such as where the participants accessed sexual health information, condoms and lubricant, and clinical sexual health services, as well as the participants’ views on various aspects of the sexual health services they used. Questions on perceptions of services addressed various aspects of quality of care. Potential shortcomings that could pose obstacles or constraints impeding access to services were also covered.

A participant information sheet was given to all potential participants (Annex II) to support their informed decision to consent to or decline participation in the study.

These materials were drafted by the UNESCO Asia-Pacific Regional Bureau for Education and finalized by the research team at the HSRPO. Only Thai versions of the materials were used in the actual study. The English versions reproduced in this report are translations of those used in the study sites.

Study sites

Individual provinces were chosen as study sites in all of Thailand’s four major regions – central, northern, north-eastern and southern. The capital city Bangkok, located in central Thailand, was chosen as an additional study site (see Figure 3). The provinces chosen all had active HIV-related services for MSM and community organizations or groups serving MSM that could identify and recruit participants for the study, as well as apply the findings in developing the work done in their own province.

Participants

Twenty participants were recruited from each study site by the research advisory committee members representing local groups or organizations providing outreach services to MSM and TG women in each area, totalling 100 participants overall.

Inclusion and exclusion criteria

The participants had to be at least 18 years old, live in the study area, be either MSM or TG women, hold Thai nationality and able to communicate in Thai.

Non-Thai citizens were not included in the study since the issues they face due to language and cultural barriers, as well as problems accessing public health insurance are likely to make their context rather different from Thai citizens.

Sex workers were not included in this study as their social context likewise considerably differs from that of MSM and TG women not involved in sex
work. For example, male sex workers working in sex venues may have regular outreach teams visiting their venue, and have more regular contact with sexual health clinics than those not engaged in sex work, but on the other hand, they may be more stigmatized than non-sex worker MSM and TG women owing to attitudes about the nature of their work.

Age
The mean age of the participants was 27.2 years (SD = 11.3 years). Age differences between the sites were not marked: Khon Kaen had the lowest mean age (25.4 years), and Phuket had the highest (29.9 years). The youngest participants in all sites were 18 years old. Ratchaburi had two participants in their mid-fifties; in the other study sites, the oldest participants were between 39 and 48 years old.

Sexual/gender identity
In the Thai context, the concept of sexual orientation is usually limited to academic or medical circles. In everyday discourses, identities such as gay or TG woman are typically considered alternative genders that are mutually exclusive with each other and with the labels “man” and “woman”, which imply normative gender expression and sexual roles (Ojanen, 2009).

The word “gay”, an English loan word used in Thailand since the 1960s, is commonly used as a self-descriptor, and especially so in urban contexts. However, since “gay” is considered an alternate gender, the expression “gay man” is not used. *Kathoey* is an indigenous term that today primarily denotes transgender women, but it is sometimes considered coarse, so many use euphemisms, such as *sao praphet song*, literally denoting a “second category girl” (Ojanen, 2009). Compared to the word “gay,” the word “bi” connotes a more normative, masculine social role (Wipha and Wichai, 2004). Some bisexual men prefer to call themselves simply “men” (Pramoj na Ayutthaya, 2008).

In this study, 61 participants called themselves gay, 31 chose to describe themselves as *sao praphet song*, four said they were bisexual, and four said they were simply “men.” Table 1 summarizes the gender/sexuality self-identification in each study site. Anecdotal evidence suggests that gay identities are more common in Bangkok, and less familiar to those living in rural areas, whereas transgender identities and MSM, who simply consider themselves “men”, are more common in rural areas. The composition of the sample reflects this perception, as all but one participant in Bangkok identified as “gay”.

### Table 1: Self-identification in terms of gender and sexuality

<table>
<thead>
<tr>
<th></th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gay</td>
<td>8</td>
<td>11</td>
<td>13</td>
<td>19</td>
<td>10</td>
<td>61</td>
</tr>
<tr>
<td>Sao praphet song</td>
<td>6</td>
<td>8</td>
<td>6</td>
<td>1</td>
<td>10</td>
<td>31</td>
</tr>
<tr>
<td>Bisexual</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Man</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

Urban and rural contexts
The participants were also categorized by the type of the area in which they lived. A division was made into metropolitan areas, municipalities, *tambon* municipalities, and fully rural areas. The term “metropolitan” only applies to Bangkok, whereas “municipality” denotes urban areas outside Bangkok. *Tambon* (subdistrict) municipalities are small towns or relatively densely populated rural areas. Table 2 below summarizes the types of areas in which the participants lived. Ratchaburi had the most rurally-based participants, followed by Khon Kaen. Virtually all participants in Chiang Mai lived in urban areas.

### Table 2: Type of residential area

<table>
<thead>
<tr>
<th>Type of residential area</th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan area</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Municipality</td>
<td>5</td>
<td>10</td>
<td>14</td>
<td>0</td>
<td>19</td>
<td>48</td>
</tr>
<tr>
<td>Tambon municipality</td>
<td>10</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Rural area</td>
<td>5</td>
<td>6</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>14</td>
</tr>
</tbody>
</table>

The participants were also asked how long they had lived in their current area. The Ratchaburi participants had by far lived the longest in their area, with a mean length of stay of 17.4 years. The other sites, being national or regional growth centres with more employment and educational...
opportunities, had more participants with a shorter length of stay in their current area (mean length of stay circa 11 to 12 years).

**Education**

Roughly one-third of the participants had university education (typically a Bachelor’s degree), and roughly half of those who didn’t had completed secondary education (Table 3). The participants in Ratchaburi, who were the most rural-based, had the lowest overall level of educational attainment, whereas those living in Bangkok had the highest. This reflects the national pattern whereby people living in municipal areas are over three times more likely to participate in higher education than those living in rural areas. In 2005, the higher education participation rate was 24.1 per cent in municipal areas and 7.1 per cent in rural areas (World Bank Group, 2009).

<table>
<thead>
<tr>
<th>Table 3: Highest educational attainment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ratchaburi</td>
</tr>
<tr>
<td>Primary school</td>
</tr>
<tr>
<td>Junior high school</td>
</tr>
<tr>
<td>Senior high school</td>
</tr>
<tr>
<td>Vocational school</td>
</tr>
<tr>
<td>Bachelor’s degree</td>
</tr>
<tr>
<td>Master’s degree</td>
</tr>
</tbody>
</table>

**Public health insurance coverage**

Although Thai citizens now enjoy universal coverage of public health insurance, the system is three-pronged. Civil servants are covered by the Civil Servant Medical Benefit Scheme (CSMBS) and smaller similar schemes. Private formal sector employees are covered by the Worker Compensation Scheme (WCS) for work-related injuries and illnesses, and the Social Security Scheme (SSS) for other illnesses. Thai citizens covered by neither of the above are covered by the Universal Coverage Scheme (UCS). These systems vary widely in terms of their per-capita expenditure and somewhat in terms of the illnesses and conditions they cover. The UCS, which covers 76 per cent of the population, has the lowest per capita expenditure (International Labour Organisation East Asian Subregional Office, 2008).

In this study, Khon Kaen, Phuket and Ratchaburi had one participant each covered by the CSMBS. Chiang Mai had 12 participants covered by the SSS/WCS, whereas Ratchaburi only had one, other provinces falling in between. Others were covered by the UCS, which was the most common type of public health insurance in every study site (as it is in the general population), except Chiang Mai.

**Limitations of the study**

Given the qualitative nature of the study, the findings are illustrative of the study populations (MSM and TG women), rather than generalizable to them. The study does not cover the experiences of sex workers or non-Thai citizens living in Thailand.

For practical reasons, the participants recruited for this study were individuals already connected with organizations or groups operating drop-in centres. Therefore, the experiences of those not at all connected to such services are not covered. Such individuals might face even more significant barriers to access and thus utilize sexual health services less than those included in this study.

While the interview logs identified each participant’s characteristics, such as age, sexuality or type of residential area (urban vs. rural), the only systematic identification in the FGD transcripts was study site. Thus, such details were only revealed when the speaker specifically referred to one of these aspects, or when gender-specific pronouns used by the participants as self-referents revealed in general terms whether they were transgendered or not).

From the FGD participants’ accounts it was clear that drop-in centre staff and volunteers contributed heavily in the FGDs, since the participants talked both of providing and using services, as well as recounted issues encountered with their organizational clients or people met through their outreach work. While their point of view offered a wealth of information, they are likely to be better informed about sexual health and the services available than that of people with no involvement in such work.
The views and experiences of practitioners working with MSM and TG women were not systematically addressed as another research project commissioned by UNDP on these was underway at the same time. However, as stated above, many participants worked or volunteered with outreach organizations and thus had a hybrid service user/provider role.

The participants’ HIV status was not asked, and the specific barriers and issues experienced by HIV-positive MSM and TG women were not systematically evaluated. However, some participants did volunteer perspectives and experiences explicitly from the point of view of a person living with HIV.

**Ethical considerations**

The potential risks involved in participating in this study were primarily related to divulging sensitive information to the research team. Confidentiality of the data and the privacy of participants during data collection were thus key concerns. The participants’ names were not asked, and thus the resulting data is not linkable to individual participants.

The participants were briefed of the characteristics and purpose of the study and of their right to withdraw at any point should they wish to do so, using a participant information sheet (see Annex II). They gave informed verbal consent to participate.

Each participant received 300 baht to compensate for their time and travel expenses. Participating also gave them an occasion to receive condoms, lubricant and relevant information. However, these materials, any services provided to the participants, or any potential volunteer status at the drop-in centres where they participated, were available to them at the centres regardless of whether they participated in the study.
FINDINGS: HEALTH-SEEKING BEHAVIOURS, ACCESS AND PERCEIVED QUALITY OF CARE

Stigma and discrimination

As noted above, existing research has identified that Thai MSM and TG women continue to be stigmatized and discriminated against in contemporary Thailand. This perception was supported by the FGDs in all the study sites for which a transcript was available (Bangkok, Chiang Mai, Khon Kaen and Phuket). For example, a Chiang Mai FGD participant noted:

When a man and a woman date, society thinks it’s normal, but when a man and a man date, society views it as abnormal. Some couples have to date in secrecy. A couple made of a man and a woman can walk hand in hand without anyone blaming them, but a gay and a gay - still not that much [condemnation], but be it a kathoey with a man, they will get [negative reactions].

A Phuket FGD participant involved in outreach work noted that Thai Muslim gays and TG women face particularly intense pressure from their families and communities, which often means they have to choose between leaving their community and hiding their identity:

Gay Muslims won’t stay in their communities, because even today it’s very restrictive. They can’t let loose, except in some cases, whose families can really accept them. Their child can go stay elsewhere – it’s not like chasing them out . . . but they’ll have to know it by themselves – where to live in order to feel happy . . . Or like one sao prophet song . . . who lives in Krabi, [over there] they were so strict she couldn’t do anything, so she had to come stay in Phuket, have a sex change, do her hair, and not go back. Her family does accept her but she won’t go back because the community wouldn’t accept her, and she doesn’t want the community to view her parents as freaks. There are lots of Muslim kathoeys, even though it’s against their rules.

However, most accounts of stigma and discrimination related to apparently Buddhist contexts, which means stigma and discrimination against MSM and TG women are a part of the Thai Buddhist sociocultural mainstream. Chiang Mai FGD participants gave examples of stigmatization and stereotypes in a northern Thai context:

Where I live, if one kathoey is filthy and sickly, in prison, addicted to drugs, or has AIDS, they’ll attach that stigma [also] on ordinary kathoeys . . . [thinking] you’ll have to be like that . . . [And if one kathoey is] good at flower arrangement, people think that I will also surely know how to arrange flowers.

The FGDs also generally reflected that living with HIV or having AIDS are likewise heavily stigmatized: “Society stigmatizes having AIDS as loathsome in every respect . . . it’d be dark in each of the eight directions [if I tested positive]”, noted a Chiang Mai FGD participant, and added that having HIV or AIDS is stigmatized whereas having cancer, for example, is not, because in people’s minds, having HIV is linked to promiscuity, but having cancer isn’t. STIs are stigmatized for the same reason: “we still view sexual matters as something that need to be concealed, embarrassing, incorrect.
Findings: Health-seeking behaviours, access and perceived quality of care

This sets the backdrop in which the health-seeking behaviours and perceived quality of care among Thai MSM and TG women need to be understood. Given this kind of societal atmosphere, it is not surprising that many participants held the assumption that especially in service settings not specifically designed for MSM or TG women, insensitive comments and questions and unhelpful stereotypes would be commonly encountered.

Perceptions of illness

Four distinct types of ill health were identified and discussed in the FGDs: common illnesses, HIV and AIDS, other STIs, and symptoms resulting from the use of hormonal products among TG women.

There were no marked differences between the study sites in terms of how illness was perceived, but each FGD had its own emphases in terms of which topics were discussed more. For example, the Phuket FGD participant sarcastically noted that “[even if] a kathoey is run over by a car, they’ll still think she died of AIDS,” and explained that especially in the past,

Compared with men or women – employed, having social insurance, but also having [HIV] – they could live with it. They still had their lives, they still could conceal it, because they had work, their parents could accept them – their parents knew their child had it, but would still support their child, but kathoey had it really rough in the past because our families would not accept us and we couldn’t find work. Where could we go? To Phra Bat Nam Phu [a Buddhist temple operating an AIDS hospice] . . . The media added to our suffering by stigmatizing us. Seeing many kathoey get ill – when they’d go to Wat Phra Bat Nam Phu, they’d only see kathoey, gays, effeminate ones at that. Even closeted, masculine gays could still remain employed . . . though they’d get ill they’d still have the right to treatment.

Having access to employment and thus health insurance or money to buy ARVs was particularly important in the past, before universal access to ARVs for Thai citizens was achieved. The Phuket participant’s account helps to understand how the limited employment opportunities of TG women and feminine gays meant they lacked access to ARVs and thus were likely to develop AIDS if they were infected with HIV. This probably explains why TG women and effeminate gays are still linked to HIV and AIDS in the popular imagination. A similar account was given by a Chiang Mai FGD participant, who noted the high number of kathoey who died of AIDS some ten years ago in her area.

Perceptions about common illnesses

Nobody in the FGDs or interviews attached anxiety or fear of stigmatization to minor, common illnesses per se. They were seen as treatable with over-the-counter medicine: “If I’ve got a headache or a flu I’ll just buy some medicine” (Bangkok FGD). However, more serious illnesses were feared and some people were noted to be reluctant to know they were ill, even with diseases with no stigma attached to them:

If I don’t get the test, I won’t know. I won’t feel ill. . . . I won’t feel like I’ve got cancer. But having taken the tests, oh no, I’ve got diabetes, high blood pressure, feel very stressed, can’t eat this, can’t eat that – what a change from eating well and feeling happy! (Phuket FGD).

Perceptions about HIV

A connection between minor, common illnesses and HIV was noted in the sense that certain quite ordinary symptoms such as “having fever, coughing,
the skin getting darker, or having red rash – would make one suspect . . . if one has got HIV” (Khon Kaen FGD). Other similar symptoms evoking anxiety of HIV infection included “chronic diarrhoea, fever like that when you have influenza – when I begin to have frequent stomach trouble, I tend to start worrying whether I’ve been infected” (Bangkok FGD).

With common reluctance to know about having even a nonstigmatized illness, it is no wonder there would be even greater reluctance to find out one had a stigmatized illness like HIV. A Chiang Mai FGD participant pondered about the impact of stigma and familial expectations at some length:

It’s a deeply anchored thought: “If it was me, could I live with it?” If I really got it, I still can’t figure out how I’d react. Would I cry? . . . Even though there are ARVs, even though there are services, nobody still wants to get it. I’d be most afraid about the people around me. I’d not be afraid of society, but afraid people around me would spread the news mouth-to-mouth. It’s like my family has high expectations for me, I’ll need to work, need to take care of them, many things. If one day my family found out I had the virus, many people would feel disappointed.

Perceptions about STIs

STIs were commonly described as embarrassing and worrisome but not as frightening as HIV. They were perceived to be treatable and less severe: “STIs are easier to go test than to take an AIDS test, HIV test. Because after the test they can be cured by the treatment, you feel like taking the test. [STIs are] nothing particularly frightening, because they’re not chronic” (Chiang Mai FGD). This participant generalized the curability of some STIs to all STIs.

Some FGD participants said they would suspect having an STI if certain commonplace symptoms lasted longer than usual. For example, a Chiang Mai FGD participant noted that having a sore throat would make one suspect one had contracted gonorrhea if the symptoms could not be alleviated with ordinary treatments for a sore throat or were prolonged. Similarly, a Phuket transgender FGD participant said she’d first wait for a few days if she got a fever, and only after that seek a doctor to receive diagnosis and care. Many FGD participants viewed that STIs should be treated by a physician rather than with self-medication: “due to my anxiety I’d go see a doctor to be on the safe side, because if I bought medicine to take by myself, I’d be afraid, afraid it wouldn’t be cured or was drug-resistant”, noted a Bangkok FGD participant regarding symptoms that could be due to gonorrhea.

The idea of treating STIs with traditional medicine was alien to all those who commented on this question, raised by the FGD convener. One participant in Khon Kaen noted that “I wouldn’t believe it, because they’re modern illnesses. So, you’ve got to use modern medicine. If you used traditional medicine, I’m not quite sure it would be appropriate.” The role of herbal products in treating HIV was acknowledged, yet “it’s not really treatment, just strengthening [the body], detoxifying [it] to put the insides to better shape; but the medicine from the hospital will also need to be taken” (Khon Kaen FGD).

Perceptions of negative health consequences of hormone use

The side effects of hormonal preparations used by many TG women in Thailand were discussed especially in the Khon Kaen FGD. They could be diverse and rather debilitating:

- feeling sleepy, feeling devoid of energy, not having sexual desire,
- the dove falling asleep [i.e., not having erections], not having sexual interest in the opposite or the same sex, and also feeling blurred, forgetful . . . like not having a clue about anything . . . with imagination like those addicted to drugs.

Concern about risks to the liver and kidneys were also noted in the Khon Kaen FGD. The participants in this FGD mentioned the options of taking “detox breaks” off the hormonal treatment, or taking diuretics believing they would expedite the detoxification of the body. However, not using hormones at all was not even mentioned as a viable option, and these side effects seemed to be perceived as a necessary evil by those who commented on them.
Health-seeking behaviours

Health-seeking behaviours were assessed both through the individual interviews and FGDs, with information from the interviews quantified when appropriate, to assess commonalities in health-seeking behaviours. Interview and FGD quotes are used to illustrate participants’ behaviours.

Types of sexual health services accessed

The interviewees were asked about their utilization of sexual health services, in general and during the past one year in particular. This section covers the kinds of services the participants chose to receive. The underlying motivations for seeking services at all and reasons for choosing particular venues and services are reported below.

Table 4 shows the number of participants accessing each type of sexual health service in each area (many participants used more than one type of service, and each type is counted, but not multiple instances of using the same type of service by the same participant). This table is not time-limited. A degree of interpretation was involved in the quantification of the replies – for example, a very common reply “blood test” was generally interpreted as an HIV test.

A number of participants did not indicate the type of service (if any) they accessed. Some apparently did not count some types of services as utilization of sexual health services, especially receiving condoms and lubricant, which only 13 identified in response to this question, but when specifically asked where they accessed these (reported above), 74 said they accessed these through a drop-in centre and 39 reported receiving them from a hospital or clinic.

The most commonly cited type of service was an HIV test; 35 participants – roughly a third of the participants – said they’d been tested. Eighteen, or roughly a fifth of the participants, said they’d received counseling or advice – this was particularly common in Ratchaburi, where eight participants reported this. Most of those who had received counseling or advice did not state what issues they consulted on. Thirteen participants said they used

The services to receive condoms and lubricant, mostly in Ratchaburi, which accounted for eight of the cases, but as shown below, when specifically asked, many more indicated they received these through drop-in centres and hospitals/clinics, but apparently did not think it meant using sexual health services. Eight participants said they had accessed STI diagnosis and treatment services, scattered across four of the five sites with no participants from Phuket reporting use of these services. Four participants referred to HIV treatment and care. Four talked of accessing sexual health services for other reasons; for example, a 26-year old bisexual participant in Ratchaburi had consulted a physician about the small volume of his ejaculate.

There were no noticeable differences between gay and TG women participants in the ratio of those who said they had received an HIV test, as roughly a third of both gay (23 out of 61) and TG women (11 out 31) reported having been tested. However, of the eight participants who identified as neither, only one mentioned having taken an HIV test. Though the sample size is too small to generalize this finding, a Khon Kaen FGD participant talked of a bisexual man, who didn’t consider himself to be at risk, despite having unprotected sex with multiple partners of various genders. This may indicate a misperception among non-gay identifying MSM that they are somehow less at risk than those who identify as gay or TG woman, and merits further investigation.
Among those who received counseling or advice, gay participants were slightly overrepresented (13 of the 18), whereas TG women were slightly underrepresented (4 out of 18), and among those who cited accessing condoms as the reason for their health visit, TG women were slightly overrepresented (6 out of 13). However, as both the overall figures and differences between groups were low, these differences are by no means conclusive.

Accessing information on sexual health

Asked specifically where the interview participants accessed information on sexual health, all identified sources of such information. Table 5 summarizes these sources per study site.

Table 5: Sources of information on sexual health

<table>
<thead>
<tr>
<th>Source</th>
<th>Chiang Mai</th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop-in centre</td>
<td>19</td>
<td>18</td>
<td>12</td>
<td>3</td>
<td>12</td>
<td>64</td>
</tr>
<tr>
<td>Internet</td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>8</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>Hospital/clinic</td>
<td>5</td>
<td>5</td>
<td>8</td>
<td>10</td>
<td>6</td>
<td>34</td>
</tr>
<tr>
<td>Friends</td>
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<td>5</td>
<td>7</td>
<td>5</td>
<td>1</td>
<td>19</td>
</tr>
<tr>
<td>Print media</td>
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<td>2</td>
<td>6</td>
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<td>TV</td>
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<tr>
<td>Pharmacy</td>
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<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>Support group</td>
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<td>0</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
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<td>2</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>17</td>
</tr>
</tbody>
</table>

Since the participants were recruited through local groups or community organizations providing MSM-specific sexual health information, it is unsurprising that these groups’ drop-in centres were the most popular source of information among the participants. For example, one 41-year old TG woman in Chiang Mai noted with satisfaction that by going to “M-Plus [a local organization serving MSM and TG women], I got to know it all.”

However, while drop-in centres were almost universally used among the Chiang Mai and Ratchaburi participants to access information, in Phuket only three participants accessed information through them. A Phuket FGD participant lamented that while sex workers and those who were visibly identifiable as MSM or TG women were quite easy to reach, those who hid their sexuality were not:

Outsiders sometimes don’t dare to enter. When we go distribute condoms, men who love men, men who do service work [i.e., sex work], they’ll dare to come and ask for counselling, but ordinary people . . . don’t – they’ll walk past several times, some people even 3-4 times, and finally come and get their brochure. It’s more to do with Thai culture. Really, sexual matters are to be concealed.

Both Khon Kaen and Bangkok had 12 participants who said they used a drop-in centre for getting sexual health information.

In Chiang Mai, one FGD participant first mused that those who most lacked access to information were “country folks, orchard keepers, farmers, labourers, those who live hand-to-mouth, and ethnic minorities”, but added that also wealthier, working-age city people without contacts to their group were also often ill-informed. The participant then told of the local group’s experiences of trying to reach out to gay staff at various hotels, who often are not interested in the information offered, thinking that they are not at risk due to “not being promiscuous”.

The Internet was the second most popular source of information on sexual health, but its popularity greatly differed across areas. It was most popular in Bangkok, where the participants also had the highest levels of educational attainment (typically a Bachelor’s degree), and might also have the most advanced data search skills.

MSM-specific clinics, HIV and STI clinics in public hospitals, as well as general hospitals, clinics and provincial public health offices were the third most common source of information, and particularly so in Phuket, where using the drop-in centre was reported to be less common. Visiting a clinic or hospital for other reasons was sometimes cited as a reason to also access sexual health information at the same facility. For example, a 40-year old gay participant in Phuket noted he regularly visited the hospital to donate blood (and had already done so 39 times), whereas a 20-year old TG woman
in Khon Kaen noted she used a certain clinic, since “I’ve gone there to have hormones injected and so have come to know the staff well.” These examples point at the possible benefits of several services integrated into one clinic or hospital. A 29-year-old gay participant in Bangkok noted he would go to a specific clinic, having been referred there by the local drop-in centre.

The FGDs also included examples of how drop-in centre staff and volunteers helped MSM and TG women to access sexual health services, but this was typically done to guide the clients to receive testing or treatment, rather than just information. For example, when asked how the Bangkok FGD participants would find sexual health services in case they visited Chiang Mai, a participant replied: “In some places we go, we might not have the [local] information on sexual health services, but upon meeting [the local] volunteers, they’d have it, and they could take us there – everything…. They couldn’t give us the treatment but they could take us to the right place.”

Friends were the fourth most popular source of information. One FGD participant in Bangkok noted that “if a friend already had used services there, they’d of course tell us ‘go there, they’re good’”, underlining the importance of word-of-mouth in building reputation for the services. However, only one interviewee in both Bangkok and Chiang Mai cited friends as a source of information in the individual interviews, and the Bangkok interviewee (19 years, gay) noted the friend in question was a medical doctor, possibly indicating a preferred link to the health care system for information.

Quite a few who did access information from friends used the term phi, which denotes a somewhat older person, or run phi (a student more senior than oneself). No participants specifically indicated they accessed sexual health information from a person younger than themselves, which may indicate the trust many have with those older and more experienced. Obviously, if the friend in question also happens to be involved with a drop-in centre, he or she can more easily act as a publicity channel for the services.

Information on the Internet was reportedly sometimes used in combination with information from friends. For example, one 26-year-old gay interviewee in Bangkok noted that “the Internet gives an overview, but people you know give the details,” whereas an FGD participant in Bangkok had the opposite combination, of first hearing personal experiences from friends and then getting the hospital’s name “from my friends, and I’ll then find out more on my own, like where the hospital is… look it up on Google…where it is and what they offer.”

Diverse print media were also cited as sources of information by 14 participants in all study sites except Ratchaburi. These publications included information leaflets on sexual health, textbooks and academic journals, two popular health magazines (Klai Mor and Men’s Health), and a men’s lifestyle magazine (GM).

None of the Bangkok or Chiang Mai participants said they used television as a source of information, while altogether eight participants did so in other areas, such as a 36-year-old gay interviewee in Ratchaburi, who noted in response to the question about accessing sexual health information that he “always follows the news.”

Pharmacies were noted as a source of information by altogether six participants in Ratchaburi, Phuket, and Chiang Mai. It is conceivable this might typically be linked to self-treatment as noted by a Khon Kaen FGD participant: “If it’s medicine for treating specific diseases, STIs, I wouldn’t know the names of the drugs, so the pharmacist would…explain which drugs to take.”

Support groups or organizations serving people living with HIV (such as Violet Home in Chiang Mai, Wednesday Friends’ Club in Bangkok, or hospital-based groups) were mentioned as sources of information by five participants in Bangkok, Chiang Mai and Khon Kaen.

Only three said they had learnt about sexual health through their educational institutions: one at a university in Chiang Mai, another from a school counsellor in Ratchaburi, and a third in a health education class in Khon Kaen. This may point to a limited role of sexuality education and educational institutions in general in providing useful information about sexual health to MSM and TG women in Thailand at present.
Similarly, only three interviewees referred to consulting one’s parents or relatives – one 19 year old TG woman in Ratchaburi said she would consult her relatives, a 23-year old gay interviewee in Bangkok said he would ask his parents first, and a 25-year old Phuket TG woman said she’d talk with her mother, who according to her is “modern – we can talk about anything”. The rarity of consulting one’s family members probably reflects the sensitive nature of the issue. In the Bangkok FGD, one participant noted they wouldn’t dare to ask their parents, and another noted they would not want to make their parents worried. One thought that those close to their siblings might be able to consult them.

Two more participants received information from the radio (both in Phuket), one from billboards (also in Phuket), and three explicitly noted they had received training as a part of their volunteer activities (in Khon Kaen and Bangkok). One participant in Khon Kaen said her village arranged training on sexual health.

A majority of the participants said they used more than one source of information.

**Accessing condoms and lubricant**

When specifically asked where they accessed condoms and lubricant, all interviewees except one identified such sources, summarized in Table 6.

<table>
<thead>
<tr>
<th></th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop-in centre</td>
<td>15</td>
<td>16</td>
<td>6</td>
<td>18</td>
<td>19</td>
<td>74</td>
</tr>
<tr>
<td>Hospital/clinic</td>
<td>5</td>
<td>8</td>
<td>15</td>
<td>7</td>
<td>4</td>
<td>39</td>
</tr>
<tr>
<td>Convenience store</td>
<td>4</td>
<td>5</td>
<td>3</td>
<td>7</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Outreach</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Vending machine</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Friend</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

As with information, drop-in centres were understandably the most popular source of condoms and lubricant, given that the participants were recruited through organizations or groups managing such centres. Roughly three-quarters of the participants used the drop-in centres to access condoms and lubricant.

Drop-in centres provide not only condoms but also lubricant, which some (for example, a 54-year old TG woman in Ratchaburi) lamented was not the case with general hospitals, health centres and clinics. Furthermore, one 25-year old gay participant in Ratchaburi noted he used the local drop-in centre since “they don’t charge [for the condoms], and you can ask often,” which seems to imply some hospitals and clinics in that area impose a limit on the number of condoms they provide in a certain time period.

Almost 40 per cent of the participants reported accessing condoms through hospitals and clinics, despite the commonly noted limitation that many did not provide lubricant. In Phuket, hospitals and clinics were again more popular sources than the drop-in centre. One 39-year old gay participant in Bangkok worked in a hospital and could access condoms there as a sort of fringe benefit.

A quarter bought condoms and lubricant from convenience stores that were liked, aptly, for the convenience they provided. Or, as a 21-year old bisexual interviewee from Phuket noted, “you don’t have to wait or feel embarrassed.”

Drop-in centres also served as a source of condoms and lubricant for eight participants across all the study sites, who themselves did not go to the drop-in centre, but received them as an outreach service, such as a 36-year old gay participant in Ratchaburi, who said that the local drop-in centre “have a staff member deliver them to my home at the end of every month.” Outreach locations also included the workplace and various festivals.

Seven participants across all study sites except Bangkok said they used vending machines, such as a 19-year old TG participant in Ratchaburi, who noted it was a “rather convenient” option. Four participants (in Chiang Mai, Phuket and Khon Kaen) used pharmacies, but none commented on their reasons for doing so, or their satisfaction with the goods obtained.
Four participants (in Khon Kaen and Chiang Mai) accessed condoms and lubricant through friends, some of whom were identified as getting these from the drop-in centres.

**Underlying motivations to access sexual health services**

The interviews did not systematically address the underlying motivations for seeking sexual health services, and therefore yielded limited data on this issue. The FGDs had more discussion of such motivations.

Among the few participants who did analyze their own motivations in the interviews, possible symptoms of STIs (such as genital discharge) were generally the main reason to seek STI-related services. The two main reasons reported by participants to have an HIV test were: 1) perceiving that one might have been at risk of HIV transmission due to one’s past behaviours or accidents, such as suspected condom breakage (which, a Bangkok FGD participant noted, one could not be sure of if one had been very drunk while having sex); and 2) certain general health symptoms that were thought of as possible symptoms of HIV infection. As already seen above, cough, darkening of the skin, diarrhea, rash, and weight loss were all seen as possible signs of HIV infection by some MSM and TG women. A Bangkok FGD participant shared the view that STI diagnosis and treatment tended to be initiated following physical symptoms, whereas HIV testing was more aimed at alleviating one’s worry about possible infection, though such worry could also stem from commonplace physical symptoms.

The Khon Kaen FGD participants talked of some people who felt they did not need to take an HIV test: “those almost certain they surely don’t have it, and those certain they do have it, but don’t want to get the confirmation.” One 30-year-old gay interviewee in Khon Kaen had the latter stance: “I don’t want to get tested because I don’t want to know. And I wouldn’t want others to view me as some sort of freak.” His comment emphasizes how stigma and fear of HIV still prevent some people from accessing sexual health services. In contrast, an FGD participant in Bangkok said the information they had received had made them view that knowing one’s HIV status would be beneficial: back in times when I hadn’t received any information, and didn’t know any organization, I’d feel like, ‘Why bother? If I’ve got it then I’ve got it.’ I didn’t know anything. But having received information over and over again, it’s made me aware that knowing it would allow me to take care of myself.

A Bangkok FGD participant (an outreach volunteer) noted a greater willingness to get tested among older persons: “Old people tend to be worried . . . when we go on outreach and ask them if they’d like to get tested . . . there are more of those who do get tested than those who don’t.”

**Frequency of service use in the past one year**

The interview participants were asked how many times they had accessed sexual health services in the past one year. Table 7 shows this data.

<table>
<thead>
<tr>
<th>Table 7: Number of visits to a sexual health facility in the past one year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>No visits</td>
</tr>
<tr>
<td>Once</td>
</tr>
<tr>
<td>2-3 visits</td>
</tr>
<tr>
<td>4-5 visits</td>
</tr>
<tr>
<td>6-10 visits</td>
</tr>
<tr>
<td>Over 10 visits</td>
</tr>
<tr>
<td>No data</td>
</tr>
</tbody>
</table>

Overall, roughly one-fourth to one-third (assuming those with missing data had not made any visits) of the participants had not accessed any sexual health services in the past year; roughly one-fifth had paid one visit and a quarter had used the services 2-3 times, the rest reported using them even more often.

These service utilisation counts are quite similar across the sites, except for Phuket, where half of the sample had not paid a single visit to sexual health services, and no participants had paid more than 3 visits. While fewer of them also reported receiving HIV testing and STI-related services than participants
in the other sites (see above), more of them said they accessed sexual health information and condoms/lubricant at hospitals or clinics than participants in the other sites. This might mean that many of the Phuket participants would access these at medical settings if they felt they needed them, but, in fact, rarely if ever did so. It is not clear whether these characteristics of the Phuket sample reflect population-level lower service utilization among MSM and TG women in Phuket than in the other sites, but they do suggest a need to evaluate the situation in that site further. However, a Phuket FGD participant, who was involved in outreach work, said she was “certain” that most people in the site did not know about the main drop-in centre and specific clinic, and added this might have been because publicity work had been too focused on service work (sex work) areas, and because people were still afraid to approach the outreach workers or the specific clinic.

Forty-six of the 61 gay participants (75 per cent), 18 of the 31 TG participants (58 per cent), two of the four self-identifying bisexuals and two of the self-identifying “men” said they had used sexual health services at least once in the past year.

Types of sexual health facilities used

The interview participants were also specifically asked where they received sexual health services. Table 8 shows the full extent of venues and providers they mentioned. Table 9 only shows the venues accessed during the past one year.

For a few participants, consulting friends or relatives, finding information on the Internet, or buying medicine or condoms at a pharmacy or a convenience store constituted using sexual health services, while for most others it did not, since these actions were mentioned much more often in response to specific questions about accessing information, condoms and lubricant (reported below). These actions are included in the tables to reflect the ways the participants conceptualized the meaning of “accessing sexual health services”.

As Table 8 shows, altogether 77 participants, or over three quarters, reported some history of accessing sexual health services from a hospital or a clinic, with no major differences between study sites. However, comparing between the sexual/gender categories the participants used to identify themselves, 90 per cent (55 out of 61) of the gay participants reported having accessed sexual health services from a hospital or clinic, while only 58 per cent (18 out of 31) of the TG women did so. This might in part be due to the wide coverage of the services available through the Chiang Mai drop-in, where five TG women reported having received services from the drop-in, but not from hospitals or clinics. However, the difference could also be due to the specific problems and obstacles TG women face in primarily clinical settings (see below). Three of the four “men” and one of the four bisexuals had used sexual health services in hospitals or clinics, but their number is too low to warrant any generalizations.

Just under a half (47 out of 100) of the participants counted their visits to drop-in centres as constituting use of sexual health services. Phuket had the lowest count in this respect, only 6 participants, and Ratchaburi had the highest, 13 participants. Fifty-five per cent of the TG women (17 out of 31), considered their visits to a drop-in centre meant using sexual health services, a slightly higher proportion than of the gay participants who did so (44 per cent, 27 out of 61). Again, three of the four “men” and one of the

<table>
<thead>
<tr>
<th>Table 8: Venue/source of sexual health services ever accessed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Hospital/clinic</td>
</tr>
<tr>
<td>Drop-in centre</td>
</tr>
<tr>
<td>Friend/relative (information)</td>
</tr>
<tr>
<td>Pharmacy</td>
</tr>
<tr>
<td>Internet (information)</td>
</tr>
<tr>
<td>Convenience store</td>
</tr>
</tbody>
</table>

Promoting Health-Seeking Behaviours and Quality of Care among Men who have Sex with Men and Transgender Women: Evidence from 5 Provinces in Thailand
Findings: Health-seeking behaviours, access and perceived quality of care

Four bisexuals thought they had accessed sexual health services at a drop-in centre.

Few participants mentioned other people or instances as sources of sexual health services they had personally used in the past – less than five participants per category. Those who did so counted accessing information or advice from friends or relatives, or buying condoms, lubricants or medicine from a convenience store or pharmacy as using sexual health services.

When asked to list all the sexual health services they had used in the past one year (Table 9), hospitals and clinics were by far the most common choice: 58 participants reported having accessed sexual health services through them.

Table 9: Venue/source of sexual health services accessed in the past one year

<table>
<thead>
<tr>
<th></th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/clinic</td>
<td>8</td>
<td>11</td>
<td>9</td>
<td>16</td>
<td>14</td>
<td>58</td>
</tr>
<tr>
<td>Drop-in centre</td>
<td>5</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Friend/relative (information)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

These data suggest a division of labour between hospitals/clinics and drop-in centres, especially in Bangkok, Chiang Mai and Phuket. In Bangkok, the drop-in centres provide advice, counselling, referrals, condoms and lubricant, but not clinical testing and treatment, which the participants more commonly thought of as constituting sexual health services. Thus, it is not surprising only one participant there thought their drop-in centre visit constituted using sexual health services.

However, in Ratchaburi and Khon Kaen, the drop-in centres also provide more clinical services, and in these sites, five and eight participants, respectively, thought their drop-in centre visit meant using sexual health services. In Phuket, the responses to other questions suggest the drop-in centre seemed to have generally quite low utilization among the participants in general. The Chiang Mai centre seemed to have clinical services (such as HIV testing) available, but only one participant mentioned using them in the past one year.

These data showed minimal use of other sources of sexual health services than hospitals/clinics or drop-in centres.

The one-year data also illustrate the differences in accessing sexual health services among the sexualities represented: 44 out of 61 gay participants (72 per cent) reported having accessed sexual health services at a clinic or hospital in the past one year, as opposed to 12 out of 31 TG women (39 per cent), or to one of the four “men” or bisexuals each. At the drop-in centres, 9 out of 61 gay participants (15 per cent), six out of 31 TG participants (19 per cent), one bisexual participant, and no participants considering themselves as simply men thought their drop-in centre visit constituted using sexual health services. This suggests, firstly, that regular visits to clinical HIV and STI related services are more common among males with a gay identity than among biologically male individuals who have sex with men and have identities other than gay; and secondly, that drop-in centres might have a particular advantage over more clinical contexts in providing such services to TG women.

Reasons to choose certain sexual health service venues/providers over others

The interviewees were asked why they had chosen the venues they had previously accessed. Some had already provided reasons why they chose certain services. Generally, two types of reasons were given: first, because they needed or wanted to access a certain type of service available in the given venue, such as an HIV test or STI diagnosis and treatment (already covered above) and secondly, because the clinic or other service had positive characteristics that made the choice of using that service seem more favourable than other services. The latter kinds of reasons are covered in this section (Table 10).

Overall, the most common reason stated for choosing a certain sexual health service venue or provider was that one trusted that venue, cited by 13 participants, and commonly noted in Chiang Mai, which accounted for
seven such replies. Reasons as to why certain services were trusted (which only some participants gave) were all related in some way to the participant’s belief that by using the said services, their confidentiality and privacy would be upheld – either because they believed the staff could keep secrets, or because they were confident nobody they knew would turn up in the same clinic or hospital. For example, a 23-year old gay interviewee in Chiang Mai said “many people think their services are good and that they can uphold confidentiality. There won’t be anyone there I know, definitely.”

Table 10: Reasons stated for choosing certain sexual health services

<table>
<thead>
<tr>
<th>Reason</th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trustworthy, credible</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>7</td>
<td>15</td>
</tr>
<tr>
<td>Personal connection</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>Familiarity</td>
<td>3</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td>Convenient location</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>Part of a research project</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>Specific service</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>Free of charge</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Completeness of services</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Referral</td>
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<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Convenience</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Social insurance</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Personally recommended</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Promptness of the services</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Informality</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
</tbody>
</table>

In many cases, trust was cited together with familiarity with the services (12 participants), which in turn was usually the result of personally knowing some of the service providers, either at a drop-in centre or a clinic (12 participants). For example, a 55-year old gay interviewee in Ratchaburi noted the people running drop-in centre were his friends, a 22-year old gay interviewee in Khon Kaen said he had relatives working in the hospital, and a 27-year old TG woman, also in Khon Kaen, said “the drop-in is like a home, [frequented by] just people I know.” In the case of a 40-year old gay interviewee in Phuket, familiarity with the venue extended to the moment of his birth – he noted he had been “born and bred” in the same hospital where he now accessed sexual health services. In four cases, the participant had not known any of the service providers personally, but had had a friend personally recommend the services, and in five cases, a referral had been made from a drop-in centre to a clinic. A Khon Kaen FGD participant noted the drop-in centre/outreach staff might not only recommend services but even “take them to have the test, take them right there”; this possibility was also noted in the Bangkok FGD. This underlines the importance of social networks and personal contacts in popularizing the services.

A convenient location of the services (near one’s home or workplace) was cited by altogether 10 participants as a consideration, also making it a major factor in deciding to use one venue over others, especially in Bangkok and Ratchaburi.

Nine interviewees, mostly in Chiang Mai and Bangkok, noted participation in a research project as a reason to choose the venue they used. Two Bangkok participants noted the project they were involved in included checkups every 4 months, another participant in Bangkok stated that the checkups for the project were free, and a 23-year old TG woman in Chiang Mai added that “they compensate for our time.”

For eight participants across all of the sites except Phuket, the availability of MSM-specific services was a consideration in choosing a sexual health venue. A Bangkok FGD participant had a snappy description about the advantages of group-specific services:

I’d go to . . . clinic because I know it’s a specific men’s health service. That is, the staff will have received training about taking care of men’s health, and so they’d be more likely to have the skills and the knowledge. If we go to an ordinary hospital, some staff members won’t be friendly, and sometimes when I sit waiting, they’ll call out loud: “For the AIDS test!” and then call my name.
In Ratchaburi and Bangkok, altogether 7 participants stated that if the services were free of charge, that would add to their desirability. In effect, using a hospital that was one’s chosen primary service provider on one of the three social insurance systems amounted to the same thing (receiving the services for free); this was cited by 2 participants in Khon Kaen and Phuket each.

Providing a complete package of services and having sufficient equipment, informality, promptness and general convenience of using the services were reasons cited by fewer participants. One of the other reasons cited by individual participants was also using other services in the same venue, for example having hormones injected (TG woman, Khon Kaen, 20 years) or donating blood (gay, Phuket, 40 years).

**Constraints and obstacles in accessing sexual health information and services**

To see the other side of the equation, the research team asked the interviewees about any constraints and obstacles they had in accessing sexual health services. This was asked both in general terms, and with specific questions on the physical aspects of the venue and location of the services, personnel, cost and quality of the services. The participants were also asked to relate second-hand experiences they might have heard from their friends or acquaintances. The specific questions yielded higher frequencies of perceived constraints and obstacles than the general ones, and are reported separately to reflect this.

**Constraints and obstacles identified in response to non-specific questions**

When asked if they themselves had had any constraints or obstacles in accessing sexual health services, 28 participants (4 in Ratchaburi, 9 in Khon Kaen, 2 in Phuket, 7 in Bangkok and 6 in Chiang Mai) mentioned constraints and obstacles. Eight participants noted multiple problems, which are included in the below figures. The number of problems identified in response to this non-specific question was much lower than in response to specific questions about various aspects of the services, such as staff or the physical venue. Table 11 summarizes these issues.

**Table 11: Personally experienced constraints and obstacles in accessing sexual health services (stated in response to a non-specific question)**

<table>
<thead>
<tr>
<th></th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inconvenient service hours</td>
<td>0</td>
<td>5</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>Waiting time</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Lack of trust in confidentiality or privacy</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Distance</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>Lack of understanding on MSM</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Non-specific for MSM and TG</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Disrespect</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Give too little information</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Low quality of commodities</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

Inconvenient service hours of sexual health services were the most commonly noted problem, especially in Khon Kaen, where a 20-year old gay participant noted: “I’m not free to come, I’ve got to study during the day.” Mostly, the problem was that the services were not provided in the evening or during weekends, which formed an obstacle for those working or studying in the daytime. However, a 34-year old gay interviewee from Chiang Mai said the clinic he used only operated on Mondays – a rather more restricted service.

Long waiting times (Bangkok, Khon Kaen and Ratchaburi) and distance to the clinic (Chiang Mai, Khon Kaen and Phuket) were also considered obstacles.
Lack of trust in the confidentiality or privacy of the clinic were noted by altogether five participants, in Khon Kaen and Ratchaburi. A 22-year old TG woman in Ratchaburi said she was “afraid others find out, afraid the staff don’t keep confidentiality”. Lack of privacy was linked to the physical layout of the facilities in Khon Kaen by a 24-year old TG participant: “having a sign at the district public health office that reads ‘Centre for Assisting People Living with HIV and AIDS Patients’ is too revealing. When you go there to attend a training, people look at you and it makes you feel afraid others will know you’re positive.” Privacy was also an issue for a 20-year old gay student in Khon Kaen, who noted he doesn’t want to make his sexuality known through accessing services.

Lack of understanding about the client groups and outright disrespect were relatively rarely commented on. Perhaps the worst reaction was observed by a 24-year old gay Bangkokian, who said the service provider “didn’t give me information, was unfriendly, and told me that being gay, I should go receive services elsewhere.” The criticism expressed by a 39-year old gay participant in Chiang Mai was not as specific: “when using state services, they don’t speak nicely, don’t understand the nature of MSM.” A 22-year old man from Ratchaburi, who had complained about the condoms he had received and felt were substandard, had been dismissed with the comment “that’s what free stuff is like”.

When asked if they had heard of such problems from their friends or others, 34 interviewees responded in the affirmative. Table 12 summarizes these issues.

The constraints and obstacles the participants had heard of from others were quite similar to those experienced first-hand. Accounts of disrespectful service providers were more common in the second-hand accounts. Most were general comments about verbally impolite or unfriendly service providers (Khon Kaen and Chiang Mai), which individual interviewees in Ratchaburi and Chiang Mai and three in Bangkok commented were typical in state hospitals. Another two related to judgemental attitudes; for example, a 48-year old TG woman in Khon Kaen had heard that “the way the staff deal with questions, it’s like blaming. Makes young people unwilling to go there.” One 33-year old gay participant in Chiang Mai had heard of “inappropriate service provider behaviour, like touching the [client’s] body more than is necessary”.

Table 12: Second-hand reports of constraints and obstacles in accessing sexual health services (stated in response to a non-specific question)

<table>
<thead>
<tr>
<th></th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting time</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>Disrespect</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Lack of trust in</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>confidentiality or</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>privacy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Embarrassed, afraid to</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>go</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Afraid of results</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Distance</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Others</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>11</td>
</tr>
</tbody>
</table>

Second-hand accounts of perceived lack of privacy or confidentiality added concrete details to those experienced first-hand: A 20-year old gay participant in Chiang Mai had heard of a provider “talking of a case they were currently giving counselling on,” and another, 25-year old gay participant talked of someone whose service provider “had spent a long time asking questions, with the documents spread on the table, they were afraid these would not be kept confidentially”.

Some issues were only noted in second-hand accounts. These included the fear and embarrassment involved in going to receive sexual health services at all, which had prevented some of the participants’ acquaintances from utilizing services. Others had not gone due to their fear of knowing the results; some had been tested but not returned for the results. A 30-year old gay participant in Phuket “had heard of someone, who couldn’t receive the services because they had no money, and so they had to go back home”.

Promoting Health-Seeking Behaviours and Quality of Care among Men who have Sex with Men and Transgender Women: Evidence from 5 Provinces in Thailand
Location of the services

When specifically asked, 11 interviewees considered the location of their sexual health services problematic (one in Ratchaburi, six in Khon Kaen, and two in Chiang Mai and Bangkok each). The location of the services was described as a personally significant obstacle by only one participant, a 37-year-old bisexual man in Ratchaburi, who noted that “the services are far from my home, and the cost of transportation is high, 200 baht each time. My daily salary is 185 baht.”

Most participants either identified no problems regarding the location of the services, or even emphasized that the services were already easy to reach, located nearby, on a main road, had public transportation connections available, or that they got the travel costs paid through a research project they participated in at their clinic.

Obviously, those on lower incomes may be more affected by transportation costs – one Bangkok FGD participant noted the return journey on a taxi to a clinic not located near any underground station would cost about 400 baht, but added that paying the taxi fare would still be preferable to utilizing less understanding services located closer-by, and to the inconvenience of travelling to the clinic by bus.

Furthermore, since the participants were recruited through local groups, those living within easy reach of their drop-in centres may have been more likely to participate than those for whom it was inconvenient due to the distance. Looking across the entire interview and FGD dataset, every study site except Phuket had some participants who viewed that those living outside large city centres lacked convenient access to the services. For example, a 27-year-old TG woman in a rural district of Khon Kaen noted the services “aren’t sufficient yet, still only exist in cities. In the countryside there is great shortage. TGs in the countryside are far from the services and lack the opportunity [to use them].”

Even in Bangkok, one 20-year-old gay interviewee noted that “the number of drop-in centres in the city outskirts should be increased, because at the moment the centres are mostly all in urban areas.” Though not noted by any participant, the time spent travelling from the outskirts of Bangkok into the centre might in fact be longer than the time spent travelling from a rural district into the provincial capital, due to the traffic jams Bangkok often suffers from. On the other hand, public transportation is more comprehensive in Bangkok than in rural areas, some of which only have infrequent public transportation connections, and some don’t have any at all. This could likewise be an obstacle to those living in rural areas and not having a car or a motorcycle, as asking one’s friends or relatives for a ride to a sexual health clinic might be too embarrassing.

Ten participants (one in Ratchaburi, two in Khon Kaen, five in Bangkok, and two in Chiang Mai) noted there were too few centres (drop-in centres and clinics) to cover the size of the target groups. Seven explicitly called for district-level or suburban centres (four in Khon Kaen, and one in Bangkok, Chiang Mai and Ratchaburi each). Eight participants called for (more) outreach services (three in Phuket, two in Ratchaburi and Chiang Mai each, and one in Bangkok).

Better networking, better distribution of condoms and lubricant in the countryside, better distribution of sexual health information in the countryside, and mobile clinics were each recommended by one participant. The wish for mobile clinics was expressed by a 20-year-old gay interviewee in Ratchaburi, who felt this type of service would help to avoid being recognized when using the services.

A 54-year-old TG woman in Ratchaburi also called for opening hassle-free access to cross-province services provided at no cost to the client. This might be particularly important for seasonal labour migrants who may lack access to free services in one of the areas they live during the year, since most Thais covered by public health insurance can access medical services for free in only one self-chosen location, except in case of accident or emergency, and changing one’s primary service provider can involve significant delays. The CSMBs provides free services in all public hospitals and clinics, but it only covers a minority of the population, and in this study only three participants were covered through it. In the interview dataset,
every site had some participants who reported having accessed sexual health or HIV treatment services cross-province, and some stated they had done so because that was their chosen primary service provider in their public health insurance scheme.

Five participants in Khon Kaen lamented their drop-in centre was hard to find. One said it was on a small side street with no sign on the main road.

A 39-year old gay participant in Phuket noted the current location of the drop-in centre was “convenient and appropriate for those who work in the bars, but students haven’t accessed it much yet.” A Phuket FGD participant echoed this view. A 24-year old TG woman in Chiang Mai similarly thought service branches should be established at educational institutions she viewed as having large numbers of MSM. Her perception is supported by a survey among 17-20 year old Chiang Mai youth, which systematically sampled both students and out-of-school youth, and found that 21.4 per cent of the males in “general schools and universities” considered themselves either gay, kathoey, bisexual, or unsure of their sexuality, as opposed to only 6.7 per cent in the out-of-school group (Tangmunksongvorakul et al., 2010). However, whether most MSM or TG woman students would feel safe accessing such services at their educational institution would require further investigation.

A few found it inconvenient that the services weren’t one-stop – especially that preventive services (provided at a drop-in centre) and curative services (provided at a sexual health clinic) were not given under the same roof. In Bangkok, Chiang Mai and Khon Kaen, where some clinics were criticised as having incomplete equipment, individual interviewees and FGD participants noted this means treatment will need to be given at general hospitals, where staff may be prejudiced:

> There was this case I took a younger person with [genital] warts [to a clinic], but they couldn’t treat it, so they had to go have them operated at their [chosen] hospital. I’d like them to be able to treat it right there . . . [because] at the hospital we’ll need to go see a [new] doctor, and some of them still have bias against us. I’d like it to be one-stop, rather than just diagnosing the illness (Bangkok FGD).

One Chiang Mai FGD participant wished the drop-in centre services could be provided at a hospital and incorporated to those offered at a sexual health clinic. A 24-year old Chiang Mai TG woman shared this idea, but added that “they might still be separate from the ordinary services.” Similar comments were also made by others in favour of specific services located at a hospital – especially in Bangkok where the FGD participants noted one clinic’s location inside a larger general hospital made it easy to enter, since onlookers could not know which kind of services they went to receive in the hospital.

In contrast, a Chiang Mai FGD participant thought others would be able to see which services they accessed at a hospital, and preferred the setting of a Chiang Mai public sexual health clinic, which looks so much like a generic provincial health office that others do not even know it is in fact a clinic. A few others, like a gay 25-year old participant in Ratchaburi, didn’t like hospitals, especially state hospitals: “I would like them to come do checkups at the drop-in centre. I don’t want to use state services, I’m too afraid to go.” A few others also wanted check-up services at the drop-in centre, at least sometimes. Though these participants’ different experiences have led them to prefer services offered in different kinds of settings, they all shared a concern for services that can be utilized without being identified by onlookers.

### Physical venue of the services

When specifically asked about constraints and obstacles related to the physical environment of their sexual health services, 57 participants identified some – in other words, more than half of the participants thought there was room for improvement. However, some first said they found the services appropriate, but when asked what they would like to improve about the physical venue, did offer views on where there was room for improvement. Table 13 summarises these issues.

By far the most common constraints and obstacles noted by the participants were that the facilities were cramped (and thus overcrowded on busy days), and lacked separate, private spaces for specific functions, especially
counselling. These problems were observed both with sexual health clinics and drop-in centres, but more commonly with the former, and though such problems were mentioned in all study sites, they were most commonly talked about in Phuket. A few complained that the lack of storage space meant the common areas looked cluttered and untidy with objects and equipment that should be kept out of sight.

Lack of privacy was also linked to the lack of specific units for different groups – for example, a 20-year old TG woman in Ratchaburi called for “separating the rooms for each type of service, such as a room for men, a room for gays, and a room for sao prophet song.” This issue had divided opinions as a couple of participants didn’t like group-specific rooms, but there were clearly more of those who called for group-specific facilities than those who opposed them.

For some, lack of privacy resulted from signage that too clearly pointed out to onlookers what sort of issues and people the clinic in question dealt with. Others, such as a 25-year old gay interviewee in Bangkok, found his clinic’s signage insufficient and the layout inappropriate:

The system is really confusingly designed. There’s no signage. People won’t know where to go first. The clinic’s in two floors, which is really inconvenient. It’s hard to find, hard to access. Ordinary people don’t know it. The flow of the services should be rearranged and the area made more spacious.

Two gay participants in Chiang Mai were not at all impressed with the general appearance of their local sexual health clinic, which the first, a 20-year old, said was “old, dirty, dark and makes people unwilling to go there for checkups.” The other, a 24-year old, had a similar view: “The building’s rather frightening, old, not private.” To improve the clinic, the same participant said it should have “separate functions for separate rooms, good ventilation, and be clean and tidy.”

Two drop-in centres in Bangkok and one in Khon Kaen were critiqued by one participant each for being cramped, disorganized and not clean enough. The Bangkok FGD participants talked of how dirty clinics made them think of unsafe clinical practices like reusing injection needles and syringes, underlining the symbolic significance of clean premises. These participants thought private clinics were generally cleaner than state ones.

Besides the lack of sufficient seating on busy days some participants noted, waiting areas were generally not mentioned as problematic. However, three participants (two in Bangkok and one in Phuket) expressed a wish the waiting areas could be a place to sit back and relax, with internet access, books and sexual health materials to browse while waiting.

**Personnel**

When specifically asked about constraints and obstacles related to the personnel of their sexual health services, such as the participants’ relationship with the personnel, or the demographic characteristics (e.g., age and sexuality) of the service providers, 56 participants identified at least one issue, and many identified several. Table 14 summarizes these issues.

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**Table 13: Constraints and obstacles related to the physical venue of sexual health services**

<table>
<thead>
<tr>
<th></th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cramped</td>
<td>2</td>
<td>5</td>
<td>11</td>
<td>6</td>
<td>3</td>
<td>27</td>
</tr>
<tr>
<td>Lack of privacy</td>
<td>4</td>
<td>8</td>
<td>8</td>
<td>2</td>
<td>4</td>
<td>26</td>
</tr>
<tr>
<td>Lack of specific unit</td>
<td>5</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Untidy</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Problems with signage</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Lack of parking space</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Dirty</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Others</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>5</td>
<td>5</td>
<td>11</td>
</tr>
</tbody>
</table>
Despite the existence of group-specific sexual health services in each study site, problems with the service providers’ attitude and/or manners were most commonly reported, overall and in Khon Kaen, Bangkok and Chiang Mai in particular. In Ratchaburi and Phuket, such problems were less often addressed. Staff manners experienced as problematic were described as unfriendly, uncaring or impolite, whether in terms of their verbal expressions, tone of voice, or non-verbal behaviours.

In many cases, though not all, these issues were experienced as being related to the attitudes the staff held. For example, a 27-year old TG participant in Khon Kaen thought the staff should improve their “speaking skills – I’d like them to have a bit of psychology in how they speak, rather than just utter the first thing that comes to their mind, such as in ‘when you have anal sex, doesn’t it [your anus] get torn?’ I felt shocked, felt they shouldn’t have asked that.”

Some participants felt their provider lacked empathic understanding about the client group, such as a 26-year old gay participant in Bangkok, who thought that “the staff aren’t yet that open-minded, or accept the thoughts, the feelings of the clients that much – they still look at them and give advice on [the clients’] way of life from their [personnel’s] own point of view.”

Overall, a fifth of the participants didn’t fully trust the confidentiality of the services. This was most commonly reported in Ratchaburi, where eight participants had such a concern. One of them, a 22-year old TG woman said: “My level of trust in [them] keeping confidentiality is fifty-fifty.” Some cited convincing reasons not to think confidentiality was guaranteed: “sometimes the [clinic] officer will slip and speak to me of the characteristics of the client just before me” (gay, 23 years, Chiang Mai).

While dissatisfaction with the service providers’ attitudes, manners or demographics was more often related to the clinical services, the drop-in centres were more often criticised of not safeguarding confidentiality. For example, a gay 21-year old Bangkokiian noted that “they’re informal, but you can’t share secrets with them because they like to gossip. So, I feel more at ease talking with the staff at the . . . clinic”.

For many participants, the practitioners’ demographic characteristics were not important. For example, a 23-year old TG woman in Chiang Mai noted that “any phet [gender/sexuality] will do – what’s important is that they understand MSM and have open-minded, non-stigmatizing attitudes.” However, 17 participants felt that certain demographic characteristics of the service provider caused either embarrassment or lack of shared understanding. Among those who expressed preferences for certain age or gender/sexuality of the service provider, opinions were very divided on what characteristics were preferable.

Perhaps the best indication of a relatively common preference was that of the seven gay interviewees who indicated their own preference for a certain gender/sexuality of the service provider, four said they preferred someone like themselves, and three said they didn’t like to consult a woman service provider. In reverse, no gay interviewees were opposed to seeing a gay service provider nor said they particularly liked to see a woman service provider. For example, a 25-year old gay Bangkokiian said that if “she’s a woman and I’m a man, I do feel a bit embarrassed to undress for her to check me”, and a 39-year old gay interviewee in Phuket said that “if the officer was of the same group, they’d probably better understand the nature of what it’s like to belong to this group.” One FGD participant in Bangkok held both of these views and added that a heterosexual man would also not be preferable:
I think that if they’re a woman, however positive her attitudes, in accessing the services for the first time, I could not know about her positive attitudes. Even if she looked friendly and merry, I still might not dare to reveal all my information to her. But if they were of the same kind, I might be better able to give them that information. A [heterosexual] man I’d better not see at all because however positive his attitudes, I’d still feel shy about undressing before a [heterosexual] man.

In this sense, the safest choice for gay clients would probably be a gay practitioner.

Among the TG women who commented on the role of the service provider’s gender/sexuality, two specifically expressed a preference for a TG service provider, for example a 24-year old in Khon Kaen: “I’d like a doctor who’s also a TG, so we’d understand each other easily.” Yet, one (Ratchaburi, 54 years) specifically said she preferred “a woman that can be trusted. I won’t let a soi prapet song doctor check me, because they can’t keep secrets.” A fourth (Khon Kaen, 18 years) also preferred a woman practitioner: “I’d like the officer to be a woman, because women will understand other women better than men.”

The thus far limited educational opportunities of TG women may mean that medically qualified TG women, especially physicians, can be hard to find — a Phuket FGD participant named one TG woman physician whom she thought was the only one of her kind in the country. In this sense, although having TG women staff would be preferable for many TG women clients, a relatively safe alternative would be to use non-TG women as staff, at least safer than having men as staff. As a 27-year old Chiang Mai TG woman put it: “I’d like them to be a TG. If they’re a man, a woman, I’ll feel embarrassed. But if they’re a woman, it’s a bit better.”

Two participants in Ratchaburi, who both considered themselves simply “men”, had the opposite preferences. The first, a 22-year old said: “With a man, I feel shy, because it’s like we’re the same sex so I wouldn’t want him to know I’ve got a sexuality like this.” The second, a 19-year old, said in contrast that “I don’t feel comfortable talking to a woman, because it might be difficult to communicate about the illness I was facing.”

Views on the practitioner’s age similarly divided opinions. Of the interviewees, six commented on the matter, with three favouring an older practitioner, and three preferring a practitioner of roughly equal age. Even the reasons for preferring either characteristic were similar: credibility and ease of communication. A 23-year old TG woman in Ratchaburi preferred “a service provider who’s a senior, 40 years or older, because they’d have more credibility and be able to give advice”, whereas a 20-year old gay interviewee in Chiang Mai thought that a younger practitioner “would make one believe they’re got experience”. Similarly, a gay 23-year old in Chiang Mai thought that “if the service provider’s older, the discussion will be more informal than with a practitioner of the same age”, yet a 22-year old gay interviewee in Khon Kaen thought that:

There’s a gap between [the client’s and service provider’s] way of thinking. I think they probably have old-fashioned bias [and there is] an age gap. It boils down to [notions of] ‘appropriateness’ because there are some things you can discuss with friends, but not with your seniors.

In these terms, there wasn’t a clear preference for an older practitioner or for one of similar age.

Staff shortages were noted in both clinics and drop-in centres, especially in Khon Kaen and Phuket, where a 41-year old gay participant noted: “there’s too little staff . . . they should have several service teams [for the staff] to be sufficient for the number of clients.” The typical consequences of this shortage were long waiting times, hurried services, limited information provided, and having to receive services when it was convenient for the clinic, not for the client. A 37-year old bisexual participant in Ratchaburi was quite disappointed: “they have little staff, sometimes only two people. There have been times I’ve gone there and didn’t get serviced, only lost time and money [by travelling there].”
Criticising the level of knowledge or skills among the staff was rare, only done by five participants, and many even emphasized their trust that the staff were experienced professionals. A few, however, did identify limitations: “they didn’t have enough knowledge because they couldn’t give me a clear answer” (gay, 33 years, Ratchaburi). One 25-year old gay participant in Khon Kaen felt that the technical skills of the staff left room for improvement: “I wish they could take a blood sample painlessly, and add more expertise for the staff in checking the throat or the anus.” A Chiang Mai FGD participant, an outreach volunteer, also recounted negative experiences some clients they had taken for a blood test had had: “some of the stockier young people had been stuck [with the needle] some 5-6 times, and the specialist nurse still couldn’t find [the vein], so they had to call in the medical technician. Those juniors had to be stuck 7 times before they could draw the blood.”

The Bangkok, Chiang Mai and Phuket FGDs also talked of how lack of staff understanding about each client group can affect clinical outcomes, especially when using non-group specific services. A Phuket FGD participant, a drop-in centre volunteer, talked with some sarcasm of what might happen if an MSM or TG woman went to a general hospital rather than visited a drop-in centre first, where a referral could be made to a specific clinic:

If they went straight to the hospital, they wouldn’t give us friendly service. They’d view us as a troublemaker, having an STI. Some people don’t understand. They’d not know which doctor to send us to. We’d explain and explain but not be understood in an ordinary hospital. They’d have pus oozing out down there by the time they’d finished speaking, and the staff still wouldn’t know whether to send us to an internal-medicine doctor or a dentist.

The Bangkok FGD similarly linked understanding of sexuality to correct testing procedures:

If they’re a sao praphet song, there will be some diversity the service provider might not think of. . . . Like some young TGs might use their ‘snake’ [i.e., penis], others might not, and yet others might just use it for their private pleasure [i.e., to masturbate] – there are differences. If we’d go see a doctor in certain clinics where they think we just don’t use the ‘front works’ [i.e., penis], they’d just check our ‘backside’ [i.e., anal], and so our ‘little sister’ [i.e., vagina] with gonorrhoea would be left undiagnosed. They wouldn’t check it because they don’t understand our way of life.

The Chiang Mai FGD was on similar lines:

The treatment processes are different. For example, if we talk of STIs among men who love men, there’s the issue of gonorrhoea in the throat . . . even if we go to see an ear-eye-throat-nose specialist, even they won’t be able to check and diagnose our illness. We’ll have to go to a specific clinic that has proper testing equipment. If we go to a hospital, we’ll [just] tell the doctor we’ve got a sore throat. If we’ve sucked someone’s ‘thingie’, we won’t be able to talk about it.

Other issues noted by participants across the study sites included a wish that the staff be physicians, wear uniforms, have better coordination among themselves, that drop-in centre staff would help to “control the behaviour of the group members,” and that clients would have their own assigned practitioner they could see every time they went to receive services, in order to increase a feeling of continuity in the care provided. A Phuket FGD participant expanded on the issue of continuity:

if the doctor took good care of our data, they’d not need to redo the tests that often but rather be able to follow-up on our data . . . as soon as you got there, they’d have your data ready for use . . . rather than say, [the doctor’s] in a meeting, and you’d have to start filling in [the details] all anew.

When participants felt the staff were already appropriate, they mentioned having a sufficient number of staff and various qualities that made them trustworthy: professionalism, skills and knowledge, understanding of MSM or TG women and their sexual health, non-stigmatizing attitudes, safeguarding confidentiality, conveying an informal, friendly or even familial, sibling-like atmosphere in which the participants felt they could consult on any given issues, and received clear and comprehensive explanations.
Costs incurred in using services

Costs incurred using the services were generally not a significant obstacle to using the services, since most participants got the services either free of charge or at a cost they thought was manageable.

An FGD participant in Bangkok noted that especially when travelling outside Bangkok, having or not having enough money could be the determining factor in whether to receive services while still out of Bangkok, or to wait for one’s return to Bangkok to receive free-of-charge sexual health care, as well as whether care would be accessed in the private or public sector.

Whether services should be completely free of charge led to divided opinions among participants. A Phuket FGD participant thought that completely free services would not encourage service use, whereas FGD participants in Chiang Mai were adamant that even low treatment fees deterred use and would result in fewer people using the services.

A few mentioned transportation costs as a problem, but for most participants, even these were not a significant obstacle. However, for those living far from provincial centres and on low incomes, such costs could be a significant obstacle: “There is no treatment fee since I use the [UCS] Gold Card, but the cost of transportation is higher than my daily income, and if I have to take time off work to receive treatment, then there will be no income, only costs” (bisexual, 37 years, Ratchaburi). And as noted above, treatment costs could also be a problem for seasonal migrants unable to access free services in their current area, while registered with a hospital in another province.

Quality and accessibility of medicine

Accessibility and quality of medicine were mostly not considered to be problematic by study participants.

Only a few participants felt the medicine they received wasn’t of acceptable standard. One 29-year old gay participant in Bangkok noted it was: “good, but they might want to improve the smell, don’t let it smell the way it naturally does.” One 24-year old gay participant in Chiang Mai said “they don’t have certain medicines, so sometimes I’ve had to receive treatment elsewhere – very expensive.” A 33-year old gay participant in Bangkok commented on accessing antiretroviral treatment: “for ARVs, I had to enter the project, and so had difficulty accessing them, since I had to wait almost a year.”

However, the participants in this study were a heterogeneous sample in clinical terms – many indicated they had never had any STI treatment, while some had; some were living with HIV and commented on their ARV, and for many, this information on service utilization was not evident from the data set. To properly assess the quality of STI or ARV therapy, specific samples would need to be drawn from clients of the respective clinics, and participants’ comments on the services clearly linked to each clinic they use. From this study’s dataset, it was often difficult to assess whether participants were commenting on sexual health clinics, HIV clinics, or drop-in centres.

Scope of the services provided

Since several interview questions yielded replies on aspects or types of services the participants thought were insufficiently (or not at all) provided, these questions were analyzed together. Overall, there were accounts from 58 participants who identified such areas. This count does not include their comments on the quality of services already provided, the appropriateness of the staff, the physical layout of the facilities, or the geographic coverage of the services, which were already covered above. The issues covered were rather diverse and geographically dispersed throughout the five study sites.

Nine participants (3 in Bangkok, 2 in Khon Kaen and Chiang Mai, and 1 in Ratchaburi and Phuket) thought the services weren’t publicised actively enough. A 19-year old gay interviewee in Bangkok said: “I’d like the state to do more publicity work, and continuously, not just every now and then.” A 22-year old bisexual participant in Khon Kaen suggested a way to increase publicity at a low cost: “they should publicize information on sex and the location of the services through Facebook,” and a 18-year old Ratchaburi TG woman linked publicity work to societal acceptance: “I wish there was publicity work to give society an opportunity to accept [sexual/gender diversity].

Findings: Health-seeking behaviours, access and perceived quality of care

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A component of the services which is already supposed to be provided by both drop-in centres and clinics, but which was quite commonly identified as missing or insufficient, was sexual health information. Nine participants (1 in Ratchaburi, 2 in Khon Kaen, 4 in Phuket, and 2 in Bangkok) thought the staff provided too little information, and seven (3 in Bangkok and 1 in all the other sites) thought information materials like leaflets were insufficiently available. For example, a 22-year old TG woman in Ratchaburi said her “service unit distributes condoms and lubricant, but not correct information.” A 25-year old gay participant in Bangkok called for materials that would cover sexual health matters as appropriate for MSM: “I’d like to have the materials improved, to go beyond sexual illnesses among heterosexual men and women, and not just provide info on using condoms.” For example, this could mean covering how STIs specifically affect MSM, rather than heterosexual men and women.

Six TG participants (1 in Ratchaburi, 3 in Phuket, and 2 in Chiang Mai) wished they could access information and counselling on surgical operations and on the safe use of hormones: “I’d like to have a service centre directly for sao phraphet song, on taking hormones and providing counselling on surgical operations” (21 years, Phuket). A 20-year old in Ratchaburi had similar wishes: “I’d like them to have a separate sao phraphet song room, on taking oral contraceptives, on beautiful skin, rather than . . . talk about sexual matters – that would be both fun and informative.”

The hormones themselves should also be available through the hospital rather than just pharmacies, thought a 27-year old TG woman in Chiang Mai. The Bangkok and Khon Kaen FGDs also discussed the unmet need for advice on appropriate dosage and on blood tests for hormone levels in the body, recognizing the dangers of hormone overdose but also the lack of reliable information on the topic. Two gay participants also wanted information on “how to take care of yourself and look good” (20 years, Phuket) or “how to develop your body and look good” (19 years, Bangkok), and one suggested general health promotion could also be done at the clinics. Such services could both facilitate safer hormone use among TG women and incentivise the use of sexual health services.

Counselling in general was thought to be lacking by five participants (2 in Khon Kaen, 2 in Bangkok, and 1 in Chiang Mai), even in the context of clinical services: “the provision of counselling before using the services – it shouldn’t be a case of being tested as soon as you walk in” (24 years, gay, Chiang Mai). A 21-year old gay participant in Bangkok said he’d only wanted counselling when he went to a sexual health clinic, but there had not been a clearly indicated counselling room, so he had not dared to ask for counselling.

Three participants (2 Bangkok, 1 in Chiang Mai) specifically wanted “information on sexuality, because it is hard to understand and makes people confused,” and three wanted counselling on sexological issues, such as “taking care of the sexual organs [and] on having sex” (gay, 19 years, Bangkok). Basic sexological issues (e.g., pain when having sex, premature or delayed orgasms, or how to have mutually enjoyable sex) puzzle MSM and TG women just as they do heterosexual men and women, but evidence-informed materials or counselling appropriate for MSM or TG women, may still be lacking in Thailand. In some cases, such matters are clearly linked to the decision to use or not use condoms and lubricant, such as when MSM think condoms cause pain or decrease sexual arousal, or when a TG woman feels that as a woman, she does not have enough negotiation power to demand her partner to use condoms. And besides having the potential to improve quality of life among MSM and TG women, also providing broader sexological services could act as an incentive to utilize sexual health services.

Two gay participants in Chiang Mai called for “information about taking care of yourself” (34 years) and “quality follow-up services” (23 years) for people living with HIV.

Three participants (1 in Bangkok, 2 in Chiang Mai) called for a better referral system: “add referrals in case the client is ill, because a referral system doesn’t exist yet” (20 years, gay, Bangkok); “I wish there was a clear referral system in case someone has to be referred for higher level services” (gay, 39 years, Chiang Mai). One participant in Bangkok suggested a shared patient database would be helpful: “I’d like there to be exporting, linking and
retrieving of patient data using a single database, in order not to waste time whenever you begin anew [receiving services in a new place] – treatment would become more continuous."

Three participants in Khon Kaen complained about the clinical equipment available at their clinic: “I feel the medical equipment isn’t as complete as at the hospital” (48 years, TG woman); one explicitly said they should “modernize the equipment” (gay, 30 years).

Discontinuation of service use

The interviewees were also asked if they had ever stopped using sexual health services at any given venue. Twenty interviewees, or one-fifth of the sample, said they had done so. Table 15 shows the most commonly cited reasons for discontinuing service use.

Table 15: Reasons to discontinue use of sexual health services

<table>
<thead>
<tr>
<th>Reason to Discontinue Service Use</th>
<th>Ratchaburi</th>
<th>Khon Kaen</th>
<th>Phuket</th>
<th>Bangkok</th>
<th>Chiang Mai</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unfriendly staff</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Long waiting time</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Reluctant to provide services</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Distance</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Lack of confidentiality</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Moving to another area</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Others/no specific reason</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>9</td>
</tr>
</tbody>
</table>

The highest number of complaints leading to discontinuation of services was in Chiang Mai, where altogether eight participants said they had stopped using some services. Of these, six were TG women and two were gay; however, these six TG women clients didn’t specifically cite bias against TG women clients as their reason to discontinue service use.

Unfriendly service providers were the most common reason to discontinue service use, cited by 7 participants. Ratchaburi and Chiang Mai had 3 interviewees with such complaints each. Specific wordings included “didn’t talk nicely”, “stigmatizing”, and “not welcoming.” In three cases, the service providers were outright reluctant to provide the services requested. A 23-year old TG woman in Chiang Mai said she wouldn’t go to a general health centre anymore, where she had previously gone to request condoms, because they seemed unwilling to give the condoms. A 25-year old TG woman in Khon Kaen had asked for counselling at a private clinic, but had been told it was not their responsibility. A third TG woman, 22 years old and also in Chiang Mai, cited the staff’s perceived reluctance to serve and among other reasons, stopped using the services: “slow service, many steps, inconvenient, staff didn’t seem wholeheartedly involved.”

Other reasons included long waiting times, long distance to the venue, costs and lack of confidentiality. A 41-year old TG woman had felt the latter depended on both the staff and the physical venue: “I’d like the staff to have some ethics, love their work, be friendly, and the venue should have rooms separated by curtains so others couldn’t see inside while one is receiving counseling”. One 25-year old gay client in Chiang Mai said he was scared to return to a hospital where the operation he had received had been painful and he had been advised to take antibiotics afterwards, which might indicate he was afraid of being infected while receiving the services.

Moving to another area was cited by two participants, and was the only reason that did not fault the service provider.
CONCLUSIONS AND LESSONS LEARNED FOR PROGRAMMING

In Thailand, MSM and TG women were estimated in 2010 to have a national overall HIV prevalence (13.5 per cent) roughly 10 times higher than the general adult population (National AIDS Prevention and Alleviation Committee, 2010). Only in the last few years have HIV related services to these groups begun to expand significantly. The study was conducted to assess whether these services are now meeting these groups’ needs, what obstacles still hamper their health-seeking, and to facilitate the creation of evidence-informed strategies for health service planning for these groups.

The National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation 2007-2011 (National AIDS Prevention and Alleviation Committee, 2007) stated that stigma and discrimination against men who have sex with men would be addressed by building awareness about sexuality. The findings of this study show, however, that stigmatization of MSM, TG women, and people living with HIV continue to hamper HIV prevention among MSM and TG women. The resulting fear of exposure makes some unwilling to have any contact with outreach workers or relevant clinical services, and anticipated, perceived or actual negative bias among service providers discourages service use.

Of the 100 participants of this study, representing TG women, gay, bisexual and other MSM groups connected to local group-specific sexual health groups or organizations in five sites across Thailand, roughly three quarters considered they had accessed sexual health services in the past one year. The majority had accessed sexual health information, condoms and lubricant, but only a third indicated they had been tested for HIV in the past one year. Twenty said they had discontinued using services owing to dissatisfaction about a given venue.

Overall, the participants’ accounts suggest that the existing services still need improvement both in terms of geographic coverage, scope and quality of the services, as outlined below:

**Insufficient geographic coverage.** The accounts of the participants in this study suggest that the locations in which the services are provided are convenient mostly for those MSM and TG women staying in central Bangkok and the capital cities of provinces where services now exist. Those living on the outskirts of Bangkok or outside provincial capitals may find the locations inconvenient, with money and time spent traveling to access services constituting significant obstacles to those on low incomes.

**Low awareness of HIV and services among target groups.** Some participants commented that outside the groups of MSM and TG women connected with local organizations, HIV awareness in general, awareness of personal risk, and awareness of existing services may all still be low, suggesting more publicity work is needed. It might also need to be targeted, since those living in rural areas, on low incomes, and MSM not identifying as gay might all have particularly low levels of awareness about their health risks and service availability.
Inappropriate staff attitudes and manners. The most commonly raised complaint about sexual health service personnel by the participants, noted by about one-fourth, was that there was room for improvement in terms of manners and attitudes. In some cases, the problem was explicitly linked to lack of correct understanding and stigmatizing attitudes about MSM and TG women, which could deter use and lead to incorrect treatment. Lack of empathy, unconditional acceptance and service-mindedness were also criticized, especially in state-operated venues.

Insufficient privacy and confidentiality. Another key concern noted by the participants was that the physical venues were cramped and offered little privacy (noted by roughly one-fourth of respondents). About one-fifth said they did not trust the staff could keep confidentiality, and some gave examples of blatant violations of confidentiality they had come across or heard of, such as staff gossiping about the previous client. These criticisms were usually made in general terms, suggesting these issues are not specifically linked to clients being MSM and TG women. Lack of confidentiality was also commonly noted about drop-in centres.

Insufficient staff and opening hours. Fifteen participants complained that services with too few staff led to long waiting times; seven complained about inconvenient opening hours.

Lack of TG specific services. In this study, a smaller proportion of TG women reported using services at hospitals or clinics than of the gay participants; some explicitly voiced their dissatisfaction about the lack of TG specific services. At the time of writing (early 2012), the only TG specific services existed in the city of Pattaya.

Insufficient scope of services. A wide variety of services was talked about in this study, but they were rarely provided under one roof, which a majority of the participants thought was problematic or inconvenient. Some clinics and hospitals provided a limited number of condoms and no lubricant, whereas some drop-in centres offered no clinical services. Some services were perceived to offer insufficient sexual health information. No sexual health service venues seemed to offer hormones or even information about safer hormone use for TG women, even though doing so would both promote TG women’s health in itself and incentivise use of other aspects of the sexual health services, such as HIV testing or prevention.

Less than optimal staff demographic profile. Seventeen participants expressed their unease of receiving services from providers of certain gender or age. While personal preferences about staff demographics varied widely, the participants’ accounts suggest that gay service providers might be most liked among gay clients, whereas among TG women, either TG or non-TG women might be most acceptable.
RECOMMENDATIONS

For community groups/organizations
• Build an organizational culture that does not tolerate any violation of client confidentiality.
• Continue to expand community-level networks, both within existing coverage area, and into areas not currently covered, especially suburban and rural areas, as well as provinces not yet covered at all.
• Seek opportunities to integrate clinical services (such as voluntary, confidential HIV testing and counselling, as well as STI diagnosis and treatment) into the work of the drop-in centre.
• Encourage use of personal contacts in bringing in new clients and providing referrals to clinical services, to instil trust among potential clients in the service providers.
• Seek opportunities to provide specific services meeting the needs of TG women in particular.

For policy-makers
• Channel resources for countering stigma and discrimination about MSM, TG women and people living with HIV.
• Ensure destigmatization messages are mainstreamed and presented in a wide range of contexts, including but not limited to sexuality education provided within general education.
• Seek new solutions and channel resources for a higher geographic coverage and better public awareness of services available to MSM and TG women.
• Channel resources and for establishing specific services for TG women, including services related to hormone use.
• Ensure free-of-charge access to sexual health services not limited to one health service provider, to meet the needs of mobile populations of MSM and TG women.

For public health service providers
• Build an organizational culture that does not tolerate any violation of client confidentiality.
• Continue to increase staff awareness and acceptance of MSM and TG women, and provide opportunities for further training on the specific health issues they have.
• Encourage staff to build personal linkages with MSM and TG women community members, to instil trust in the service venue. Social networking sites can be a good tool for this.
• Reorganize the physical venue so that privacy can be maintained. Private, sound-proof spaces are needed for exchange of confidential information. Locating a group-specific service venue inside a generic service venue (e.g., hospital, provincial health office), that can be entered without being seen by others, and has discreet signage can be helpful.
• Adjust operating hours so that they are suitable for all groups of clients, including services provided during weekends and evenings.
• Strive to hire gay staff for gay clients and women (TG or non-TG) staff for TG clients.
Ensure key services are provided within the same venue, and pilot test integrating other services, such as health, fitness and cosmetic services with the sexual health venue to incentivise service use, as appropriate to each context.

Strive to partner with community groups/organizations so that clinical services can also be accessed through drop-in centres.

**For development partners (UN, INGOs and donors)**

- Channel resources for countering stigma and discrimination about MSM, TG women and people living with HIV.
- Channel resources for establishing specific services for TG women, including services facilitating safer hormone use.
- Seek new solutions and channel resources for a higher geographic coverage and better public awareness of services available to MSM and TG women.
- Commission further research on the sexual health service needs and awareness on HIV and existing services among groups not represented in this study, such as sex workers and non-Thai MSM and TG women living in Thailand; and among non-gay identifying MSM, who were represented to a limited extent in this study.

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ANNEXES

Annex I: Interview guideline

Introduction
Hello. My name is… and I’m a researcher at Khon Kaen University. I would like to ask your permission to interview you. This interview is a part of a study on health-seeking behaviour among men who have sex with men, supported by UNESCO-Bangkok. We are very grateful that you have agreed to participate in this study.

Your participation is voluntary. All of your answers will be kept confidential. If there are any questions that you don’t want to answer, please let us know, and we will skip those questions. You can quit the interview at any time. However, we do hope you will participate in this study as your opinion is important to the study. Is there anything you would like to ask at this point, before we begin the interview?

Date/month/year of interview..............................................................................................................

Province...................................................................................................................................................

Personal information
1. How old are you?.......................................................................................................................................
2. What is your sexuality? (man, gay, bisexual, sao praphet song)
3. Where do you live now? (Is it an urban (metropolitan, city municipality, tambon municipality) or a rural (subdistrict administrative organization) area?)
4. How long have you lived here?
..............................................................................................................................................
..............................................................................................................................................
5. What is your highest educational attainment?
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..............................................................................................................................................
6. Which kind of public health insurance do you have? (Gold card / Social security / Civil servant / state enterprise package)
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..............................................................................................................................................
Questions on health-seeking behaviour
1. When you need information regarding sexual health, such as safe sex, HIV, sexually transmitted infections, and so on, where do you seek this information?
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2. When you need condoms and lubricant, where can you get them?
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..............................................................................................................................................
3. When you need sexual health services, such as counselling, HIV testing, or STIs testing and care, where do you go to get it?
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..............................................................................................................................................
4. How many times did you access sexual health services last year?
.............................................................................................................................................. times
..............................................................................................................................................
5. If yes, where did you go and why, the latest 3 times?
Place.....................................................Reason..........................................................................
Place.....................................................Reason..........................................................................
Place.....................................................Reason..........................................................................
6. What made you decide to choose these sexual health facilities you used (record as indicated in Item 5) during the last 3 times?
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..............................................................................................................................................
Questions on access to sexual health services, regarding the physical venue and its environment
1. From where you live, is it convenient or difficult to access sexual health services? How?
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..............................................................................................................................................
2. Does your current sexual health facility have any limitations in terms of its buildings and location? How? (E.g., registration area not private, no counselling room, etc.)
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3. What do you think about the location of your sexual health facility?
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4. What would you like to improve about your sexual health facility in terms of its buildings and location?
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..............................................................................................................................................
Questions on sexual health service access, regarding staff
1. What do you think about the staff who provide you sexual health services? (number, knowledge, competency, etc.)
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..............................................................................................................................................
2. Please describe your relationship with the service providers. (Feel familiar and informal, feel comfortable to discuss symptoms and receive counselling, trust the confidentiality, trust that will receive appropriate referral, trust that diagnosis and treatment will be correct and timely?)

3. What demographic or cultural characteristics of the service providers make you feel uncomfortable to receive sexual health services? Why?

4. How would you improve the staff in your sexual health facility?

4. Do you think that the cost of service is appropriate? (Including other expense related to accessing the service, such as transportation)

5. Are there any sexual health services you need, but your current facility doesn’t have?

Questions on problems and obstacles in accessing sexual health services

1. Have you ever had any problems or obstacles in accessing sexual health services?

2. Have you ever heard about problems or obstacles in accessing sexual health services from your friends or other people?

3. Have you ever quit using any sexual health services? If yes, why?

4. Do you have any other views on sexual health services you would like to share with us?

Thank you very much for sharing your valuable information. If you have any questions or inquiries, please contact Dr. Pattara Sanchaisuriya, telephone no. 043-202 83
Annex II: Participant information sheet

Research document

1. Purpose and rationale

The Health Research System Promoting Office (HRSPO) of Khon Kaen University, with support from the United Nations Educational, Scientific and Cultural Organization (UNESCO), is conducting a research project to collect strategic information for improving sexual health service accessibility among men who have sex with men in Thailand by increasing understanding about how they access sexual health information and services. The data collected is to be used for adjusting the National Strategic AIDS Prevention and Alleviation Plan for the years 2012-2016.

2. Process

In case you consent to participate in this study, the process will be as follows: A researcher from HRSPO, Khon Kaen University, will interview you. Your name will not be recorded in any way. The interview will last no longer than 60 minutes, and will cover the following issues:

- Where have you received blood tests for HIV or other sexual health services?
- What kinds of obstacles have you faced in accessing sexual health services?
- What kinds of HIV testing or sexual health services do you need?
- Have you ever received services from a volunteer or outreach worker from HIV prevention organizations, such as Rainbow Sky, Bangkok Rainbow, The Poz, MPlus+, Violet Home, Andaman Power or SWING? Have these services facilitated your access to blood testing or sexual health services at public health facilities?

3. Risks or discomfort

This research study does not involve any risks for you. Only general, not private, information about health service access will be collected. The interviews will be anonymous and confidential.

4. Benefits from participating in this research study

To compensate for your participation, you will receive 300 baht, and will also have an opportunity to request condoms, lubricant and information on sexual health services in your area from the drop-in centre. You can keep this document in case you need further information.

5. Other options

Alternatively, you can decline to participate in this research study. Doing so will have no effect on receiving any services from the community-based organization you might be accessing or be a volunteer of, or on receiving any health services.

6. Costs

Participating in this research study will not incur you any costs.

7. Compensation for time spent while being interviewed

If you complete the interview, your time and travel costs will be compensated at the rate of 300 baht.

8. If you have any inquiries

After receiving explanation by the interviewers and this document, if you still have inquiries you would like to make, you can contact Dr. Pattara Sanchaisuriya, Health System Research Promoting office, Khon Kaen University, tel. 043-202 834, or Khun Rapeepun Jommaroeng, UNESCO, tel. 02-391 0577, ext. 116.

9. Consent

Participating in this research study is completely voluntary. You have the right to decline answering any questions for any reason, or stop giving the interview at any point. Doing so will not have any negative consequences for you, whether on receiving public health services, services from community based organizations or on being a volunteer or an outreach worker.

Thank you very much for your valuable time.
Annex III: Terms of Reference

Project information

Based on the report of the United Nations Special General Assembly (UNGASS 2010), the average HIV prevalence among men who have sex with men in Thailand was 13.5 per cent. In 2007, the HIV prevalence [among MSM] was 30.7 per cent in Bangkok, 16.9 per cent in Chiang Mai, and 20.0 per cent in Phuket. In Ratchaburi, it was found in 2007 that 60 per cent [of MSM] had not had a single HIV test in their lifetime, and of these 60 per cent, 46 per cent used condoms inconsistently.

The Health System Research Promoting Office (HSRPO) Northeast region, Khon Kaen University, with support from United Nations Educational, Scientific and Cultural Organization (UNESCO) have started a research project to collect strategic information for improving sexual health service accessibility among men who have sex with men in Thailand by increasing understanding about how they access sexual health information and services. The data collected is to be used for adjusting the National Strategic AIDS Prevention and Alleviation Plan for the years 2012-2016. This should help to facilitate access to public health services among MSM, and thereby reduce new infections and loss of life due to HIV infection by encouraging early treatment.

Objectives of the research advisory committee

1. To ensure that the questions and tools used are appropriate and correspond to the needs of the study area.
2. To ensure that the study is conducted in line with international human rights standards.
3. To represent government bodies and non-governmental organizations, working in the study areas, likely to directly benefit from the data collected, and in the position to use the data to support existing local projects and make them more responsive to the needs of the target groups.
4. To provide opinions and make inquiries about the report draft.

Roles and responsibilities of the committee

1. Provide opinions and communicate with research team via e-mail.
2. Attend one meeting before data collection commends (this meeting will take roughly half a day, with transportation to and from Bangkok within the same day. The meeting is projected to take place in June 2011.)
3. (Local non-governmental organizations only) Recruit 20 key informants in each province.
4. Attend a meeting after a report draft has been created (this meeting will take roughly half a day and be held in Chiang Mai around 11-15 July 2011).

Scope of the task

This committee will serve as a national advisory committee, but members are invited as provincial stakeholders in the study areas, with the responsibility to advise the research team and work together with the team as equal partners in a multilateral setting.

Duration of the task

Committee membership will last from the moment the research team receives written confirmation of willingness to participate, to August 31, 2011.

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4 Chemnasiri Tareerat; Netwong Taweesak; Visaruttratak Surasing; Varangrat Anchalee; Li Andrea; Phanuphak Praphan; Jommaroeng Rapeepun; Akarasewi Pasakorn; van Griensven Frits, “Inconsistent condom use among young men who have sex with men, male sex workers, and transgenders in Thailand”, AIDS education and prevention : official publication of the International Society for AIDS Education 2010;22(2):100-109.
Qualifications of committee members

The committee members should be representatives of the MSM community; project staff or researchers working with community or non-governmental MSM organizations; or staff of public sector bodies providing services that correspond to the characteristics of this study. There shall be one community representative and 1-2 public sector representatives [per study area]. Staff should be in a position where they are affected by this study.

Able to communicate and express their opinions via e-mail.

Able to attend the meeting prior to the commencement of the project in Bangkok and the discussion session in Chiang Mai after data collection has been finished (or send a formal representative).

Administrative responsibilities

Travel costs and per diems for the post-data collection discussion session will be paid in accordance with the regulations of AIDSNET, Chiang Mai.

In case there is an additional meeting, all expenses will be paid by the HSRPO, KKU.

Committee members will neither incur costs due to participating in the committee, nor will they receive honorariums.

Annex IV: Research Advisory Committee Members

Ms. Pannee Chaiphosiri, Bureau of AIDS, TB and STIs, Department of Health, Bangkok Metropolitan Administration

Ms. Patcharin Tonprasert, The Office of Disease Prevention and Control 4, Ratchaburi province.

Mr. Thanasak Pansap, Ratchaburi Provincial Public Health Office.

Ms. Angkana Teeraswas, The Office of Disease Prevention and Control 10, Chiang Mai province.

Mr. Jirapat Longkul, The Office of Disease Prevention and Control 6, Khon Kaen province.

Ms. Saovanee Rattanadilok Na Phuket, Phuket Provincial Public Health Office.

Mr. Tanachai Chaisalee, Drop-in centre manager, Rainbow Sky Association of Thailand, Bangkok.

Mr. Choovit Thongbai, Bangkok Rainbow Organization, Bangkok.

Mr. Chawachol Poonyaprakan, Rainbow Group, Ratchaburi province.

Ms. Wiyada Phansurin, AIDS Network Development Foundation Northern Office, Chiang Mai province.

Mr. Jirawat Chaiyakhan, M-REACH Manager, M-REACH, Khon Kaen province.

Mr. Rattathammanoon Mephol, Field Manager, Andaman Power, Phuket province.