Programmatic Guidance for Reducing HIV and Key Population Stigma and Discrimination:

For the Greater Mekong Region Countries of Thailand, Lao PDR and Myanmar

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Abbreviations

AED	Academy for Educational Development
ART	Antiretroviral therapy
ARV	Antiretrovirals
CAB	Community advisory board
CME	Continuing medical education
CPS	Comprehensive Package of Services
FHI	Family Health International
GIPA	Greater involvement of PLHIV
GMR	Greater Mekong Region
HPI/GMR-C	Health Policy Initiative in the Greater Mekong Region–China
ICRW	International Center for Research for Women
IEC	Information, education, and communication
IPPF	International Planned Parenthood Foundation
ISDS	Institute for Social Development Studies
Lao PDR	People's Democratic Republic
MSM	Men who have sex with men
NGO	Nongovernmental organization
PLHIV	Persons living with HIV
POLs	Popular opinion leaders
PWID	People who inject drugs
RDMA	Regional Development Mission for Asia
S&D	Stigma and discrimination
SAN	Stigma Action Network
SHARAN	Society for Service to Urban Poverty (New Delhi)
SOP	Standard of practice
STI	Sexually transmitted infection
SW	Sex worker

SWING	Service Workers in Group
TB	Tuberculosis
TG	Transgender
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary counseling and treatment
WWP	White Coat - Warm Heart Project

Introduction

HIV and key-population-related stigma and discrimination (S&D) are recognized globally and in the Greater Mekong Region (GMR) as key barriers to an effective HIV response as they negatively impact on HIV testing, disclosure, linkage into care and treatment, and mental health, in addition to reducing quality of life and life chances and contravening human rights. Global evidence demonstrates that the experience and fear of S&D keeps people from seeking HIV testing (Liu, Li et al. 2005; Hutchinson and Mahlalela 2006; Wolfe, Weiser et al. 2006; Babalola 2007a; Bwambale, Ssali et al. 2008; Khumalo-Sakutukwa, Morin et al. 2008; Thu Anh, Oosterhoff et al. 2008), is associated with poorer mental health outcomes (Li, Lee et al. 2010), and poorer quality of life (Rongkavilit, Wright et al. 2010), and can also to lead to delays in uptake of HIV treatment, leading to sub-optimal timing of HIV treatment initiation, as well as lower adherence rates once on treatment (Roberts 2005; Stirratt, Remien et al. 2006; Ware, Wyatt et al. 2006; Calin, Green et al. 2007; Melchior, Nemes et al. 2007; Rajabiun, Mallinson et al. 2007; Rao, Kekwaletswe et al. 2007; Nam, Fielding et al. 2008; Sabina, DeSilvaa et al. 2008; Thrasher, Earp et al. 2008; Dlamini, Wantland et al. 2009; Kip, Ehlers et al. 2009; Naidoo, Dick et al. 2009; Tam 2011; Rao, Feldman et al. 2012). In addition, respondents' own stigmatizing attitudes can be negatively associated with likelihood of having tested for HIV (Kalichman and Simbayi 2003; Pulerwitz, Michaelis et al. 2008). Stigma also plays a role in lack of or delay in disclosure of HIV status to others, a key facilitating factor for prevention, timely linkage into care, and adherence to treatment (Medley, Garcia-Moreno et al. 2004; Nyblade, MacQuarrie et al. 2005; Mills 2006; Kinsler, Wong et al. 2007; Andrewin and Chien 2008; Rithpho, Grimes et al. 2009).

Tackling S&D for improved HIV prevention and treatment is particularly critical in GMR countries of the Lao People's Democratic Republic (Lao PDR), Myanmar and Thailand, given that the epidemic is concentrated and growing amongst groups who face not only HIV-related S&D, but also the underlying and HIV-associated stigmas of sex work, drug use, gender identity, and same-sex relationships.

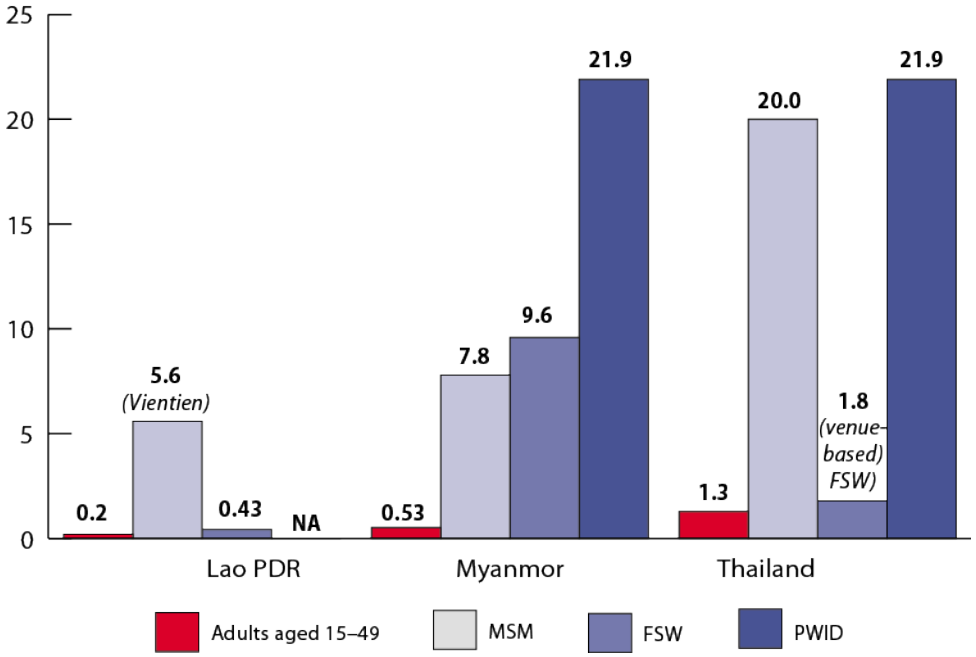
Background of the epidemic in Lao PDR, Myanmar, and Thailand

The HIV epidemics in the three countries vary from low prevalence in the general population in Lao PDR (National Committee for the Control of AIDS December 2010), to higher prevalence and concentrated epidemics in Myanmar and Thailand. Despite the varying prevalence rates among the three countries, the epidemiological and behavioral data indicate that the groups most vulnerable to HIV are the key populations of men who have sex with men (MSM), transgender people, people who inject drugs (PWID), and sex workers (SW). These groups, who are marginalized in all three countries and face S&D for a variety of reasons (including gender identity and sexual orientation, behaviors such as sex work or drug use, as well as HIV status), are disproportionately affected by the epidemic (***Table 1***).

In all three countries, MSM, SW, and PWID are more likely to be living with HIV than the general adult population. In Thailand, it is estimated that the largest

proportion of new infections during the period 2012-2016 will be among MSM (41%). In Lao PDR, the only country in the region with low HIV prevalence (0.2% in 2009), it is noted that the current situation poses a "potential for a concentrated epidemic," in which SWs, MSM, PWID, and clients of SWs are identified at higher risks (Centre for HIV/AIDS/STI (CHAS) and UNAIDS 2012).

Figure 1 HIV prevalence among general adults aged 15-49 in comparison with key affected populations in Lao PDR, Myanmar, and Thailand



Source: *Centre for HIV/AIDS/STI (CHAS) and UNAIDS (2012); National AIDS Programme (2012).*

Such a disproportionate concentration of HIV burden in these populations in all the three countries underlines the vulnerability to HIV infection of individuals in these groups. This in turn demands greater attention to addressing the surrounding environment that impedes these individuals and their communities' ability to protect themselves and their partners from HIV. S&D is key among the barriers in the enabling environment surrounding key populations.

In Thailand, two particular challenges of note may be related to fear of S&D. The first is that although Thailand has achieved 77% coverage of HIV treatment for persons living with HIV (PLHIV), over 60% of PLHIV are registering CD4 levels of less than 100 cells/mm at the time of ART initiation (Department of Disease Control, Thai NGO Coalition on AIDS et al. 2012), speaking to the urgent need to understand and address the reasons for such late initiation of treatment. Second are the low rates of HIV testing among groups at most risk of HIV, in particular MSM. A recent study among MSM in the three provinces of Bangkok, Chiang Mai, and Phuket found that only 29% of MSM had been tested for HIV in the past 12 months, while the higher testing rates among other key populations were still at around only 50%, with testing for venue-based female SWs at 50.4%, male SWs at 51.4%, and PWID at 40.8% (Department of Disease Control, Thai NGO Coalition on AIDS et al. 2012).

Stigma and discrimination in the region

S&D are present and prevalent in the everyday lives of PLHIV and key populations across the GMR and surrounding countries and occur in a range of sectors (Boer and Emons 2004; Paxton, Gonzales et al. 2005; Genberg, Hlavka et al. 2009; UNAIDS, Marie Stopes International et al. 2009; UNAIDS, International Planned Parenthood Federation et al. 2011; Nemoto, Iwamoto et al. 2012). Including in and toward the family (Kittikorn, Street et al. 2006; Li, Wu et al. 2008), by the community (Maneesriwongul, Panutat et al. 2004; Genberg, Kawichai et al. 2008; Liamputtong, Haritavorn et al. 2009; Gaudine, Gien et al. 2010; Pharris, Hoa et al. 2011; Rudolph, Davis et al. 2012), within the health care system (Khoat, Hong et al. 2005; Paxton, Gonzales et al. 2005; Yang, Zhang et al. 2005; Li, Lin et al. 2007; Chan, Stoové et al. 2008; Chan, Stoove et al. 2008; Phrasisombath, Thomsen et al. 2012), and in the employment sector (Rao, Angel et al. 2008; Liu, Canada et al. 2012). Self-stigma (i.e., internalized stigma), which is a reflection of the external stigma experienced, is also present and prevalent (Li, Lee et al. 2009; Li, Wang et al. 2009; UNAIDS, Marie Stopes International et al. 2009; UNAIDS, International Planned Parenthood Federation et al. 2011).

Mirroring the global evidence cited in the introduction, data from the region suggest that the experience and fear of stigma is a barrier to HIV testing and disclosure (Yoddumnern-Attig, Kanungsukkasem et al. 2004; Yang, Li et al. 2006; Rongkavilit, Wright et al. 2010; Rudolph, Davis et al. 2012), is linked to avoiding or delaying health care (Lieber, Li et al. 2006; Phrasisombath, Thomsen et al. 2012), and negatively impacts mental health (Li, Lee et al. 2009; Rongkavilit, Wright et al. 2010) and adherence (Sabin, Desilva et al. 2008; Li Li, Lee et al. 2010; Tam 2011). Holding stigmatizing beliefs can also be a barrier to HIV prevention practices. A study in China (Liu, Li et al. 2005), controlling for other factors, demonstrated that respondents holding stigmatizing beliefs toward PLHIV were more likely to also report having had a sexually transmitted infection (STI) and having multiple sex partners, including commercial sex partners, and less likely to use condoms or be willing to have an HIV test. A recent study among *Kathoey* (the Thai term for transgender persons) SWs in Bangkok found only half reported an HIV test in the past 12 months, and also found, controlling for background and other risk factors, that respondents who had experienced S&D as a child as measured by abuse by fathers and brothers (transphobia and verbal or physical violence) were less likely to report using condoms for anal sex with customers in the past 6 months (Nemoto, Iwamoto et al. 2012). More than half of respondents in the study reported ongoing daily living challenges related to their gender identity, including in finding work and in their relationships with their families.

Table 1 summarizes some of the key evidence from Myanmar and Thailand focused on data collected by the PLHIV Stigma Index Survey.

Table 1. Stigma and discrimination: Selected facts and figures from the PLHIV Stigma Index (stigmaindex) in Myanmar and Thailand, and other selected sources

S&D are prevalent and manifest in all sectors of life (UNAIDS, International Planned Parenthood Federation et al. 2011): - Respondents reported experiencing S&D in the family, community, education, health care, religious organizations, and the workplace. - In Thailand, 32% of respondents have experienced the loss of employment or sources of income, and 30% believed that such discrimination was a result of their HIV-positive status. - 20% of the Thai respondents and 9% of Burmese respondents experienced denial of health care services due to HIV status, including family planning, sexual, and reproductive health services.
Fear of HIV infection, including infection through casual contact, remains a leading trigger for S&D. - 22% of the Thai respondents estimated that S&D are caused by fear of infection, and similarly, 22% believe that fear of infection from casual contact is the reason that other people discriminate against them (Thailand Network of People Living with HIV and AIDS 2010). - A study in Thailand (Boer and Emons 2004) found that "Incomplete beliefs about documented modes of transmission were significantly related to stigmatizing beliefs toward [PLHIV]" and also that respondents holding "inaccurate beliefs about HIV transmission reported more fear toward [PHIV] and homosexuals and more irritation toward PWA and commercial sex workers."
Socially driven stigma fuels multiple layers of S&D (Thailand Network of People Living with HIV and AIDS 2010) - Thai respondents also reported shame (20%), disapproval of lifestyle or behaviors (11%), and religious or moral standards (5%) as reasons people had stigmatized or discriminated against them. - In addition to S&D due to HIV status, the Thai respondents also reported that they believe that they are stigmatized and discriminated against because of their sexual orientation (14%), because they are engaging in sex work (6%), because of their drug use (6%), or because they belong to groups such as an ethnic minorities (5%), migrant workers (2%), or prisoners and juvenile delinquents (0.86%).
Internalized stigma prevails and associates with health-seeking behaviors (Thailand Network of People Living with HIV and AIDS 2010). - Thai respondents reported that, as a result of their HIV-positive status, they "feel ashamed" (64%), "feel guilt" (48%), "felt they should be punished" (43%), have low self-esteem (44%), or "feel suicidal"(17%). - As a result of their HIV status, 27% of the Thai respondents stated that they avoided going to clinical services in their communities while 15% avoided going to hospital when necessary.
S&D pose a barrier to timely uptake of and adherence to ART. - A recent study on access to ARVs provided under the Health Security System (Kongsin and al. 2009) in Thailand identified anticipated stigma such as fear of not being accepted by society and family and fear of disclosure of HIV status (i.e., fear that utilizing ART services may compromise their confidentiality) as contributing reasons why PLHIV do not access available ARVs.
Despite the pervasive discrimination resulting in human rights violations, few use legal redress mechanisms (Thailand Network of People Living with HIV and AIDS 2010). - Only 13.29% of the Thai respondents (21 persons) reported that they have redressed human rights violations through legal mechanisms while a majority (74.68%, or 118 persons) never use such mechanism. - Lack of confidence or lack in confidence that such legal redress would achieve a successful outcomes is the main barrier to seeking redress (46.72%).

The governments of Lao PDR, Myanmar, and Thailand, as well as USAID recognize the presence of S&D; the barriers they present to effective HIV prevention, care, and treatment; and the consequent importance of addressing S&D as part of the HIV response. The governments of Lao (National Committee for the Control of AIDS December 2010) and Myanmar (Ministry of Health – Myanmar 2011) incorporate S&D as a cross-cutting theme in their national HIV responses, while Thailand has taken a more direct and proactive approach through the inclusion of reduction of S&D as one of eight key goals in its new National Plan for Strategic and Integrated HIV and AIDS Prevention and Alleviation, 2012-2016. USAID/RDMA includes S&D as

one of the key enabling environment factors to be addressed in delivering a Comprehensive Package of Services (CPS). In response—and in support of the response to address S&D in the region—this guidance document provides an overview of S&D in these countries, definitions and a programmatic and measurement framework for S&D-reduction, guiding principles for S&D-reduction programming, and an illustrative operational example of how these principals could be applied in Thailand to scale-up S&D reduction in the health care system.

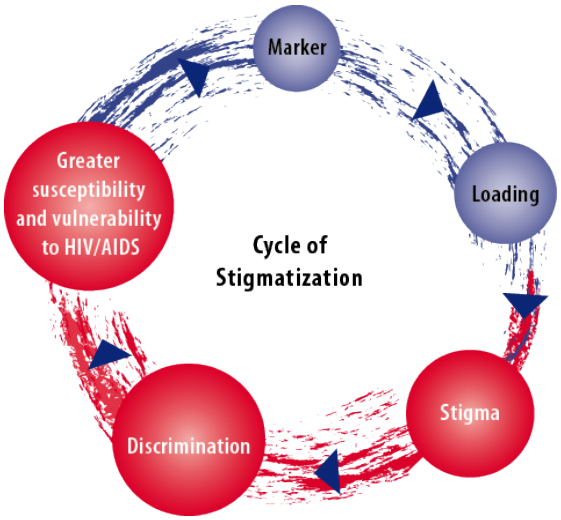
Background

Defining stigma and discrimination

Stigma is a social process of devaluation of an individual or group that often ends in discrimination. The process of stigma can be divided into four key steps, as described by Link and Phelan (2001): 1) distinguishing and labeling differences; 2) associating negative attributes with those differences; 3) creating separation between "us" and "them," all leading to; 4) status loss and discrimination. In the first step, society identifies and labels differences that "matter" (for example, living with HIV or being a member of a key population). Society then links those differences to "socially undesirable characteristics" or attributes, creating negative stereotypes—for example, assuming (or holding a belief or attitude) that PLHIV are promiscuous or irresponsible, that all people who use drugs are dangerous, or that SWs are lazy and not willing to work at a "regular" job.

Identifying, labeling, and associating difference with negative attributes then allows society to marginalize and separate people or groups whom they have labeled and marked with negative attributes, creating separation and distance and in the process creating an "other" or "out" group, allowing the "us" or "in" group to treat the "others" in ways that would be unacceptable if that individual were part of the "in" group. All of this then allows, justifies, and drives discrimination, which in turn leads to disadvantage and unequal outcomes (e.g., in access to economic, health, and social resources), often further intensifying the marking, labeling, and distancing, creating a vicious cycle of stigma (See ***Figure 2***). In the GMR and globally, PLHIV, MSM, transgender persons, SWs, and PWID are all groups that society stigmatizes. These groups, and the individuals identified as part of them, have been labeled, associated with negative characteristics, set apart from mainstream society, and discriminated against.

Figure 2. Cycle of stigmatization



Source: Sartorius and Schulze (2005); UNAIDS (2007).

Discrimination is an endpoint of the process of stigma and occurs when a person or group is treated unfairly or unjustly (by act or by omission) because they have been identified and labeled as different, associated with negative attributes, and separated and held apart from "general" society. PLHIV and members of key populations face many forms of discrimination, including in employment, housing, health care, education, as well as in less formal settings, like the home and community. Some of these forms of discrimination are legally actionable under the law—for example if a person is fired from a job because of his or her positive HIV status and laws are in place to protect PLHIV in employment. However there are also discriminatory actions that are not within the purview of the law—for example, PLHIV working in the informal economy selling food who lose their livelihood because customers will no longer buy from them, or a young woman living with HIV or a transgender person being shunned or excluded from family and community social gatherings. To make a distinction between forms of discrimination that are, or are not, legally actionable, these latter forms of discrimination are often labeled as "experienced" or "enacted" stigma. While not legally actionable in most cases under the law, these forms of discrimination can

Stigma Terminology
Adapted from Jain and Nyblade (2012)

Anticipated stigma: Real or imagined fears of societal attitudes and behaviors (e.g., from family, community, health care professionals) if HIV or other stigmatized behavior (e.g., drug use) is disclosed.

Experienced (enacted) stigma: Forms of stigmatizing behaviors or discrimination that are not typically actionable under law and are experienced by PLHIV or key populations.

Internalized (self) stigma: Acceptance by the self that the external stigma—society's judgment of oneself as being of a "lesser status"—is true and justified. Can manifest in low self-esteem and low sense of worth, self-blame, and self-isolation/withdrawal.

Secondary (courtesy) stigma: Stigma experienced by individuals who are associated with PLHIV or key populations (e.g., family, partners, friends, health care professionals).

Compound/layered stigma: Experience of one or more multiple stigmas (e.g., stigma toward MSM, transgenders, migrants, poor women, PWID, plus HIV stigma).

be extremely harmful and are often the forms that are most common and which people fear most in their daily lives.

The process of stigma, including the experience of enacted S&D, can lead PLHIV or members of key populations to internalize the external stigma, accepting the devaluation that comes through the process of stigma as justifiable and deserved, which can then lead to numerous negative outcomes, including shame, depression, and self-isolation. This is known as internalized stigma, or self-stigma. Stigma may also be extended by society to individuals who are associated with PLHIV or other key populations—for example family members of PLHIV or people who provide PLHIV with health or other services (e.g., workers for nongovernmental organizations [NGOs])—which may lead these individuals to want to distance themselves from the direct targets of the stigma; for example through family members forcing PLHIV or key populations to leave the household, or by service providers refusing to provide services to these populations. This is known as "secondary" or "courtesy" stigma.

In addition to the actual experience of enacted stigma or discrimination and its internalization as self-stigma, the fear that stigma might occur if status is disclosed (whether related to someone's HIV status or their status as a member of a key population) is important to consider because this fear—even in the absence of experienced stigma or discrimination—can act as a barrier to HIV prevention, care, and treatment. This fear of stigma is called "anticipated" stigma. When a person anticipates or experiences more than one stigma, this is known as "compound" or "layered" stigma. For example, a SW who is also living with HIV may already be experiencing stigma for being a SW and then have the stigma of being HIV positive layered on top, compounding and intensifying the stigma.

Defining human rights and the link to stigma and discrimination

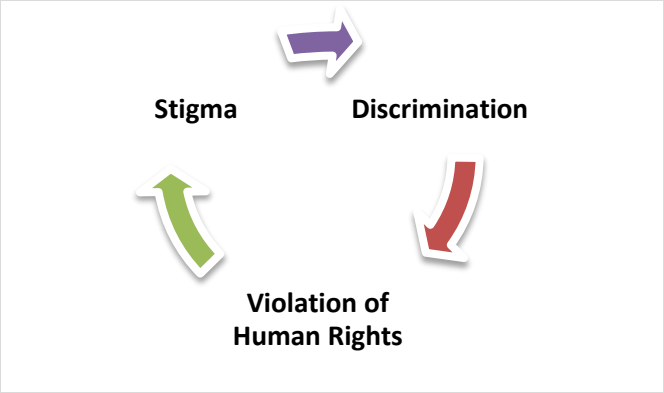
Human rights are legally guaranteed under international human rights law. They protect against actions that interfere with fundamental freedoms and human dignity and support the agency of individuals and populations (Gruskin and Tarantora 2008). The right to non-discrimination and equality are enshrined in the *Universal Declaration of Human Rights* and other international human rights instruments that prohibit discrimination on any ground (or combination of grounds) such as "race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (United Nations 1948). The term "other status" has been evolving over time and now encompasses health status, including HIV status, disability, and sexual orientation and gender identity (UN Committee on Economic 2009). Discrimination in any form against PLHIV or those thought to be infected or key affected populations is therefore a clear violation of their human rights. In addition to being a violation of human rights in itself, discrimination directed at PLHIV, those believed to be HIV-infected, or key affected populations leads to the violation of other human rights, such as the rights to health, education, dignity, privacy, equality before the law, and freedom from inhuman, degrading treatment or punishment (UNAIDS 2005).

Discrimination in the context of right to health is defined as "any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social, or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health" (UN Committee on Economic 2000).

The link between stigma, discrimination, and human rights

Stigma, discrimination, and human rights violations form a vicious, regenerative circle (***Figure 3***). The process of stigma leads to discrimination, which leads to violations of human rights, which in turn can create, legitimize, and reinforce stigma that then leads to continued discriminatory action and further human rights violations (Maluwa, Aggleton et al. 2000).

Figure 3. Cycle of stigma, discrimination, and human rights violations



Source: UNAIDS (2005)

One of the key characteristics of human rights is that they impose obligations (primarily on states) to respect, protect, and fulfill the right to equality and non-discrimination. In the context of HIV- and AIDS-related discrimination, the obligation to respect requires states to ensure that their laws, policies, and practices do not directly or indirectly discriminate based on HIV or AIDS status. The obligation to protect requires states to take measures that prevent HIV- and AIDS-related discrimination by third parties, and the obligation to fulfill requires states to adopt appropriate legislative, budgetary, judicial, promotional, and other measures that address HIV- and AIDS-related discrimination and compensate those who suffer such discrimination (Maluwa, Aggleton et al. 2000). A human rights framework also provides access to existing procedural, institutional, and other monitoring mechanisms that should not only enforce the rights of PLHIV but should also counteract and redress discriminatory action (Maluwa, Aggleton et al. 2000).

However, there can be certain challenges to the human rights approach. To begin with, the first three steps in the process of stigma (identifying and labeling differences, attributing negative connotations to those differences, and creating separation), which end in discrimination, are not typically legally actionable. Second, human rights emphasize the autonomy of the individual (and groups) and their freedom to act or not to act in certain ways (unless the law requires it). Because of the principals of autonomy and freedom, discriminatory behaviors such as not buying food from

PLHIV or refusing to include MSM or transgender persons in social gatherings cannot be sanctioned under a human rights framework (i.e., people cannot be forced or imposed to buy food or to gather socially with those they do not want to). Third, S&D often occur in settings not covered by human rights legislation, such as within families, among friends or acquaintances, or in social encounters. S&D in these settings (or in forms that are not legally actionable, as described above) may be what individuals fear most and may also be the most common forms of S&D and, consequently, have the largest negative impact.

Therefore, although it is necessary and essential to uphold human rights and have laws, policies, and systems in place for redress of legally actionable discrimination, these steps are not by themselves sufficient to address S&D. In addition, programs are needed that focus on preventing and addressing the first three steps in the stigmatizing process, which lead to discrimination.

Gender, stigma, and discrimination are closely intertwined for multiple reasons. To begin with gender—being female or being transgender—can be cause for S&D. Both gender and S&D, in turn, can make women and transgender persons more vulnerable to HIV, potentially adding stigma of HIV to that of being a woman or transgender, further intensifying the S&D and therefore vulnerability to HIV, in a vicious circle (***Figure 2***). In addition, women and transgender persons who are also SWs may face yet another layer of stigma for being SWs. Second, gender inequalities mean that women often have unequal access to economic, social, and political resources and are therefore not only more vulnerable to S&D, but also have fewer resources with which to cope with and challenge S&D. As a result, they may also be less able to "hide" their status (whether it be HIV status or status as a SW) because in order to access health and other resources to survive, they must join or utilize public and NGO services, where the chance of inadvertent disclosure is a threat. Men on the other hand may have more access to resources that allow them to better protect their confidentiality, for example by going to private health services or traveling out of their communities to seek services.

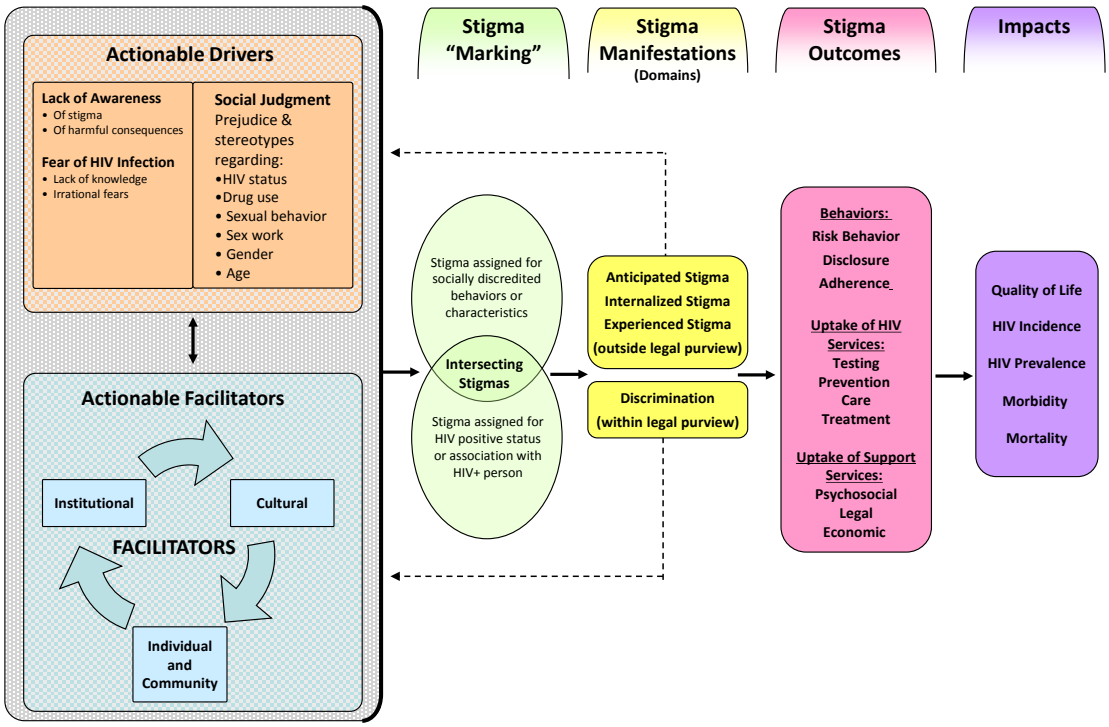
Data are still quite limited on differences in levels, location, and types of S&D experienced by men, women, and transgender persons, and data that are available show a mixed picture. For example, studies in South Africa (Simbayi 2007) and Bangladesh (Middleton-Lee 2011) found that men had higher levels of internalized stigma than women, but the opposite was true in the Dominican Republic (Middleton-Lee 2011), while in South Africa the effect of perceived stigma on avoiding voluntary counseling and treatment (VCT) was greater for women than men (Hutchinson and Mahlalela 2006). Other studies have documented that women face more S&D than men within the family and community (Paxton, Gonzales et al. 2005; Middleton-Lee 2011) while men are more likely to experience S&D from community leaders, local religious leaders, and local government authorities (Middleton-Lee 2011). In the Dominican Republic, more women than men reported fear of stigma (i.e., anticipated stigma) in the form of gossip and also experienced more of nearly every form of enacted stigma (Urena 2009); these findings are similar to those in an earlier study in Tanzania (MacQuarrie, Nyblade et al. 2006).

A framework for programmatic implementation and measurement

As noted in the introduction, stigma and resulting discrimination are globally recognized as barriers to an effective HIV response, and in particular to reaching those most vulnerable to HIV, who often face multiple, compounded stigmas. However, what are often less clear are the potential pathways through which stigma operates to influence desired programmatic outcomes and larger-level impacts, as well as the potential entry points for S&D-reduction programmatic intervention and measurement. ***Figure 4*** (Stangl, Go et al. 2010), which is slightly adapted from a framework developed through a global consultation process, provides a structure that delineates key entry points for S&D-reduction programs, highlights key components that can be measured to monitor and evaluate progress toward reducing S&D, and illustrates the pathways or process through which stigma can negatively influence desired outcomes and impacts in the HIV response.

The framework begins on the left-hand side with a focus on key programmatically actionable drivers and facilitators of S&D that lead to the identification and marking of individuals and groups as socially unacceptable (stigma marking) based on behaviors, characteristics, and/or HIV status (which can intersect and overlap to create compound stigma). This "marking" then manifests for PLHIV, key populations, and others in several ways (stigma manifestations/domains). These manifestations influence a range of outcomes, including risk behaviors and uptake of HIV prevention, care, and treatment services, which ultimately influence individual quality of life, HIV incidence, and HIV prevalence.

Figure 4. Reducing HIV-related stigma and discrimination: A framework for program implementation and measurement



Source: Stangl, Go et al. (2010)

With a focus on programmatic action to reduce S&D, the framework focuses only on the "immediately actionable" drivers of S&D that can be directly addressed through programming and reform. The drivers highlighted in this framework (lack of awareness of stigma and its harmful consequences, fear of HIV infection, and social judgment) all negatively influence S&D. However, key facilitators of S&D can either positively or negatively influence S&D and may take longer to address than the drivers. These facilitators can be institutional (e.g., laws, policies), cultural (e.g., gender, sexuality, health beliefs, religious beliefs), or individual and community (e.g., power, social support, social assertiveness, resilience). For example, anti-discrimination laws and policies can protect against discrimination, whereas laws that criminalize HIV or same-sex relationships can propagate stigma.

These drivers and negative facilitators then collectively lead to the marking of individuals and groups as socially unacceptable or deviant, based on either HIV status, membership in a key population, behaviors considered to put one at risk for HIV, or association with a person living with HIV. The framework highlights that individuals and groups living with or at risk of HIV often face multiple or layered stigmas, which together can compound or intensify the potential negative influence of stigma. Once individuals or groups have been marked, the stigma manifests in four key ways:

- *Anticipated stigma:* The fear of negative social ramifications should one's HIV or key population status become known, or should one associate with a person living with HIV or a person from a key population
- *Internalized stigma:* Self-endorsement of the negative beliefs and feelings from others about PLHIV or key populations
- *Experienced/enacted stigma:* The experience of prejudice and discrimination, based on HIV status or association with a person living with HIV or a person from a key population that falls outside the purview of the law
- *Discrimination:* The experience of prejudice and discrimination that falls inside the purview of the law

All individuals are capable of anticipating, internalizing, experiencing, and perpetuating S&D, and the existence of stigma within stigmatized groups is also important to understand and address. For example, stigma may occur among transgender persons toward a transgender person living with HIV or among PLHIV toward MSM or SWs, regardless of HIV status.

Manifestations of stigma can lead to a number of negative outcomes for HIV-positive and HIV-negative persons as well as members and non-members of key populations; these outcomes can undermine HIV prevention, care, and treatment efforts and ultimately influence the course of the HIV epidemic. For example, anticipation and experience of stigma can reduce willingness to be tested for HIV and inhibit disclosure of HIV status, while fear of stigma and experienced and internalized stigma can lead to late entry into treatment and challenges in adherence. All of these in turn can influence broader goals of improved quality of life and reduced HIV incidence, prevalence, morbidity, and mortality.

Programs seeking to reduce S&D will necessarily focus efforts on the actionable drivers and facilitators side of the framework. More guidance on how to address individual drivers and facilitators is provided below. In addition, an example of how to adapt the framework to a specific institutional setting (health care facilities) to guide S&D-reduction programming is also provided in the case study at the end of this document. Measurement to support S&D-reduction programming and policy will occur at two points in the framework: at the drivers level and at the manifestations levels. Such measurements will allow programs to understand what is driving stigma manifestations and how to tailor interventions accordingly, as well as to track progress to evaluate program effectiveness by examining levels in the drivers and manifestations over time. Successful programs that are changing drivers of S&D should see a reduction in levels of manifestations over time.

Guiding principles for stigma and discrimination-reduction programming

In the GMR, as well as globally, core principles for S&D-reduction programming have emerged for both the content of programing, as well as approaches. Research has demonstrated that there are common underlying drivers of S&D that are immediately programmatically actionable across diverse epidemic, socio-economic, and cultural contexts and with a range of target groups (Nyblade, Pande et al. 2003; Ogden and Nyblade 2005; Pulerwitz, Michaelis et al. 2010). General principles for approaches to deliver this content have also emerged, based on the experience of S&D reduction programming across a range of country and epidemic contexts (Apinundecha, Laohasiriwong et al. 2007; Khumalo-Sakutukwa, Morin et al. 2008; Nyblade L, MacQuarrie K et al. 2008; Nyblade, Khuat Thu et al. 2008; Oanh, Ashburn et al. 2008; Nyblade, Stangl et al. 2009; Li, Lee et al. 2010; Li, Liang et al. 2010; Pulerwitz, Michaelis et al. 2010; Stangl, Carr et al. 2010; Richter, Nuankaew et al. 2012). Based on this evidence and experience, we provide the following overarching guidance for designing and implementing S&D-reduction programming in the GMR countries of Lao PDR, Myanmar, and Thailand. We offer six key guiding principles that apply to all programs aiming to achieve the reduction of S&D.

Guiding Principles for S&D-Reduction Programing

1. Address immediately actionable drivers of S&D: lack of awareness and understanding of S&D; unfounded fears; and attitudes, assumptions, stereotyping, and beliefs that drive the negative labeling, shaming, blaming, and devaluation of PLHIV and key populations
2. Ensure that PLHIV and key populations are at the core of the S&D-reduction response, both in focus and in leadership
3. Create alliances, form new partnerships, and strengthen opinion leaders for influence and expanded reach and as role models
4. Start at home: Institutionalize and routinize the reduction of S&D
5. Measure for design, monitoring, evaluation, program improvement, and accountability
6. Integrate human rights principles

- **Address three immediately actionable drivers of S&D, for all target groups**

  Actionable driver one: Building awareness of HIV and key population stigma and discrimination. Addressing this driver helps individuals and institutions to concretely understand the forms S&D take (i.e., how S&D manifest in attitudes, behaviors, policies, and laws), what they tangibly look like, what they do (i.e., the negative impact of S&D on individuals, families, the local community,), as well as how they fuel HIV transmission. Research and programmatic experience have shown that often there is an intention-action gap with respect to S&D, that often people stigmatize and discriminate without knowing that they are doing so. Their intention is not to stigmatize or discriminate, but a lack of awareness and understanding allows it to happen. Concretely understanding what constitutes S&D and why reducing it is beneficial is a necessary first step to reducing S&D.

  Actionable driver two: Understanding and addressing the context-specific underlying, unfounded fears around HIV transmission, sexuality, gender identity, and drug use. Research has shown that despite decades of information, education, and communication campaigns around HIV transmission and prevention, in many places, people, including health care providers, still fear that they can contract HIV through casual contact with PLHIV. This fear can drive stigmatizing actions such as physical or social isolation, refusal to eat or buy food handled by a person living with HIV, or, in health care settings, provision of sub-standard care. Where the public deeply associates HIV with key populations, the public may assume that most MSM, SWs, or PWID also have HIV, and their fear that HIV can be casually transmitted may also drive their S&D toward these groups. Addressing fears of casual transmission of HIV requires providing in-depth information on how HIV is and is not transmitted, for example by explaining why mosquitos cannot transmit HIV like they do malaria or how long HIV can live outside the body, and under what conditions. The information should be provided in an interactive manner (so questions can be asked and answered) and tailored to respond to specific fears related to people's daily living context, for example by explaining in detail why there is no risk of HIV transmission when eating food cooked by a person living with HIV.

  Although they are less well documented than fear of HIV transmission as a driver of HIV S&D, unfounded fears around MSM, SWs, and PWID may also be fueling S&D toward these groups. For example, anecdotal evidence suggests that there is a fear that recognizing and accepting MSM will somehow "lead or encourage" lots of boys and young men to engage in homosexual behavior or that allowing harm reduction programs will lead to increased drug use. Whether it is fear related to HIV transmission, or toward key populations, S&D reduction programs need to understand and then directly address the specific fears that may be driving stigmatization in a given context;

  Actionable driver three: Recognizing, discussing, and challenging the attitudes, assumptions, stereotyping, and beliefs (socially based S&D) that drive the negative labeling, shaming, blaming, and devaluation of PLHIV and key populations. Addressing this driver involves building empathy and a common understanding to break down the "us" versus "them" mindset and finding common ground in shared

humanity. A critical component of this is beginning conversation and dialogue, by opening up safe spaces to discuss and reflect on the sensitive and often taboo topics of sexuality, gender identity, gender-based violence, and drug use and the values and beliefs that underlie socially-driven stigma. Creating this dialogue helps individuals and institutions to differentiate the stigmatized individual, or group, from a specific behavior that is viewed as socially unacceptable or immoral, and to understand that behaving in a non-stigmatizing or discriminatory way toward a person is not equivalent to condoning or encouraging a specific behavior. For example, a health worker who provides S&D-free services to a client who injects drugs, or a client who is a SW, is not, by that action, approving of or encouraging drug use or sex work.

How:

All three of the above drivers can be addressed through a range of approaches, depending on the specific target audience. Such approaches include participatory learning workshops, traditional and popular cultural forms (e.g., street theater, quiz shows, soap operas), and other more conventional communication forms such as print materials (e.g., fact-sheets, posters), radio, and television. The approaches work best when the drivers are tackled through multiple channels that include at least one participatory approach (Nyblade L, MacQuarrie K et al. 2008; Nyblade, Khuat Thu et al. 2008; Pulerwitz, Michaelis et al. 2010; Stangl, Carr et al. 2010). Providing interactive and safe spaces to learn, reflect, ask questions of a trusted and knowledgeable facilitator, and gain skills for behavior change is central to addressing these three drivers of S&D. Combining this approach with exposure to the same messages through different communication channels, and repeatedly over time, reinforces learning and behavior change. For example, a community intervention in Viet Nam found a dose-response type of effect in exposure to stigma-reduction activities. The more activities respondents self-reported being exposed to at the end of the intervention, the lower their stigma score compared with respondents who self-reported exposure to fewer activities (Nyblade, Khuat Thu et al. 2008).

In addition to strengthening people's understanding of the forms of S&D and what they should not do, it is also important to demonstrate the types of supportive attitudes and behavior that are desired. For example, a program in India trained PLHIV to conduct audio-record interviews with other PLHIV and someone they identified as demonstrating the kind of supportive and exemplifying behavior that they would like others to follow. These stories, which paired the voices of PLHIV and someone who supported them, were then woven into a series of radio diaries aired over 13 episodes (Stangl, Carr et al. 2010).

One of the most widely used, flexible, and easily adaptable tools for addressing these three drivers is the *Understanding and Challenging HIV Stigma: Toolkit for Action* (Kidd and Clay 2003). This tool, based on a multi-country study on S&D (Nyblade, Pande et al. 2003), has been widely adapted, translated, and used in the GMR and globally (see the following text box). The first adaptation in the GMR occurred in Viet Nam, and additional adaptations have been created for Cambodia, Thailand, and China (see ***Appendix 1***). In addition, the GMR has led the way in adapting the original tool (which focuses on HIV stigma) to address S&D toward specific key

populations. There are now tools that focus on reducing S&D toward PWID (Viet Nam), SWs (Viet Nam and Cambodia), and MSM (Cambodia and Viet Nam) (***Appendix 1***). All of the toolkits provide a menu of participatory exercises (the first three chapters focus on the three drivers discussed above) that can be selected and used in different formats, from shorter sensitization meetings to longer training of trainers' workshops. The toolkit provides exercises focused on those who stigmatize, as well as exercises for those experiencing stigma, to support coping with and challenging S&D. Individual exercises have also been incorporated into or combined with other curricula that focus, for example, on universal precautionary practices for health providers (Viet Nam) or combining S&D and gender-based violence reduction for health providers (India toolkit).

Understanding and Challenging HIV Stigma: Toolkit For Action

Toolkit Objectives:

- Create necessary understanding and awareness of stigma and discrimination
- Address knowledge "gaps" and associated fear
- Provide a safe space to discuss socially driven stigma (shame, blame, judgment)
- Strengthen PLHIV and their families
- Provide space and a process to determine appropriate and feasible responses
- Provide tools to use in these responses

How was it developed?

- Based on research results from a three-country comparative study on S&D
- Through a participatory content development process among 3 countries, 75 participants, 50 organizations
- Living document: in a second edition, new modules continue to be developed (e.g., youth, TB)
- Adaptations: S&D toward MSM, SWs, and PWID and for health providers

What is it?

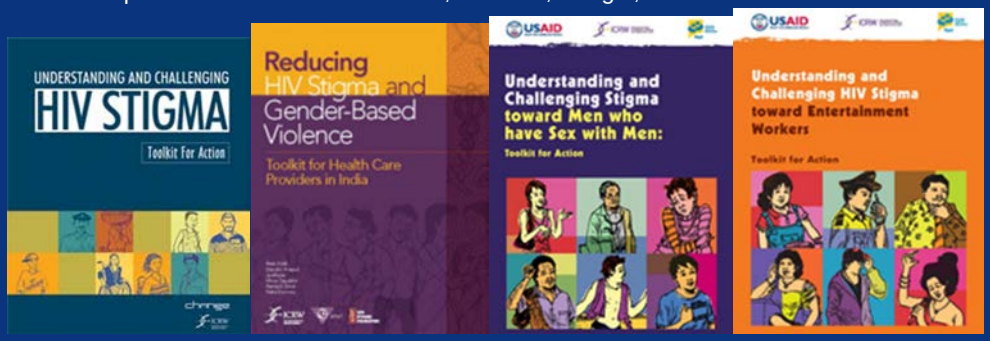
- Flexible resource collection: Select from and adapt for use with different groups
- User-friendly materials: Easy-to-follow instructions, simple English for easy translation
- Resource for participatory learning: Built around discussion and small group activities
- Problem-based curriculum: Problems, concerns, and practical solutions, rather than theories or information, become topics for discussion

Who is it for?

- Successfully used with a wide range of audiences in over 40 countries: Policymakers, religious leaders, health providers, NGO staff, community members, PLHIV, youth, caregivers

Languages

- Original Available in: English, French, Kiswahili, Vietnamese, Amharic, Portuguese, Khmer
- Partial adaptations and translations: Thai, Chinese, Bangla, Dari



Source: Kidd et al. (2003). *Understanding and Challenging HIV Stigma: Toolkit for Action*. ICRW and AED, Washington, DC.

- **Ensure PLHIV and key populations are at the center of the stigma-reduction response, both in focus and in leadership**

  To do this, S&D-reduction responses must first address the vulnerabilities and needs of those most affected by S&D. This response includes having in place the necessary support, tools, and skills to address self-stigma (i.e., internalized stigma), cope with external stigma, and lead the effort to challenge S&D. Doing so requires first ensuring

that basic needs and human rights are met. This includes provision of health care, including HIV treatment and prevention, as well as employment and income-generating opportunities, both of which are often restricted because of S&D. Ensuring health and supporting opportunities for employment and income generation reduces internal stigma by building self-worth and external S&D by countering the perception that PLHIV and key populations are unproductive members of families and communities or are a burden on society.

It also includes strengthening existing networks and supporting development of new ones where appropriate. Networks provide a critical support system and safety net, offering a community to belong to that understands the fear and experience of S&D, provides strength and safety to challenge S&D as it happens, and supports members in demanding the right to live free of S&D. Networks also then offer the organizational structure for empowerment and capacity strengthening, addressing self-stigma, building self-worth, and nurturing resiliency. All of these elements are building blocks for an S&D-reduction response led by PLHIV and key populations.

Positive Partnership Project: Economic Empowerment as a Means to Reduce Stigma and Discrimination

Initiated and implemented by the Population and Community Development Association (PDA), the Positive Partnership Project (PPP) is a micro-credit scheme using economic empowerment as a means to reduce stigma and discrimination in Thailand. The program, supported by USAID and Pact Thailand, provides small occupational loans to a pairs of individuals, with each pair comprising an HIV-positive and an HIV-negative person, or a "buddy pair." In addition to providing micro-credit, the program also implemented specific S&D-reduction-focused community activities, including monthly meeting, monthly HIV education campaigns through anti-stigma IEC materials such as posters and radio spots, and funfair activities. As a result, the project demonstrated the positive outcomes of decreased self-stigma and increased self-worth among PLHIV loan recipients and lower levels of stigma toward PLHIV among the HIV-negative loan buddies, family members of loan pairs, and members of communities where HIV-positive loan recipients live and community S&D-reduction activities were held.

Source: K. Richter, R. Nuankaew, A. Jain, and P. Oranop na Ayuthaya. 2012. Positive Partnership Project, New Phase, Endline Report, Pact, Thailand, Bankgok, Thailand

How:

Having PLHIV and key populations at the core of the response has been accomplished through a combination of approaches, including counseling and behavior change programs to address self-stigma, micro-finance and livelihood programs to create economic opportunities, training programs to gain facilitation and media skills, processes to collect and analyze data for advocacy, organizational strengthening, "know your rights" campaigns, and provision of legal services.

For example, a recent behavioral intervention trial in Northern Thailand demonstrated that depressive symptoms and internalized shame had significant effects on health and that a behavioral intervention, delivered through a series of activity modules focusing on key challenges faced by PLHIV, including S&D, led to improvements in general and in mental health (Li, Lee et al. 2010). The Positive Partnership Project (Richter, Nuankaew et al. 2012) in Thailand (see the text box) focused on improving quality of life of PLHIV by improving income while reducing S&D. This was accomplished by combining low-interest loans with capacity building

activities and a range of communication-focused activities for the general community. Through developing and delivering S&D-reduction programs for the general community, other programs also have simultaneously addressed self-stigma, improved self-esteem, strengthened capacity, and in the process provided economic opportunities. For example, the Lotus Sangam group in India, through the development and production of a play focused on S&D toward MSM, was able to lower self-stigma, build the confidence and skills of its members, and provide employment for the actors, while at the same time working to reduce family and community S&D toward MSM in rural India (Stangl, Carr et al. 2010).

- **Strengthen leaders, form new partnerships, and target key institutions for influence and expanded reach**

  Successful S&D-reduction programs support the engagement of a range of leaders and key institutions that shape the environment around PLHIV and key populations and work to build new alliances and partnerships between those experiencing S&D and those with the most power to shape stigmatizing attitudes and norms and change discriminatory behavior in communities. Opinion leaders, including national policymakers, local government officials, health providers, religious leaders, police, teachers, youth, parents, and the media can model desired non-stigmatizing attitudes and discriminatory behavior, and "lead by example" to influence each other and the general community.

  However, to accomplish these aims, these opinion leaders need to be strengthened to lead on S&D-reduction, beginning with support to increase their own understanding of S&D and the benefit of reducing it, to improve knowledge and overcome fears around HIV transmission and key populations, and to grapple with their own socially driven stigma toward PLHIV and key populations. Once empowered with knowledge and understanding, opinion leaders are more likely to welcome partnerships with PLHIV and key populations to tackle S&D and themselves become models of non-stigmatizing attitudes and behavior.

  Similarly, fostering non-traditional alliances between key institutions that provide critical services and are often identified as sources of S&D (e.g., health care, education, the judiciary, law enforcement, employers) and PLHIV and key populations (e.g., alliances between police academies and SW networks, between health worker associations and networks of MSM, between medical training programs and networks of PLHIV or key populations, or between employers and PWID) helps form new partnerships to broaden the reach and strength of S&D reduction programming within these institutions

  How:

  Providing leaders with the understanding and skills they need to become advocates for S&D-reduction and role models for their communities requires first providing leaders with safe, non-threatening spaces to address within themselves, through a participatory process, the three actionable drivers to create both an understanding of why S&D-reduction is beneficial to the whole community and a motivation to act. Second, support should be provided for an action planning process to determine what

is feasible within a given community, including partnership building and resource needs. Additionally, providing some mechanism for ongoing support in the start-up phases of action is helpful, even if that support is available only at a distance from outside the community.

Community HIV S&D-reduction programs in Viet Nam (Nyblade, Khuat Thu et al. 2008) and Tanzania (Nyblade L, MacQuarrie K et al. 2008) have used the stigma-reduction toolkit described above to strengthen community leaders and then support them to design and deliver S&D reduction appropriate to their communities.

Strengthening Community Leadership for Reducing HIV-Stigma and Discrimination in Viet Nam

Working with two urban communities in Viet Nam, the Institute for Social Development Studies (ISDS) and International Center for Research on Women (ICRW) supported a community-led effort to reduce HIV-related stigma and discrimination (S&D). The program included four key activities: S&D-reduction sensitization workshops for a range of community leaders, a facilitated action planning workshop where community leaders designed and planned for implementation of the community activities, community implementation of the plans with technical support, and monitoring and evaluation. Community activities fell into the broad categories of sensitization for community members (e.g., stigma-reduction training for community educators), communication activities (e.g., posters, drama, education booklets), school activities (e.g., anti-stigma sensitization for teachers and students), assistance to PLHIV and their families, and integration of S&D messaging into ongoing party campaigns. Key lessons learned for program implementation included the critical importance of building commitment to and the ownership of the S&D-reduction process among community leaders to obtain buy-in from the larger community and the importance of building understanding and capacity for stigma reduction. Leaders have the power to mobilize communities and lead by example to change attitudes and behavior; however they first need to build their own knowledge of HIV and S&D, address their own fears and misconceptions, and build the skills and capacity to reduce S&D.

Source: Nyblade et al. (2008). *Communities confront HIV stigma in Viet Nam: Participatory interventions reduce HIV stigma in two provinces*. Washington, DC: International Center for Research on Women; Hanoi: Institute for Social Development Studies.

Similarly, a community S&D program in northern Thailand (Apinundecha, Laohasiriwong et al. 2007) began with community leadership engagement, improving the understanding of the leadership on S&D and then supporting a facilitated planning process to design the intervention and determine implementation. A community-based VCT intervention trial in four countries (including Thailand) integrated S&D-reduction into community mobilization activities that were carried out by community working groups consisting of community leaders, gatekeepers, and community health workers. Outreach workers engaged in dissemination of information (on HIV, VCT, etc.) via one-on-one or group discussions, door-to-door organizing, or community meetings and social events. Community-based outreach volunteer groups of three to five community volunteers who had participated in VCT and were provided with training to disseminate innovation and knowledge (Khumalo-Sakutukwa, Morin et al. 2008).

A central approach to both strengthen opinion leaders and build partnerships is to create opportunities that foster interaction between groups experiencing stigma and

those perpetrating it. “Contact strategies,” as they are often described, open up space to create understanding, build empathy, demonstrate that PLHIV and key populations are contributing members of society, and thereby reduce the distance between “us” and “them” that is a key part of the process of stigma. Specific approaches that have been used as contact strategies include interactive theater or other cultural media delivered by PLHIV or key populations, with PLHIV or key population members as workshop facilitators or placed within health facilities as patient advocates, or through placing health providers or police for a period of time within a network of PLHIV or key populations, for example on an internship or as part of a training rotation (see text box).

Police Cadet Internships with SWING: An Example of a Contact Strategy to Break Down Stigma and Discrimination

Service Workers in Group (SWING) is a local NGO in Thailand that promotes the wellbeing of sex workers in Bangkok and Pattaya. S&D toward sex workers are barriers to sex workers’ ability to protect their own health. For example, a key S&D-related barrier to the health of male sex workers is the frequent arrest of male sex workers for possessing condoms, despite a government directive against using condom possession as evidence of sex work. In response, SWING is working to break down the S&D among police that contributes to this practice by building a partnership with the law enforcement community through participation in the police academy’s Community Involvement Program, which places third-year cadets to work with community-based organizations. During the internship, the cadets work together with SWING staff to promote condom use among sex workers in hotspots, as well as working at the outreach center and in workshops and outreach activities. By opening up a non-threatening space for interaction between sex workers and police officers in training, SWING has created opportunity for the cadets to learn about the lives and challenges of sex workers, build empathy and understanding, and change attitudes. As two cadets explained “Now I feel male sex workers are ordinary people living in the same society as we do,” and “SWING taught us how to be open-minded and to make friends.”

Source: *Turning an enemy into an ally, Pact success story submission to USAID*, October, 2008

Innovative advocacy campaigns can be used as a first step to open up space for more in-depth contact strategies. For example, a SW collective in Bangalore, India, delivered roses to doctors in a hospital who had treated them well, thereby holding up and “rewarding” desirable behavior while also creating a discussion at the facility about why these doctors were receiving roses. This campaign then led to the hospital setting up a rotation for medical students at the collective, opening up more in-depth space for contact to break down S&D among medical students (Stangl, Carr et al. 2010). Similarly, placing PLHIV or key population patient advocates within a hospital—to help members navigate the health care facility and ensure they receive care that is S&D-free—has also worked to open up space for discussion and to break down distance between health facilities staff and groups experiencing S&D.

- **Start at home: Institutionalize S&D reduction through integration, routine practice, and systemization**

  Making S&D reduction practice an integrated part of routine, expected, and rewarded standard practice in key institutions (e.g., health care, education, and law enforcement), within NGOs working on HIV and AIDS or with key populations, and in all HIV programming (e.g., community outreach, information, education, and communication [IEC] materials), rather than a special or additional focus or task, supports the normalization of non-stigmatizing and non-discriminatory behavior.

How:

Institutions and civil society organizations working on HIV programming need to begin by examining their own institutional employment policies and practices with regard to PLHIV and key populations to ensure that they are protective and non-discriminatory and are implemented appropriately. Global standards for workplace policies, such as the International Labour Organization's *Recommendation concerning HIV and AIDS and the World of Work 2010* (No. 200) (2010),[1] as well as NGO codes of practice, such as the *Code of Good Practice for NGOs responding to HIV/AIDS,*[2] are available for adoption. A regional example for the private sector is provided by the Thai Business Coalition on AIDS, which has developed a standard for businesses responding to HIV in the workplace (see the text box) that is available for businesses and institutions to adopt and has been certified by the Labor Welfare Division,

Code of Practice for Businesses: The AIDS-response Standard Organization

The AIDS-response Standard Organization (ASO) is the standard for business enterprises in Thailand in responding to HIV in the workplace. Following the International Labour Organization's *Recommendations Concerning HIV and AIDS and the World of Work*, the standard was developed by the Thai Business Coalition on AIDS and certified by the Thailand Labour Welfare Division, Ministry of Labour, and the Department of Disease Control, Ministry of Public Health. The ASO standard is aimed to assist business enterprises in effectively responding to HIV in the workplace by promoting the following:

- Non-discrimination policies toward PLHIV
  - Policies not mandating testing for persons applying for employment
  - Policies not mandating testing during employment
  - Policies against termination of employment due to HIV status
- Development of AIDS policies in the workplace
- Confidentiality management measures to protect the confidentiality of employees' HIV status
- Measures to support employees who are living with HIV
- HIV education in the workplace
- Partnership with the community and society in HIV prevention and HIV response

Ministry of Labor, and the Department of Disease Control, Ministry of Public Health. Although this example is focused on HIV, it could be extended to focus on sexual orientation or gender identity as well. For governmental organizations and government enterprise, an example from the Royal Government of Thailand is The Ministerial Cabinet's Resolution, dated February 27, 2007, that prohibits the use of HIV status, disability, or history of drug use as the grounds for limiting employment or education opportunities, scholarship eligibility, study participation, or professional promotion or for termination of employment or educational enrollment.[3] Developing S&D reduction policies with employees so that they have ownership of the policies (see the text box on the next page, which discusses a hospital study in Viet Nam) is an effective way to support desired behavior change (Oanh, Ashburn et al. 2008). Clearly, having policies in place is a critical first step; however without

[1] http://www.ilo.org/aids/WCMS_142706/lang--en/index.htm
[2] http://www.hivcode.org/
[3] Cabinet Resolution, 27 February 2007. Source : http://www.eppo.go.th/admin/cab/cab-2550-02-27.html#25

implementation, enforcement, and mechanisms for redress, the policies will have little positive effect.

In addition to having in place non-discriminatory policies, taking a pro-active approach to recruit PLHIV and key populations, following the "greater involvement of PLHIV" (GIPA) principles (UNAIDS 2007) is a stigma-reduction strategy on multiple levels (see the text box). It serves as a contact strategy (see above), opening up space for interaction and for breaking down the distance between groups experiencing stigma and those who may be perpetrating it, as well as providing individuals who often are discriminated against in finding an employment opportunity a chance to demonstrate their capabilities and dispel misconceptions around the abilities of PLHIV or members of key populations. In addition, it provides income to fulfill family and community expectations, thereby countering stigmatizing perceptions that PLHIV and key populations are a burden on society, while also building self-esteem and helping to counter self-stigma among PLHIV.

Addressing the Dual Stigma of Drug Use and HIV in Employment in China by "Starting at Home"

In 2003, PSI launched "Huxianghao," a project to encourage people who use drugs to do so safely, to teach people who use drugs about HIV prevention, and to support people who use drugs to detoxify or reduce drug use. A key component of the program has been addressing S&D among program staff, critical to ensuring that the project staff gains the trust of the target population. As the program manager explained: *"Stigma and discrimination come not only from the public, but also from the staff of our organization, typically* [directed at] *staff with and* [coming from] *staff without drug using experiences*." Addressing S&D has been done through a commitment to hire former drug users and SWs as staff and ensuring that all staff have equal opportunities, regardless of HIV or drug use history. Staff are encouraged to learn from each other, and staff with a drug use background work as partners with staff who have no lifestyle experience or background with drug use. This approach ensures that personal experience informs program development, design, and implementation and is valued as an integral aspect of staff competency.

Source: Case study documented in *Swimming Strongly: How USAID Cooperating Agencies Are Supporting the Community Response to HIV and AIDS-Related Stigma and Discrimination, 2011*, Jenny Xia, and David Stephens, RTI International

Second, institutions and organizations need to ensure that their staff is provided with the necessary skills and supportive work environment to provide services or conduct their work in a non-stigmatizing and non-discriminatory manner. Creating this environment includes providing appropriate initial and refresher training on HIV and key population S&D (addressing the three actionable drivers of S&D described above); ensuring appropriate infrastructure and supplies are in place to protect staff, as necessary (e.g., latex gloves and sharps containers in hospitals); and putting in place standards of practice (SOPs) and redress-and-reward systems to ensure enforcement of policies and SOPs. An example of how to do this successfully in a health care facility is provided by a study in Viet Nam (see the text box on the next page) that combined training for staff with improvements in the working environment and staff development of institutional policies around S&D (Oanh, Ashburn et al. 2008). An example of how SOPs can help reinforce delivery of services free of S&D is provided

Creating a Safe and Friendly Hospital Environment: Addressing Stigma and Discrimination in Hospitals in Vietnam

Intervention Package:

- **Data collection: Baseline data collection (to demonstrate need and shape the intervention) and Endline data collection (for evaluation)**
  - **Census of hospital workers with self-administered questionnaire**
  - **In-depth interviews with hospital workers**
  - **Observation of hospital environment and practices**
  - **Monthly monitoring using checklist**
- **Hospital steering committee**
- **Training: for all hospital staff, from guards to senior doctors**
- **Staff development of "Safe and Friendly" hospital policies, implementation of policies**
- **Structural changes supporting Universal Precautions practices (e.g., "sharps" containers)**
- **Educational materials, including training manual**

Training Package: four half-days

- **½ day on basic HIV knowledge**
- **1 day on universal precautions**
- **½ day on social stigma co-facilitated by PLHIV**
  - **Naming stigma through pictures**
  - **What is the meaning of stigma**
  - **Naming stigma in hospitals—forms and Causes**
  - **How it feels to be stigmatized**

Policy Development:

- **Each trained group developed its own policy and presented it in plenary to the hospital**
- **The steering committee took all comments and combined them for the final hospital policy**
  - **Access to services by PLHIV**
  - **HIV counseling and testing**
  - **Confidentiality**
  - **Universal Precautions**
  - **Training on HIV and AIDS**
  - **Dissemination of policy**
  - **Posters on policies posted throughout hospitals**

Source: Oahn et al., 2008

by FHI's *Standard Operating Procedures of Voluntary Counseling and Testing (VCT) Services in Community and Mobile Services* (FHI 360 2011), which includes a section on a code of ethics, including confidentiality and informed consent. This SOP provides an example in which S&D can be integrated into VCT services for key populations provided by community-based organizations. Third, institutions and programs involved in delivering services, in particular outreach and communication and behavior change efforts, need to put in place a system to review all communication materials (written or visual) and approaches with a stigma lens. Oftentimes, despite best intentions, programs and materials are inadvertently stigmatizing or discriminatory. Putting in place a systematic process to ensure this does not happen is a key S&D-reduction strategy.

All of the above strategies can be supported, rewarded, and enforced through incorporation of S&D-reduction standards, criteria, or training into national accreditation processes, whether they be by government agencies, professional

associations (e.g., medical associations, nursing, and midwives' associations, teachers' associations, business coalitions, law associations), or by training institutions (e.g., medical schools, teacher trainings colleges, police academies).

- **Measure for design, monitoring, evaluation, program improvement and accountability**

  Understanding the levels, forms, and actionable drivers of HIV and key population S&D is essential to understanding how best to design programs to intervene to reduce S&D, where to focus resources, and how to monitor progress, both for accountability and to allow for continual learning for effective program implementation.

  How:

  Several global measurement efforts are currently underway that provide some guidance on ways to measure S&D quantitatively at the general population/community level (SAN 2012; Stangl, Brady et al. 2012), among PLHIV (www.stigmaindex.org), and among health providers (Jain and Nyblade 2012; Nyblade and Hunger 2012). Measures typically focus on key actionable drivers that programs are working to change (see ***Figure 1*** in the Background section), as well as the stigma manifestations. Measuring these two dimensions helps programs understand both how well they are doing in changing the actionable drivers, as well as how these efforts are effecting changes in the levels of different domains of stigma manifestations.

- **Integrate human rights principles into S&D programming**

  A review by UN agencies and other international organizations identified the following human rights principles as most relevant to HIV programming: the interdependence of rights (including attention to the broad legal and policy environment), participation and inclusion, non-discrimination and equality, accountability, and key aspects of the right to health that include accessibility, acceptability, availability, and quality (Committee on Economic 2000). S&D-reduction programming should be guided by these five human rights, from design through implementation (including work planning and budgeting) and monitoring and evaluation. The application of a human rights framework will ensure that the process of setting agendas and priorities, as well as the expected outcomes, are based on justice, dignity, and fairness and that accountability is built into the decision-making process (Gruskin and Tarantora 2008). Paying attention to human rights may thus not only achieve the reduction of S&D, but also improve the long-term success and effectiveness of the S&D programming. A description of each of the five human rights and how to operationalize them is provided discussed below;

  The interdependence of rights: This principle means that the realization of one human right often depends, wholly, or in part, upon the realization of others. For example, the realization of the right to be free from discrimination may depend on other rights such as the right to work, the right to freely receive and impart information, and the right to participation and inclusion, among others. The interdependence of rights also means

that attention to the broader legal and policy environment in which S&D-reduction is taking place should be examined and addressed. In many countries, despite S&D-reduction policies and programming, the broader legal and policy context may threaten effective S&D-reduction scale-up. For example, criminalization of sex work, drug use, and homosexual activity may legitimize and reinforce S&D toward key populations, while bylaws that criminalize homosexual activity—permitting police and other authorities to harass and assault MSM with impunity—may legitimize homophobia and transphobia.

How:

These right may be preserved through monitoring and reforming laws, regulations, and policies to ensure that these support, and do not hinder, S&D reduction efforts. Monitoring and reform may include 1) Review of laws and law enforcement practices to see whether they impact the response to S&D and HIV positively or negatively; 2) Advocacy and lobbying for legal and policy reform where needed; 3) Engagement of Parliamentarians and Ministers of Justice, Interior, Corrections, Finance, Industry, Labor, Women's Affairs, Education, Immigration, Housing, Defense, Health, and Trade and religious and traditional leaders, among others, to review the existing legal and policy environment and advocacy and lobby for changes; 4) Promotion of the enactment and implementation of laws, regulations, and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care, and support (UNAIDS May 2012). A good example of a constructive legal reform, which came about with concerted advocacy action, is the recent Deli High Court's judgment recognizing as inappropriate the criminalization of consensual sexual acts between adults in private. The basis of the decision was that it is wrong to exclude or ostracize on the grounds of difference, and also because it was seen to drive people underground, making it harder to reach them with HIV prevention, treatment and care services (Delhi High Court July 2, 2009).

Participation and inclusion: This principle means that every person and all peoples are entitled to active, free, and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural, and political development in which human rights and fundamental freedoms can be realized. In the context of S&D-reduction programming, this mean that all programs should ensure that PLHIV and key affected populations have genuine ownership over development processes in all stages of the programming cycle and that truly participatory processes are in place that are "active, free, and meaningful." The strategies to reduce S&D should empower PLHIV and key affected populations to articulate their expectations and take charge in leading S&D reduction. This also means that those who work on S&D program should communicate with, listen to, and mediate with community groups, religious leaders, government officials, and anyone else that the program might impact.

How:

Participation and inclusion can be promoted by ensuring that mechanisms exist to support the full, active, meaningful participation of PLHIV and key affected populations in all phases. The process for their involvement should address barriers that could affect participation such as attitudes, methods, resources, logistics, and

languages barriers. The GIPA principle is one example of how this can be done. A list of available programmatic tools to implement the GIPA principle is available on the UNAIDS website.[4] Another example is the process implemented by the PLHIV Stigma Index, a global effort to empower PLHIV while collecting data on PLHIV experiences with S&D to inform the national AIDS response and policies. PLHIV who conduct the research are involved in the various phases of implementation, from design through data collection and analysis.[5]

Non-discrimination and equality: This principle means that all individuals are equal as human beings by virtue of the inherent dignity of each human person and are entitled to all human rights without discrimination of any kind. In S&D-reduction programming, this means that programs should not be directed solely at those who are currently easy to reach—for example, venue-based SWs rather than street-based SWs who are often not included in programs. Unintentional discrimination must also be avoided. This can happen when, for example, the public at large is invited to participate in program design but certain groups are precluded from participating because they live in remote areas and cannot attend the meeting.

How:

Specifically, programming may need to 1) give priority to those suffering discrimination and disadvantage in any given context, especially those living in the most extreme poverty; 2) strengthen capacities for S&D data collection and analysis to ensure data are disaggregated as far as possible on grounds such as sex, geographic location, and age to ensure evidence-based programming reaches those most in need; 3) advocate temporary special measures to "level the playing field," such as affirmative action for women and special forums for participation; 4) make S&D project information available in accessible formats and minority languages; and 5) support civic education and legal reform to foster non-discriminatory attitudes and behaviors. Mobile VCT clinics serving hard-to-reach populations are a good example of how to work toward equity in providing access to services for the most vulnerable and marginalized populations who may not utilize standard VCT services such as drop-in centers (e.g., for fear of being labeled an MSM). S&D reduction programs may use a similar approach of finding creative ways to deliver services to ensure that the program reaches those who need the interventions the most. For example, community-based organizations providing HIV-related home and community-based care and support could find ways to integrate S&D reduction (counseling etc.) into their home-visit activities.

Accountability: States and other duty-bearers (such as health care workers and community-based and international organizations) must comply with the legal norms and standards enshrined in human rights instruments and domestic laws. Where they fail to do so, aggrieved rights-holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by law. In the context of S&D-reduction

[4] http://www.unaids.org/en/media/unaids/contentassets/documents/programmes/janbeagle/civilsociety/cs_B5L2_gipa.pdf .
[5] http://www.stigmaindex.org

programming, ensuring accountability involves establishing institutional reporting mechanisms that allow clients to report and seek redress if stigma or discrimination occurs (i.e., when staff discriminate, intentionally or unintentionally). Accountability also means that programs should be transparent, open for scrutiny, and accountable to the people they serve—for example, by providing information to the community on what steps the program has implemented and how. Accountable programs must also have in place 1) clear roles and responsibilities, 2) transparent decision-making processes and decision criteria, 3) open access to information, and 4) effective mechanisms to demand accountability. In addition, S&D-reduction programs should support PLHIV and key affected populations to secure and claim their rights and support from the duty-bearers (such as government agencies).

How:

Legal literacy "know your rights" programs, in conjunction with legal services, are key approaches to support PLHIV and key populations to secure and claim their rights when faced with discrimination. There are good examples of HIV-related services in the region. For example, Yunnan Daytop Drug Abuse Rehabilitation & Treatment Centre, supported by the USAID | Health Policy Initiative Greater Mekong Region and China (HPI/GMR-C), has provided legal support to PLHIV and PWID in China to cope with various legal issues. The legal service provided by Beijing Yirenping assisted in the first three court cases of HIV discrimination in employment in China (applicants for teachers' jobs who failed medical exams because they have HIV) (RTI International, International Development Law Organization et al. 2012). S&D-reduction programs can also support accountability by training judges, police, National Human Rights Commissions, and staff working in the justice system on issues of confidentiality, informed consent, and sensitivity toward PLHIV and key affected populations as well as on issues such as sexual orientation and gender identity to ensure that mechanisms to redress human rights violation will be non-stigmatizing and non-discriminatory.

Key aspects of the right to health: accessibility, acceptability, availability, and quality. To support this human right, S&D-reduction programs need to be available, accessible, acceptable, and of high quality in multiple sectors, but particularly in the health care sector. Reducing S&D should improve accessibility, acceptability, and quality of health services. S&D-reduction programs must ensure that the individuals who need the services can reach the services, afford to access them (with unnecessary burden), and feel comfortable using them. In the health care sector, S&D-reduction—for example through training of health staff—will support the provision of good quality services.

How:

An assessment of S&D can be done to help inform the scale-up of S&D programs to ensure that S&D-reduction programs are designed to address the needs of those who are most stigmatized. The PLHIV Stigma Index (www.stigmaindex.org), previously mentioned, can be a good resource to collect the necessary data to inform how best to target S&D-reduction programming. Legal hotline services as well as mobile legal services can be employed to ensure that those who need service in remote areas can

access these services. Free, or pro-bono, legal services may be provided to increase the accessibility of these services. To ensure that S&D-reduction programs, particularly those focused on addressing S&D within PLHIV and key populations, are acceptable, programs can be designed and implemented in ways that correspond to clients' lifestyles (e.g., open hours that are flexible and correspond to SWs' lifestyle or are suitable for young people). S&D-reduction programs should draw on the available local, regional, and global evidence base to strengthen quality, learning from existing experience, and adapting as necessary to ensure that activities are locally appropriate to the context.

An example application of the guiding principles for the reduction of stigma and discrimination: A potential scenario for the health care system in Thailand

To demonstrate how the guiding principles described above could potentially be operationalized at the country level, we provide the following illustrative example for how S&D-reduction programming in Thailand might begin a focus on scaling up a response in the short-term in support of the S&D-reduction goal in the National Strategy. While the focus of the operational example provided here is on the near-term, countries should be simultaneously working on beginning processes that may take longer to achieve the desired outcome, for example reviewing and the advocating for change in discriminatory laws and policies.

Step one:

A first step for Thailand (and all countries) is a rapid assessment of the current situation with regards to S&D-reduction programming. Such an assessment ensures efficiency in implementation of a national response by providing a more complete understanding of what is already underway (to avoid duplication of efforts and identify critical gaps), opportunities for synergy, integration, and leveraging of existing efforts (to maximize investment of scarce resources), and the quality of the current S&D programming that is being delivered (whether it is likely to have the desired effect and therefore be an effective use of resources) to provide replicable models and indicate areas that may need strengthening for improved results.

This assessment should include the following:

- An inventory of programs across sectors (e.g., health, education, law enforcement, military, media, community, faith, NGOs, networks) that indicate S&D-reduction as a primary or secondary objective

- For each of the identified programs, specific details collected on the following:

  - The S&D-reduction content of the program to provide understanding on what specifically is being implemented (for example, information on the specific methods and the S&D-reduction content that is being delivered through those methods)
  - Where it is being implemented (geographic location)
  - Who is participating (target groups)
  - Who is delivering the program
  - Technical support needs
  - Who is providing technical support
  - Who is funding the program

- A collection of all materials (e.g., training curriculums, IEC materials) being used in these programs

- Programmatic monitoring and evaluation results, if available
- S&D data, if available
- Evaluation of the above S&D data against the six core principles of S&D reduction to evaluate for quality, as well as reach for equitable access (For example, is the program addressing the three immediately actionable drivers of S&D? Are PLHIV and key populations at the center of, or meaningfully involved in, each program? Are programs being implemented based on where available S&D data indicate need for action?)
- Assessment of the legal and policy environment to determine whether it is an obstacle to S&D-reduction programming
- Assessment of the service-delivery environment for 1) the extent to which programs are linked (or can be linked) to each other to support referral of health care clients experiencing S&D to other services (where available) that can better help address different aspects of S&D (e.g., psychosocial supports, legal supports, economic support), and 2) quality of service delivery to ensure it is not inadvertently contributing to S&D, directly, or through omission (For example, data in Thailand show that fear of casual transmission of HIV is still relatively high suggesting that HIV prevention programs may need strengthening to better address understanding of HIV transmission.)

Step two:

The second step is a process of prioritization that includes—based on the above assessment, which provides the data to "know your S&D epidemic and response"—participatory consultations with key stakeholders to review opportunities for leveraging existing programs (by either strengthening existing efforts or adding new components) and review where new programming may be needed to fill critical gaps, given the availability of financial, human, and technical resources. This prioritization process needs to be guided by the human rights principals described above, with a focus on meaningful participation, transparency, and directing of S&D-reduction in ways that will provide the most benefit to those experiencing S&D. Prioritization, depending on the specific country-context may be by geographical location (e.g., "hotspots" or selected districts or provinces), by specific target populations (e.g., PLHIV, key populations, and religious leaders), or by sector (e.g., health, education, law enforcement). For example, for Thailand, 31 priority provinces have been selected for the National HIV strategy. The program could consider a staggered roll-out for S&D-reduction programming to these provinces by beginning with a few pilot provinces (perhaps one urban and one rural) to test and refine the program before expanding it to additional provinces.

Step three

The third step is implementation planning for the prioritized sectors, including cross-sector or group programming, utilizing the core principles of S&D-reduction programming and drawing on existing local, regional, and global resources. As an example of how this could be operationalized, and for illustrative purposes, we have

selected the health care system working together with PLHIV and key populations as an example of key priority areas for Thailand to begin scaling-up S&D reduction. The health care system was selected for this example for multiple reasons. S&D reduction programming in health care settings is well documented, influences access and willingness to utilize services, and was identified in a limited consultative process both by key populations and by the Thai Ministry of Public Health as a critical area for intervention to reduce S&D in Thailand. In addition, the health care system has structures in place that can allow for rapid scale-up and routine monitoring and evaluation to gauge progress.

To reduce S&D within the health care system in Thailand, we recommend focusing on four interconnected and reinforcing levels of the overall system: 1) facilities; 2) health care provider, client, and wider community interaction; 3) formation of health care professionals, and 4) national health system–level mechanisms.

Facilities:

To support implementation planning for the S&D-reduction in individual health facilities, we first turn to an adaptation for health facilities (Jain and Nyblade 2012) of the framework for S&D reduction programming and measurement presented in the background section (***Figure 5***). ***Figure 5*** presents this adaptation, which delineates key programmatic areas for S&D-reduction intervention in a health care facility (drivers) for both actions with individuals within the facility (staff) and at the institutional (facility) level. The adapted model focuses on S&D toward clients and health facility staff who are living with HIV, as well as secondary stigma toward health facility staff who provide care for PLHIV and key populations, and suggests specific actions that need to be taken to reduce S&D in facilities (Jain and Nyblade 2012).

Figure 5. A framework for addressing and measuring stigma and discrimination in health care facilities

Actionable Drivers to be Addressed in Health Facilities S&D toward Clients and Healthcare Staff	Reduced Stigma Manifestations (Illustrative Examples)	Improved Outcomes	Improved Impacts
Individual Health Facility Staff-level **Lack of Awareness and Understanding of S&D** • How S&D manifests • Effects of S&D **Social Judgment** Prejudice and stereotypes: • Multiple sexual partners • Drug use • Same sex behavior • Gender Identity • Childbearing • Sex work • Ethnicity • Socio-economic status **Fear of HIV Infection** • Lack of HIV transmission knowledge • Unwarranted fears related to noninvasive procedures (e.g., checking blood pressure) • Work-related exposures to HIV • Casual contact	**Anticipated Stigma** • Fear of confidentiality breach by providers • Fear of S&D from colleagues at health facility **Experienced Stigma** • Physical isolation from HIV negative clients • Unnecessary preventative measures taken (e.g., double gloves) **Discrimination** • Refusal of care • Poor quality of care • Loss of job for HIV+ health staff	• Mental health • Physical health • Quality of life • Social support • Resilience • Risk behavior • Improved service quality	• Disclosure • Uptake of HIV prevention services *(e.g., HIV testing, condom use)* • Uptake of treatment and care services • Adherence to treatment
Institutional-level **Lack of Policies and Guidelines** • Informed consent guidelines • Universal precautions • Reporting and redress system **Inadequate Trainings** • Anti-S&D policies • Coping with secondary stigma **Physical Environment** • Insufficient supplies (e.g., infection prevention) • Signs identifying clinic as serving PLHIV **Inadequate Supervision and Support** • Feedback system • Collaboration	**Secondary Stigma** • Fear of assumed HIV+ status • Loss of associations with friends, family, or community	• Staff retention	• Willingness to test • Expanded cadre of providers Serving HIV+ clients • Improved quality of care

Health facility staff-level Institutional-level

Note: While not depicted, as the focus of Figure 5 is on provision of key entry points for immediate action and measurement on S&D in health facilities, it is important to note that the environment outside the health facility plays an important role in shaping staff behavior and facility environment. Therefore, the framework is embedded in the larger social context of changing socio-cultural barriers and facilitators. These include the economic and political environment, gender and sexual cultures prevalent in society, health beliefs, ethics, and religion.

Source:Jain and Nyblade (2012)

At the individual staff level, the framework focuses on addressing the three actionable drivers of S&D with staff. This includes improving awareness and understanding of S&D in general, but particularly how it manifests in health care facilities and its impact on client health outcomes, addressing specific fears of contracting HIV in the facility by deepening understanding of true risks of infection in given encounters with clients living with HIV, and opening up discussion on social judgments among staff—what they are, where they come from, and how they affect provision of quality care and client outcomes. At the institutional level, the framework focuses on key aspects of a facility environment that can drive S&D, including a lack of policies and guidelines supportive of the provision of non-stigmatizing and discriminatory care, inadequate training of staff, a physical environment that does not adequately support staff to safely serve clients, and inadequate supervision and support.

Addressing the individual and institutional-level drivers in a specific facility is inter-related in practice. The example provided earlier (see the text box on reducing S&D in hospitals in Viet Nam) demonstrates one model of how to implement S&D reduction in facilities and address both individual and facility-level factors (Oanh, Ashburn et al. 2008). This study used a 2.5-day participatory S&D-reduction training process for all staff in a facility, with half-day sessions spread across several months, focused on addressing the three actionable drivers. The training schedule was designed in collaboration with the facility administration to ensure minimal disruption to the daily work schedule. A key part of this training was having co-facilitators who were living with HIV. Once trained, staff went through a participatory, guided process to develop their own facility policy around the provision of non-stigmatizing and non-discriminatory care. This policy was then negotiated with the administration and, once finalized, posted throughout the facilities so that both staff and clients could see what had been committed to. The intervention also included assessing what could be improved in the facility environment to support staff to be safe in their daily work life and to practice universal precautions. This included ensuring availability of sharps containers and water sources.

A critical part of S&D-reduction training for staff in health facilities is creating co-facilitator teams, each of which includes a health care worker and a person living with HIV and/or a member of a key population. This is important for multiple reasons. To begin with, it ensures that PLHIV and key populations are an integral part of the process. Second, it allows for staff in health care facilities to see PLHIV and key populations in a role beyond “patient”—one with authority that demonstrates skills and knowledge, helping challenge often-held stigmatizing beliefs that PLHIV and members of key populations are not capable, contributing members of society. The training also help address internalized stigma while empowering PLHIV and members of key populations by providing training skills, providing employment, and offering a means to actively engage in challenging S&D. Lastly, it opens up new spaces for “contact” between health providers and PLHIV and key populations, to begin breaking down the distance and finding common humanity.

To roll out a similar process in Thailand, on a larger scale, the following steps could be taken:

- Adaptation and translation of S&D-reduction training curriculum for health care workers from the existing regional and global resources (see ***Appendix 1***) to the Thailand context, focusing on the three actionable drivers and including participatory facility-level policy development by staff.

- Selection of pilot facilities for testing and refinement of the training curriculum and tools while simultaneously training a cadre of trainers-of-trainers from within the health care facilities and communities of PLHIV and key populations. Selection of facilities in which to focus initial efforts, given that the places where PLHIV and key populations are most likely to seek care could be at district-level hospitals or possibly the general (provincial) hospitals, depending on resources. In addition, training of the staff at the Tambon/sub-district health center (hospital) level would be beneficial because of their community outreach functions (see below).

- A cascade training of trainers programs that expands on a rolling basis to cover selected locations (e.g., provinces), with trainers initially trained and then training additional trainers, and with the numbers of trainers trained in each facility based on facility size. In addition, putting in place processes for ongoing quality assurance and continued implementation for periodic refresher training for initially trained staff and S&D-reduction training for new staff.

- Collection of monitoring and evaluation data (baseline and endline) for program improvement and accountability. Examples of the types of data that can be collected for this purpose are provided by a program in Viet Nam (Oanh, Ashburn et al. 2008) and India (Mahendra, Gilborn et al. 2006; Mahendra, Gilborn et al. 2007) and will be soon available from a global process that is testing and validating a brief global tool (Nyblade and Hunger 2012)

- An assessment of the facility environment, to determine what facility-level changes need to be put in place (for example, see the facility-level drivers box in ***Figure 5***) to support an S&D-free facility for PLHIV and key populations and institutionalize S&D-reduction as a routine, expected part of health care service delivery. A program in India developed a checklist for facilities to determine how PLHIV-friendly they are (Horizons, SHARAN et al. 2003); the checklist could be adapted to Thailand and expanded to include an additional focus on key populations.

Health care provider, client, and wider community interaction

In addition to the above specific focus on training for staff in health facilities and addressing specific institutional-level factors, a key component to successful S&D reduction in health facilities is creating additional opportunities beyond the S&D-reduction training for health care provider-client interaction (contact strategies) to break down distance and for health care worker outreach into the community for community-level S&D reduction to improve the enabling environment for uptake of services. To do this, Thailand could consider the following:

- Developing a system of PLHIV and key-population patient advocates who would be formally placed in paid positions at key facilities. Key facilities would include

those located near a large number of clients who are living with HIV or clients from key populations or facilities that given their location, should be (but may not be) serving more clients from key populations or are finding that PLHIV are beginning treatment at sub-optimal CD4 cell counts. Both of these may indicate that S&D are a barrier to uptake of services at that facility. Working together with networks and support groups of PLHIV and key populations and facility administration, such a program would need to develop criteria for selecting potential patient advocates, as well as a training curriculum, terms of engagement (part-time, full-time etc.), and ongoing support and mentoring.

- Providing additional training to the Tambon-level health facility staff in community S&D-reduction to help them find and develop ways to incorporate S&D reduction into their ongoing community health and outreach activities, as well as other opportunities that might arise at the community level where S&D-reduction could be incorporated. For example, under the current Global Fund Round 10 work focused on children affected by HIV, sub-district community action groups have been formed that include health facility staff.

Formation and continuing education of health care professionals

In addition to the S&D-reduction training suggested above for all staff in health facilities, incorporating S&D reduction into curricula for the training of all health professionals (e.g., doctors, nurses, pharmacists, dentists, lab technicians) is essential to moving toward making provision of S&D-free care simply part of routine, standard care. Incorporation into the training of health care professionals would entail developing short courses—which could be modeled on the training described for health facilities—for inclusion in standard curriculum. An additional option for consideration are training rotations or internships that would place students with networks of PLHIV or key populations, with NGOs working with these groups, or with clinics and outreach services specialized in providing services to PLHIV or key populations. Similarly, for health providers who are already working, continuing medical education (CME) courses focused on S&D reduction could be developed and temporary learning placements created, similar to those suggested above for students.

Institutionalize S&D reduction as a national health system best practice through existing governmental and professional association mechanisms

This aim can be achieved through inclusion of key supporting practices for S&D reduction in standards of practice and accreditation processes at the facility level—for example, through the Healthcare Accreditation Institute (http://www.ha.or.th/ha2010/th/home/index.php) or for individuals (e.g., the Medical Council of Thailand (http://www.tmc.or.th), for doctors, and for the Nursing and Midwifery Council (http://www.tnc.or.th). In addition, finding ways to reward and uphold facilities and individuals who exemplify good service delivery practices free of S&D is also a productive way to encourage desired behavior. This can be done privately at the individual level as part of management oversight and performance review of staff and in a more public way through recognition (e.g., awards) at facility and national levels.

Conclusion

While the complexities of S&D may seem to make responding complex and challenging, the reality is that because of these very complexities the opportunities, pathways, and entry points for responding are numerous. It has also become clear over the past decade, that while S&D are culturally specific and determined to a certain degree, they are fundamentally the same throughout the region and world, that the differences are more of nuance than substance. This universality allows for the development of programmatic tools, approaches, and measures that can be readily adapted across contexts. The progress achieved over the past decade, both in the region and globally, in understanding S&D, discovering entry points for intervention, and development of programmatic tools, approaches, and measures has laid a solid foundation for scaling up S&D and demonstrated that it is possible to act now to reduce S&D.

The need to reduce S&D is particularly critical in the GMR, where the epidemic is concentrated and rising among populations that are experiencing multiple stigmas that present particular challenges for programs seeking to reach those most at risk of HIV. These populations remain hidden and hard to reach for multiple reasons; however, key among these is likely fear of "status" disclosure (whether it be their HIV status or status as a member of a key population) that may trigger S&D. As available data have shown, coverage of services in the region is relatively low, and according to Report of the Commission on AIDS in Asia (2008), the coverage of effective prevention service must reach 80% of people who are most at risk of HIV infection in order to initiate the 60% behavior change needed to reverse the epidemic. Reaching 80% of key populations will require improving the enabling environment, including reducing S&D.

With the current decline in resource funding for HIV programming in the region and globally, reducing S&D can be a smart investment as it helps ensure that investments in HIV prevention, treatment, care, and support services are maximized, cost-effective, and sustainable, by removing a critical access barrier that undermines utilization of these existing services. An investment in S&D-reduction has a ripple effect across the HIV response, providing benefit to all programs across the prevention-to-treatment continuum. While S&D reduction is critical to long-term success in achieving universal access to HIV prevention, treatment, care, and support, reduction of S&D is a good in its own right because of its impact on improving quality of life and upholding the human rights of those living with and affected by HIV and AIDS, including key populations, who are disproportionately affected by the epidemic.

By summarizing existing knowledge and offering key programming principles followed by an example of how to operationalize them, this guidance note seeks to support the efforts to reduce S&D by providing a basis on which to build the future scale-up of S&D-reduction programming in GMR.

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Appendix 1. Programmatic Tools for Stigma and Discrimination Reduction

Tool Name/Reference	Target Group	Country	Language	Source
Understanding and Challenging HIV Stigma: Toolkit for Action First Edition (2003): ICRW & AED, Second edition (2007): ICRW, AED, HIV/AIDS Alliance	All groups	Global	English	www.stigmaactionetwork.org
Understanding and Challenging HIV Stigma: Toolkit for Action, *Adaptation to Cambodia (2010)*: Pact Inc. and ICRW	All Groups	Cambodia	Khmer English	www.stigmaactionetwork.org
Adaptation of Cambodia toolkits to Thailand: USAID and Pact Thailand (2011) includes training curriculum on stigma related to HIV, Men who Have Sex with Men, and Transgender persons 1) Module for General People and Health and Social Service Providers 2) Module for HIV-positive MSM and TG 3) Module for MSM and TG	• General population health and social service providers • HIV-positive MSM and TG • MSM and TG	Thailand	Thai	Pakprim Oranop na Ayuthaya, Senior Program Officer pakprim@pactworld.org
Adaptation of Cambodia toolkits to China Understanding and Challenging HIV Stigma: Toolkit for Action. USAID and Pact Inc., (2012)	PLHIV	China	English and Chinese	Shirley Lin, Program Coordinator, Pact China slin@pactworld.org
Understanding and Challenging Stigma toward Injecting Drug Users and HIV in Vietnam: Toolkit for Action, Institute for Social Development Studies (ISDS) and ICRW	PWID and PLHIV	Viet Nam	Vietnamese English	www.stigmactionetwork.org
Understanding and Challenging HIV Stigma toward Entertainment Workers, Pact Inc. and ICRW (2010)	Sex workers	Cambodia	Khmer English	www.stigmactionetwork.org
Understanding and Challenging Stigma toward Men who Have Sex with Men: Toolkit for Action. Pact Inc. and ICRW (2010)	MSM	English	Cambodia	www.stigmactionetwork.org

Tool Name/Reference	Target Group	Country	Language	Source
Family-to-Family: Psychoeducation to Improve Children's Outcome in HIV+ Families in Thailand: "Rao Rak Luk" Project. Family to Family Intervention Manual. Thai Ministry of Public Health and University of California, Los Angeles (2010)	PLHIV and their families	Thailand	Thai English	Li Li, Professor-in-Residence, Department of Epidemiology, School of Public Health, Semel Institute - Center for Community Health, University of California, Los Angeles lililili@ucla.edu
Safe and Friendly Health Facility: Trainer's Guide: ISDS, ICRW and Horizons Project (2008).	Hospital staff	Viet Nam	Vietnamese English	www.icrw.org
Reducing HIV Stigma and Gender Based Violence: Toolkit for Healthcare Providers in India. ICRW and Bhoruka Public Welfare Trust (2007)	Health providers	India	English	www.stigmactionetwork.org
White Coat - Warm Heart Project (WWP) Intervention Training Manual: Chinese Center for Disease Prevention and Control, Fujian Center for Disease Prevention and Control, Yunnan Center for Disease Prevention and Control, UCLA Center for Community Health (2012)	Health providers	China	English Chinese	Li Li, Professor-in-Residence Department of Epidemiology, School of Public Health, Semel Institute - Center for Community Health, University of California, Los Angeles lililili@ucla.edu
The PLHA-friendly achievement checklist: Self-assessment Tool for Hospitals and Other Medical Institutions Caring for People Living With HIV/AIDS (PLHA). Horizons/Population Council (New Delhi and Washington, DC) and SHARAN: Society for Service to Urban Poverty (New Delhi) (2003).	Hospitals	India	English	www.popcouncil.org
Reducing stigma and discrimination in health care settings: A Trainer's Guide. EngenderHealth (2007)	Health care providers	Global	English	www.engenderhealth.org
Reducing stigma and discrimination in health care settings: Participant's Handbook. EngenderHealth (2007)	Health care providers	Global	English	www.engenderhealth.org

Appendix 2. Interventions to Reduce Stigma and Discrimination in the Region

Reference/Name of Project	Target Group	Location	Intervention Components
Li L., Lee S. et al (2012). Improving the Health and Mental Health of People Living with HIV/AIDS: 12-Month Assessment of a Behavioral Intervention in Thailand. AJPH. Vol 100, No. 12 Li, L., Liang, L. (2012). Efficacy of an intervention for families living with HIV in Thailand: A randomized controlled trial. AIDs Behavior. 16:1276-1285	PLHIV and their families	North and Northeastern regions of Thailand	Adaptation to Thai setting of US-based intervention (Rotherman-Borus et al, 2001) through a series of workgroups. 4 modules delivered over 13 weeks: **Module 1** (healthy mind) included four weekly sessions: one each on emotional regulation while living with HIV, positive thinking and doing, HIV disclosure, and stress management. **Module 2 (healthy body)** involved three sessions: one each on medication adherence and access to care, prevention of HIV transmission to others, and self-care and healthy daily routines. **Module 3 (parenting and family relationships)** consisted of sessions on family roles and relationships, parenting while ill, and long-term plans with family members and children. **Module 4 (social and community integration):** included two sessions focusing on community participation and support and working while ill.
Apinundecha C., Laohasiriwong, W. et al (2007). A community participation intervention to reduce HIV/AIDS stigma, Nakhon Ratchasima province, northeast Thailand: AIDS Care. 19(9): 1157_1165	• Community Opinion leaders, • Youth, • PLHIV, • Temple Abott	Nakhon Ratchasima province, northeast Thailand	Eight-stage process: 1) Leader engagement 2) Information for decision and action 3) Negotiable planning 4) Management of community resources 5) Operation activities (youth volunteers trained, Dharma for releasing suffering, dharma courtyard, community learning center) 6) Development for sustainability (youth applied for development grant, local temple involvement, community shoe fund for PLHIV) 7) Evaluation 8) Forum for learning and sharing experience

Reference/Name of Project	Target Group	Location	Intervention Components
Khumalo-Sakutukwa G., Morin, S. et al. (2008). Project Accept (HPTN 043): A community-based intervention to reduce HIV incidence in populations at risk for HIV in Sub-Saharan Africa and Thailand.	Community and VCT participants (whether HIV positive or negative)	Thailand (Chiang Mai Province) Tanzania South Africa Zimbabwe	<u>S&D-reduction integrated into community mobilization activities</u>: • Community working groups consisting of community leaders, gatekeepers, and community health workers • Outreach workers engaged in dissemination of information on HIV, VCT etc. through one-on-one or group discussions, door-to-door organizing, or attending community meetings and social events • Community-based outreach volunteer groups of three to five community volunteers, who had participated in VCT, provided with training to diffuse innovation and knowledge <u>Post-test support services</u> • Information-sharing group sessions • Psychosocial support groups • Crisis counseling • Coping effectiveness training workshops • Stigma reduction workshops
Richter K., R. Nuankaew et al. (2012). Positive Partnership Project, New Phase: Endline Study Report. November 2011.	• PLHIV • Community	Six provinces in Thailand Urban: Chiang Mai, Chonburi, and Bangkok Rural: Chiang Rai, Nakhon Ratchasima, and Khon Kaen	Micro-credit scheme using economic empowerment as a means to reduce S&D. The programs provided loans to a pair of individuals comprised of an HIV-positive and an HIV negative person, or a "buddy pair." The use of micro-credit is combined with HIV education to reduce S&D which included the following: 1) Monthly meetings 2) Monthly HIV campaign activities 3) Funfair activities conducted every six months such as quiz game, darts, exhibitions etc.
Nyblade, L., Hong, K.T., et al. (2008). *Communities Confront HIV Stigma in Viet Nam: Participatory Interventions Reduce HIV Stigma in Two Provinces*. Washington, D.C.: International Center for Research on Women; Hanoi: Institute for Social Development Studies.	• Community • Community leaders	Two urban communities in Vietnam; Cam Dong and Cai Khe, located in Quang Ninh and Can Tho provinces	Community activities included: 1) Stigma-reduction 2) Sensitization workshops for authorities and representatives of social organizations 3) A workshop for community 4) Members to develop their own stigma-reduction action plans 5) Communities implementing the action 6) Plans with technical support 7) monitoring and evaluating the program activities

Reference/Name of Project	Target Group	Location	Intervention Components
Li L., Liang L. et al (2010), HIV prevention intervention to reduce HIV-related stigma: evidence from China. AIDS, 24:115-122	Market workers, China	Fuzhou, China	Engagement of community popular opinion leaders • Four weekly group training sessions and 10-12 reunion sessions over a two-year period that included interaction, discussion, modeling, role-play, and other interactive techniques to practice and refine communication skills • Diffusion of HIV-risk reduction messages during everyday conversations, to increase information on HIV and STI prevention and the HIV epidemic
Li L., Wu, Z. et al (2012). Reducing HIV-related stigma in health care settings: A randomized controlled trial in China. American Journal of Public Health, in press.	• Doctors • Nurses • Lab technicians	40 county-level hospitals in Yunnan and Fujian Provinces, China	• Training of facilitators from district disease control centers • Selection of popular opinion leaders (POLs) from within hospitals to disseminate stigma-reduction messages within their medical community • Interactive training of POLs: Four group session over one month, and three reunion sessions post initial training • Provision of universal precautions supplies to participating hospitals
Oahn K.T, Ashburn, K. et al. (2008). Improving hospital-based quality of care in Vietnam by reducing HIV-related stigma and discrimination. Horizons Final Report. Washington DC, The Population Council.	All hospital staff	Four Government hospitals in provinces of: Quang Ninh (1) Hai Phong (1) Can Tho (2)	• Data collection: Baseline (to demonstrate need and shape intervention) and Endline (for evaluation) • Hospital steering committee • Interactive Training: for all hospital staff, from guards to senior doctors: five half-day sessions over several months • Staff development of “Safe and Friendly” hospital policies, implementation of policies • Structural changes supporting Universal Precautions practices (e.g., provision of universal precautions supplies) • Educational materials, including training manual
Wang et al (2009). Intervention to train physicians in rural China on HIV/STI knowledge and risk reduction counseling: preliminary findings. AIDS Care, 21:4:468-472	Rural Physicians, China	Anhui Province, China	• 10-day training • 2 months clinical fieldwork • 2 weeks additional training

Reference/Name of Project	Target Group	Location	Intervention Components
Wu S. et al (2008). A brief HIV stigma reduction intervention for service providers in China. AIDS Patient Care and STDs. 22:6:513-520	Health Providers	County hospitals in Yunnan Province, China.	• Formation of a community advisory board (CAB) of official from the Provincial Health Bureau, health providers and administrators from county hospitals, administrators from local Centers for Disease Prevention and Control, NGO intervention specialists, and PLHIV to advise on intervention design • One 4-hour interactive session,15 health providers per session

Appendix 3. Measurement Tools for Stigma and Discrimination from the Region

Target Group	Type of Stigma and Discrimination	Measure Details	Reference
Thai youth living with HIV	• Internalized stigma • Experienced stigma • Anticipated/perceived stigma	Thai Youth HIV Stigma with four factors: 1) Personalized stigma: consequences of other people knowing their status (3 items) 2) Disclosure concerns (3 items) 3) Negative self-image: not as good as others, shame, guilt (3 items) 4) Public attitudes: what people think about HIV (3 items)	Rongkavilit, C. et al (2010). HIV stigma, disclosure and psychosocial distress among Thai youth living with HIV. International Journal of STD & AIDS. 21: 126–132.
Thai PLHIV	• Perceived stigma • Internalized stigma (shame)	Perceived stigma: eight items Internalized Shame: nine items Social Support: 4 items Family Functioning: 8 items	Li, L. et al (2009). Stigma, social support, and depression among people living with HIV in Thailand. AIDS Care. 21:8:1007-1013
Thai community, family, PLHIV	• Perceived stigma • Internalized stigma	Using a method adapted from Herek and Capitanio (1993), calculated HIV/AIDS stigma scores as the total of the scores from up to 30 items. Five different measures of HIV stigma were calculated, including (1) community stigma toward PLHIV; (2) family stigma toward PLHIV; (3) community stigma toward the family of PLHIV; (4) PLHIV stigma toward themselves (self-stigma); and (5) PLHIV perceptions of stigma by their community.	Apinundecha, C. et al (2007). A community participation intervention to reduce HIV/AIDS stigma, Nakhon Ratchasima province, northeast Thailand. AIDS Care. 19(9): 1157-1165

Target Group	Type of Stigma and Discrimination	Measure Details	Reference
Thai TB patients	• Perceived stigma	Items measuring TB and HIV/AIDS stigma Four scales: Community perspectives toward TB (perceived stigma) (11 items) Patient perspectives toward TB (12 items) Community perspectives toward HIV/AIDS (perceived stigma): (11 items) Patient perspective toward HIV/AIDS (10 items)	Van Rie, A. et al (2008). Measuring stigma associated with tuberculosis and HIV/AIDS in southern Thailand: exploratory and confirmatory factor analyses of two new scales. Tropical Medicine and International Health, Volume 13:1: 21–30
Thai Community members Thai TB patients	• Perceived Stigma	Tested above perceived stigma scales in sample of community members: Perceived stigma toward TB (11 items) Perceived stigma toward HIV/AIDS (10 items)	Kipp, A. et al (2011). Socio-demographic and AIDS-related factors associated with tuberculosis stigma in southern Thailand: a quantitative, cross-sectional study of stigma among patients with TB and healthy community members. BMC Public Health 2011, 11:675
Thai community members	• Enacted stigma	1) HIV transmission: two indices: accurate and inaccurate routes of transmission 2) Emotional reactions toward PLHIV, SW, male clients of SW, homosexuals: assessed fear, irritation, and pity toward	H. Boer and P.A.A. Emons. (2004). Accurate and inaccurate HIV transmission beliefs, stigmatizing and HIV protection motivation in northern Thailand. AIDS Care: Vol. 16, No. 2, pp.167-176
Men who have sex with men, China	• Perceived stigma • Internalized stigma	Three sub-scales: 1) Public homosexual stigma (10 items) 2) Self homosexual stigma (8 items) 3) Public HIV stigma (7 items)	Liu, H. et al (2009). Assessment of the Chinese version of HIV-and homosexuality-related stigma scales *Sex Transm Infect 2009;**85**:1 65-69*

Target Group	Type of Stigma and Discrimination	Measure Details	Reference
Community members, Thailand, Tanzania, South Africa, Zimbabwe	• Perceived • Enacted	First component: Shame, blame, and social isolation (10 items). Second component: Perceived discrimination (8 items). Third Component: Equity. (5 items).	Genberg et al, 2008: Assessing HIV/AIDS Stigma and Discrimination in Developing Countries. AIDS Behavior 12:772-780
Children affected by HIV, China	• Perceived • Internalized	Perceived public stigma (10 items) Personal stigma (10 items)	Lin, X. et al (2010). Perceived HIV stigma among children in a high HIV-prevalence area in central China: beyond the parental HIV-related illness and death.
Health Providers, China	• Perceived • Enacted • Internalized	Discrimination intent at work (4 items) Prejudiced attitudes (4 items) Opinion about health care for PLHIV (3 items) Internalized shame (3 items) Fear of PLHIV (3 items)	Stein, J. and Li Li (2008). Measuring HIV-related stigma among Chinese service providers: Confirmatory factor analysis of a multidimensional scale. AIDS Behavior 12:789-795