

UNAIDS 2020

REFERENCE

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# Evidence for eliminating HIV-related stigma and discrimination

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Guidance for countries to implement effective programmes to eliminate HIV-related stigma and discrimination in six settings



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# Executive summary

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In December 2017 the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination (Global Partnership) was formed to inspire countries to take action to remove these critical barriers to HIV services. The Global Partnership “creates an opportunity to harness the combined power of governments, civil society, bilateral and multilateral donors, academia and the United Nations to consign HIV-related stigma and discrimination to history” (1).

This report reviews the latest evidence on what works to reduce HIV-related stigma and discrimination through key programmes to reduce stigma and discrimination and increase access to justice in the six settings of focus for the Global Partnership (2). It includes guidance for national governments and key stakeholders on (a) how stigma and discrimination harm; (b) how the stigmatization process operates and how we can stop it; (c) key principles of stigma- and discrimination-reduction efforts; (d) an overview of common intervention approaches; (e) recommendations based on the latest evidence for reducing HIV-related stigma and discrimination in the six settings; and (f) an overview of considerations for monitoring the success of the programmatic interventions recommended for each setting. The six settings are:

- Community.
- Workplace.
- Education.
- Health care.
- Justice.
- Emergency.

The focus on settings is intended to support countries in developing comprehensive responses to eliminate HIV-related stigma and discrimination by articulating how stigma and discrimination operate in each setting, who is affected, and what can be done to address stigma and discrimination based on available evidence and best practice.

The interventions recommended under each setting were drawn from the latest evidence on successful interventions and programmes for reducing HIV-related stigma and discrimination or evidence on the impact of changes in laws and policies on the HIV epidemic. For all settings, particularly those in which the evidence base was lacking or less robust (workplace, justice, emergency), input on best practices was provided by technical experts working in those settings. Highlights of setting specific recommendations are as follows:

In community settings:

- Increase individual-level counselling to mitigate internalized stigma.
- Engage families and households in HIV and key population stigma- and discrimination-reduction activities.
- Implement services and programmes for people living with HIV and members of key populations to protect their health and well-being.

- Engage community leaders and implement programmes and strategies to shift community norms that drive stigma and discrimination.

In workplace settings:

- Provide training to workers on their rights within the workplace and tools and services for redress.
- Implement and enforce workplace policies that promote a healthy environment that is free from HIV and key population stigma and discrimination. Support the development and implementation of such policies applicable across the formal sector.
- Educate workplace communities on HIV, comorbidities and legal literacy to promote positive social norms related to HIV.

In education settings:

- Ensure adolescents have access to youth-friendly HIV services and comprehensive sexuality education.
- Provide educators with the training and institutional support necessary to meet the psychosocial needs of students living with HIV and who are members of key populations and to facilitate an educational environment free from HIV and key population stigma and discrimination.
- Engage families and the wider community in stigma- and discrimination-reduction activities.
- Develop and enforce policies that meet the needs of youth living with HIV or who identify as members of key populations—for example, creating an education sector-wide zero tolerance policy on HIV-related stigma and discrimination, or revising age restrictions related to HIV testing and services.

In health-care settings:

- Integrate paralegals into health facilities to provide on-site guidance and awareness-raising for people living with HIV, key populations, women, girls and other vulnerable populations about their rights and quality standards in accessing services and discrimination-free health care.
- Institute preservice and in-service training on HIV, human rights, key populations, stigma reduction, non-discrimination, gender sensitization and medical ethics for all health facility staff. Routinely assess knowledge, attitudes and practices of health-care workers towards people living with HIV, key populations, women, girls and other vulnerable populations to support health facility administrators to identify and address any issues.
- Ensure universal precaution supplies and post-exposure prophylaxis are always stocked to reduce providers' fears around occupational exposure to HIV, which will in turn reduce avoidance behaviours with people living with HIV.

In justice settings:

- Implement programmes to empower people living with HIV, members of key populations, women, girls and other vulnerable populations with legal literacy and access to redress services.
- Remove laws criminalizing drug use or possession for personal use, all aspects of sex work, sexual orientation, gender identity, and HIV exposure, non-disclosure and transmission.
- Routinely inform and sensitize duty-bearers on the legal, health and human rights aspects of HIV, on relevant national laws, and on the implications for enforcement, investigations and court proceedings.
- Routinely review existing laws, regulations and policies relating to HIV and compare them with global commitments. Address laws and policies that are discriminatory towards members of key populations, women, girls and vulnerable populations as part of the national response to HIV.

In emergency settings:

- Implement programmes and services to reduce internalized stigma and support the needs of people living with HIV, key populations, women, girls and other vulnerable populations in conflict and crisis situations by providing safe access to care and treatment.
- Strengthen capacity of community health workers by ensuring appropriate linkages between communities and formal health systems in emergency settings.
- Implement programmes to prevent, address, monitor and report violence against key populations, women, girls and other vulnerable populations in emergency settings.
- Include provisions for key populations, women, girls and other vulnerable populations in national emergency plans.

For all settings:

- Enable local networks of people living with HIV, key populations, women, girls and other vulnerable populations to monitor the impact of laws and policies on HIV services, advocate for change as needed, and engage in programme and policy development.
- Monitor stigma, discrimination and rights violations experienced by people living with HIV, key populations, women, girls and other vulnerable populations.
- Provide preservice and in-service training for duty-bearers and community leaders on HIV, human rights, key populations, stigma reduction, non-discrimination, gender-sensitization and ethics for working with people living with HIV, key populations, women, girls and other vulnerable populations.



# Introduction

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Globally, we are gaining traction. We have made tremendous progress expanding access to life-saving treatment for HIV, and new infections are declining. Yet, HIV-related stigma and discrimination stand in the way of our goals. Achieving the UNAIDS Fast-Track targets of 90–90–90 (whereby 90% of people living with HIV know their HIV status, 90% of people who know their HIV-positive status are accessing treatment, and 90% of people on treatment have suppressed viral loads) and reducing new HIV infections to fewer than 500 000 per year will remain beyond our grasp if these barriers persist (3). Stigma and discrimination impede HIV services at every step, limiting access to and acceptance of prevention services, engagement in care, and adherence to antiretroviral therapy (4). With HIV prevention tools and access to antiretroviral medicines expanding, we might ask how it is possible that stigma and discrimination could stand in our way. There are three reasons.

First, stigma is persistent and insidious. A stigma is a difference that is distinguished and labelled (5), which then enables a range of discriminatory actions that ultimately deny people full social acceptance, reducing their life chances (6) and fuelling social inequalities. Second, stigma is intersectional. (7). In the context of HIV, the “difference” is often not only whether a person is living with HIV, but also where they live, how much money they have, what colour they are, what gender they are, who they choose to have sex with and in what way, whether they use drugs, whether they are in prison, and whether they are an immigrant, a refugee, a health worker, an educator or a sex worker. Stigmatized social identities overlap, leading to multiple and converging forms of stigma that compound the negative effects of stigma on health and well-being (8, 9). HIV-related stigma has been defined by UNAIDS as negative beliefs, feelings and attitudes towards people living with HIV, groups associated with people living with HIV (e.g. families of people living with HIV), and other key populations at higher risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men, and transgender people.

Discrimination, as defined under international human rights law, is any distinction, exclusion or restriction based indirectly or directly on grounds prohibited under international law, which has the effect or intent of nullifying the recognition, enjoyment or exercise on an equal basis of others of all human rights and fundamental freedoms, in the political, economic, social, cultural, civil or any other field.<sup>1</sup> HIV-related discrimination is therefore any distinction, exclusion or restriction (sometimes referred to as acts or omissions) based indirectly or directly on a person’s real or perceived HIV status. Discrimination in the context of HIV also includes acts and omissions aimed at other key populations and groups at heightened risk of HIV. Discrimination can be institutionalized through existing laws, policies and practices that negatively focus on people living with HIV and marginalized groups, including criminalized populations.

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<sup>1</sup> United Nations Committee on Economic, Social and Cultural Rights general comment no. 20: Non-discrimination in economic, social and cultural rights. Art. 2, Para. 2 of the International Covenant on Economic, Social and Cultural Rights, 2 July 2009, E/C.12/GC/20 (<https://www.refworld.org/docid/4a60961f2.html>).

US. THEM.  
DISEMPOWERED.

Third, stigma and discrimination are forms of power and control enabled by “the broader social, cultural, political and economic forces that structure stigma” (7). They are not just something that one person imposes on another. As such, our response must be multifaceted. In addition to working with individuals, families and communities, we must also work with organizations and institutions. We must strive to change harmful laws and policies and create supportive justice systems.

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**Box 1**  
**Stigma and discrimination can lead to infringements of our basic human rights**

Stigma, where it enables discrimination, can lead to infringements of our human right to live a life free from discrimination, as enshrined in the Universal Declaration of Human Rights and other international and regional human rights treaties. Article 2 states that everyone can claim their rights, regardless of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.

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While launching a global response to eliminate all forms of HIV-related stigma and discrimination may seem daunting, we have a strong foundation on which to build. The political frameworks and commitments to support a large response to stigma and discrimination are in place, including (a) the UNAIDS Fast-Track target to eliminate HIV-related stigma and discrimination by 2020 (3); (b) the Sustainable Development Goals (SDGs) 5, 10 and 16 to reduce gender inequality, reduce inequality within and between countries, and promote just, peaceful and inclusive societies; and (c) the 2016–2021 UNAIDS Strategy and the 2016 United Nations Political Declaration on Ending AIDS, which both include elimination of HIV-related stigma and discrimination as a goal.

Countries have committed to financing the end of AIDS, including investing in the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In 2017 the Global Fund launched the Breaking Down Barriers Initiative, including US\$ 45 million in catalytic funds to 20 countries<sup>2</sup> for intensive support to scale up comprehensive responses to remove human rights-related barriers to HIV, tuberculosis (TB) and malaria services. The interventions recommended for scale-up are based on the seven UNAIDS key human rights programmes to reduce stigma and discrimination and increase access to justice in national HIV responses (see Table 1) (2).

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<sup>2</sup> Benin, Botswana, Cameroon, Côte d’Ivoire, Democratic Republic of the Congo, Ghana, Honduras, Indonesia, Jamaica, Kenya, Kyrgyzstan, Mozambique, Nepal, Philippines, Senegal, Sierra Leone, South Africa, Tunisia, Uganda, Ukraine.

**Table 1.**

Examples of interventions by UNAIDS key human rights programmes

UNAIDS key human rights programme	Intervention examples
<b>1: reducing stigma and discrimination</b>	<p>Raising awareness of stigma and its harmful consequences through media campaigns (e.g. radio, television, edutainment), contact strategies (e.g. positive interactions between people living with HIV and the general public or duty-bearers), and engagement with religious and community leaders</p> <p>Inclusion of non-discrimination as part of institutional and workplace policies</p> <p>Measurement of HIV-related stigma through the People Living with HIV Stigma Index</p> <p>Peer mobilization and support developed for and by people living with HIV aimed at promoting health, well-being and human rights</p>
<b>2: increasing access to HIV-related legal services</b>	<p>Legal information and referrals</p> <p>Legal advice and representation</p> <p>Alternative or community forms of dispute resolution</p> <p>Engaging religious or traditional leaders and traditional legal systems (e.g. village courts) with a view to resolving disputes and changing harmful traditional norms</p> <p>Strategic litigation</p>
<b>3: monitoring and reforming laws, policies and regulations</b>	<p>Review of laws and law-enforcement practices to see whether they impact on the HIV response positively or negatively</p> <p>Assessment of access to justice for people living with or vulnerable to HIV</p> <p>Advocacy and lobbying for law reform</p> <p>Engagement of parliamentarians, ministers, and religious and traditional leaders</p> <p>Promotion of enactment and implementation of laws, regulations and guidelines that prohibit discrimination and support access to HIV prevention, treatment, care and support</p>
<b>4: enhancing legal literacy</b>	<p>Awareness-raising campaigns that provide information about rights and laws related to HIV through media (e.g. television, radio, print, internet)</p> <p>Community mobilization and education</p> <p>Peer outreach</p> <p>Telephone hotlines</p>
<b>5: sensitizing lawmakers and law-enforcement agents</b>	<p>Sensitization of police regarding HIV and how it is and is not transmitted</p> <p>Importance of reaching out to and accessing populations at risk and appropriately addressing domestic and sexual violence cases in the context of HIV</p> <p>Negative consequences of illegal police activity on the HIV response and justice</p> <p>Sensitization sessions for parliamentarians, personnel of ministries of justice and interior, judges, prosecutors, lawyers, and traditional and religious leaders on legal, health and human rights aspects of HIV, and relevant national laws and the implications for enforcement, investigations and court proceedings</p> <p>HIV in the workplace programme for lawmakers and enforcers</p>
<b>6: training health-care providers on human rights and medical ethics related to HIV</b>	<p>Human rights and ethics training conducted with health-care providers, administrators and regulators and health-care providers in training at medical and nursing schools</p>
<b>7: reducing discrimination against women in the context of HIV</b>	<p>Strengthening the legal and policy environment to ensure laws protect women and girls from gender inequality and violence</p> <p>Efforts to reform domestic relations and domestic violence laws and law enforcement where these fail to protect women or create barriers to HIV services</p> <p>Efforts to reform property, inheritance and custody laws to ensure equal rights for women, children and caregivers affected by HIV</p> <p>Age-appropriate sexuality and life-skills education programmes that also seek to reduce gender inequality and gender-based violence</p> <p>Programmes to reduce harmful gender norms that put women, girls, men and boys at risk of HIV infection, including capacity development of civil society groups working for women's rights and gender equality</p> <p>Programmes to increase access to education and economic empowerment opportunities for women living with or vulnerable to HIV infection</p> <p>Integrated health services with a well-functioning referral system, including care for survivors of rape and post-exposure prophylaxis</p>

The recent establishment of the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination (Global Partnership), initiated by the Global Network of People living with HIV (GNP+), the Joint United Nations Programme on HIV/AIDS (UNAIDS), UN Women and the United Nations Development Programme (UNDP), galvanizes this momentum. The Global Partnership “creates an opportunity to harness the combined power of governments, civil society, bilateral and multilateral donors, academia and the United Nations to consign HIV-related stigma and discrimination to history” (1).

This guidance document reviews the latest evidence on what works to reduce HIV-related stigma and discrimination in the six settings of focus for the Global Partnership. It includes guidance for national governments and key stakeholders on (a) how stigma and discrimination harm; (b) how the stigmatization process operates and how we can stop it; (c) key principles of stigma- and discrimination-reduction efforts; (d) an overview of common intervention approaches; (e) recommendations based on the latest evidence for reducing HIV-related stigma and discrimination in the six settings; and (f) an overview of considerations for monitoring the success of the programmatic interventions recommended for each setting. The six settings are:

- Community.
- Workplace.
- Education.
- Health care.
- Justice.
- Emergency.

The focus on settings is intended to support countries in developing comprehensive responses to stigma and discrimination and other human rights-related barriers to HIV and other health services by articulating how stigma and discrimination operate in each setting, who is affected, and what can be done to address stigma and discrimination based on available evidence and best practice.

## **How the UNAIDS key human rights programmes and the six settings fit together**

The UNAIDS human rights programmes define the seven key programmes in which interventions are needed to reduce stigma and discrimination and increase access to justice generally. Interventions, however, are often developed for and piloted in the six settings listed above, and the evidence on what works is often specific to these settings. Interventions may address one or more key human rights programmes (typically more than one), which combined are a mutually reinforcing package.

The updated guidance on interventions to eliminate HIV-related stigma and discrimination was based on a review of the evidence on what works, and input from technical experts when evidence was lacking. Therefore, the new guidance is organized by the six settings. While some human rights programmes need to be implemented in all settings, others are relevant only for some settings (see Table 2). It is important to note that the recommendations for interventions in the six settings of focus for the Global Partnership do not replace the UNAIDS human rights programmes; rather, they provide a focus to guide intervention development, implementation and monitoring for countries.

**Table 2.**

Relationships between the UNAIDS human rights programme areas and the six settings of the Global Partnership for Action to Eliminate all Forms of HIV-related Stigma and Discrimination

UNAIDS human rights programmes	Settings for implementing human rights programmes interventions
<b>1: reducing stigma and discrimination</b>	All settings: community, workplace, education, health care, justice, emergency
<b>2: increasing access to HIV-related legal services</b>	Community, health care, justice, emergency <sup>1</sup>
<b>3: monitoring and reforming laws, policies and regulations</b>	Community Advocating for changes and monitoring impact of laws, policies and regulations Justice, workplace, education, health care, making and implementing changes
<b>4: enhancing legal literacy</b>	Community, health care, justice
<b>5: sensitizing lawmakers and law-enforcement agents</b>	Justice, education, workplaces
<b>6: training health-care providers on human rights and medical ethics related to HIV</b>	Health care, education, workplaces
<b>7: reducing discrimination against women in the context of HIV</b>	All settings: community, workplaces, education, health care, justice, emergency

<sup>1</sup> Human rights and gender programming in challenging operating environments (COEs): guidance brief. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria; 2017 ([https://www.theglobalfund.org/media/6346/fundingmodel\\_humanrightsgenderchallengingoperatingenvironments\\_guidance\\_en.pdf?u=637153281250000000](https://www.theglobalfund.org/media/6346/fundingmodel_humanrightsgenderchallengingoperatingenvironments_guidance_en.pdf?u=637153281250000000)).

As an example, let us consider human rights programme 2. Figure 1 provides examples of evidence-based interventions that could be implemented in the community, health-care and justice settings to increase access to HIV-related legal services.

Figure 1. Increasing access to HIV-related legal services by setting: intervention examples



## How stigma and discrimination harm

People living with HIV encounter a range of stigmatizing experiences, including avoidance behaviours (e.g. refusal to share food, hold hands or sit nearby), gossip and verbal abuse (e.g. name-calling, use of derogatory language), and social rejection (e.g. shunning from social events, views ignored, loss of respect and standing). Experiences of discrimination may include physical abuse, denial of health services, denial or loss of jobs, denial of housing, and arrest where HIV transmission or specific behaviours are criminalized (10, 11). Taken together, all of these forms of stigma and discrimination combine to impede access to HIV services and to reduce medication adherence and retention in care, often leading to poor physical and mental health (10–13). People living with HIV often face multiple intersecting stigmas related to other stigmatized health conditions (e.g. TB) or identity (e.g. race, economic background, gender, occupation, sexuality). People who experience other stigmatized conditions and identities are described as either key or vulnerable populations, depending on their centrality to the epidemic's dynamics or response (9, 14).

Key populations are most likely to be exposed to HIV. UNAIDS considers men who have sex with men, sex workers, transgender people, people who inject drugs, and people in prison and other incarcerated populations as the main key population groups (15, 16).

In many settings, key populations are criminalized and face heightened stigma and discrimination as a result. In justice settings, criminalization of certain behaviours (e.g. drug use, non-disclosure of HIV status) or occupations (e.g. sex work) can fuel stigma and discrimination towards people living with HIV and key populations by supporting prejudicial attitudes and actions among law enforcement (e.g. arresting people who use drugs at harm-reduction sites, coercion of sex workers to provide free sex to police officers to avoid arrest), placing key populations at heightened risk of HIV infection. These laws infringe the human rights of key populations and their ability to access justice and health services. A discriminatory legal environment hinders key populations from engaging with harm-reduction services and in behaviours that reduce the risk of HIV acquisition because of fear of arrest, harassment or other negative responses by law enforcement (17–23).

For example, in some countries sex workers can be arrested for possessing multiple condoms, as it can serve as "evidence" that they are engaging in sex work. This can result in sex workers no longer carrying condoms with them, which decreases their use of condoms when engaging in sex work, making them more vulnerable to HIV (19, 20).

People living with HIV in prison may not receive the care they need to adhere to treatment. In addition, they are often subjected to overcrowded and unsanitary conditions, which can impact further on their immune system or increase their risk of exposure to TB (24–26).

Members of key populations often grapple with stigma regardless of their HIV status, which contributes to discriminatory treatment in health-care settings (27). A study in South Africa and Zambia found that the majority of health workers interviewed held negative attitudes towards key populations (28). Studies in Botswana, Malawi and Namibia found that men who have sex with men were twice as likely to be afraid to seek health care and over six times as likely to be refused services than heterosexual people (29). Due to stigma and discrimination, members of key populations may avoid health-care settings altogether or choose to withhold vital information about themselves (e.g. drug use, sexual health) if they do seek services, which may result in inadequate care and treatment (27, 30, 31).

"WIDESPREAD STIGMA AND DISCRIMINATION, STATE AND NON-STATE VIOLENCE AND HARASSMENT, RESTRICTIVE LAWS AND POLICIES, AND CRIMINALIZATION OF BEHAVIOURS OR PRACTICES PUT KEY POPULATIONS AT HEIGHTENED RISKS AND UNDERMINE THEIR ACCESS TO SERVICES" (KEY POPULATIONS. GENEVA: GLOBAL FUND TO FIGHT AIDS, TUBERCULOSIS AND MALARIA; 2019).

For people who are able to seek testing and treatment, stigma and discrimination present additional barriers to maintaining good health. A lack of support from family and community members can impede adherence to treatment and interfere with HIV management. This is particularly notable for transgender people living with HIV. One study observed that transgender women living with HIV in the United States of America were half as likely to take at least 90% of their antiretroviral medication than women living with HIV who did not identify as transgender (32).

As demonstrated, key populations may experience heightened intersecting stigma and discrimination across settings. To this end, responses to HIV-related stigma and discrimination should not focus narrowly on people living with HIV but instead should look at the forms of stigma and discrimination experienced by groups vulnerable to HIV and how it affects their ability to prevent infection and access HIV-related services, treatment and care (33).

Vulnerable populations are subject to societal pressures, social circumstances or structural inequalities and discrimination that may place them at increased risk of exposure to HIV and other negative health outcomes. Vulnerable populations vary by country and context, but often include women and girls, adolescents living with HIV, older people living with HIV, refugees, displaced people and migrants, people with disabilities, people living with TB, populations that experience racism, and people living in rural areas.

Like key populations, vulnerable populations may be hesitant to be tested for HIV or to seek treatment and care for HIV. This may be due to concerns of mistreatment. For example, health workers may treat women and girls living with HIV as though they cannot and should not engage in sexual relationships or have children, sometimes denying them family planning services (34). This can result in coerced or forced sterilization or abortion (19, 34–41). People living with TB may avoid health settings in general because they are concerned they will be met with HIV-related stigma, regardless of their HIV status (42).

Confidentiality is another notable concern, as unwanted disclosure of HIV status can have severe consequences for some vulnerable populations. For example, in rural communities, where social structures are closely knit and access to HIV services and resources is limited, it is more challenging for people to access HIV services confidentially. Providing HIV services in such communities may also lead to secondary stigma experienced by providers. Depending on community attitudes towards people living with HIV, this can serve as a direct deterrent for people to seek or otherwise engage in HIV testing and treatment. A study in rural South Africa found that even when access to antiretroviral therapy was provided, people would not engage due to fear of HIV-related stigma and discrimination. Concerns over health providers gossiping appeared to be particularly notable in such settings (43).

Vulnerable populations may face notable barriers to accessing health care and other settings. Systematic racism and discrimination can serve as a formidable barrier and deterrent for populations that experience racism (e.g. minorities, migrants, indigenous populations) to engage in HIV services and programmes (7, 44, 45). The needs of people living with disabilities are often neglected such that health-care facilities may not be physically accessible or equipped to provide sufficient care for people living with disabilities and HIV (46, 47).

Within justice settings, the health and well-being of vulnerable populations living with HIV is not always upheld. Discriminatory laws can also present challenges for vulnerable populations. There are still over 40 countries where a person's HIV status can affect their ability to seek asylum or to migrate there (48). Consequently, a refugee, displaced

person or migrant may be more hesitant to interact with government services, including social support and health-care services, for fear of being deported. Even in settings where there are no such restrictions, HIV-related stigma and discrimination can impact on the health and well-being of refugees, displaced people and migrants. An assessment of migrants living with HIV in the United Kingdom of Great Britain and Northern Ireland observed that stigma impacted on the respondents' sense of personal safety and prompted them to cope in part by avoiding engagement with health and social services (49).

In general, the repercussions of HIV-related stigma and discrimination are more severe for vulnerable populations. For example, women and girls known to be living with HIV may face rejection from their partners and families (34, 50, 51). In some contexts, this could leave them in a position of economic insecurity and threaten their survival (51). Women and girls may also be subject to violence from their partners, families or communities as a result of their HIV status (34, 50, 52). Experiences of stigma and discrimination can be damaging to the self-esteem and mental well-being of members of vulnerable populations, and may lead to depression or suicidal thoughts or attempts (46, 50, 53, 54). A study in the United States found that loneliness and HIV-related stigma were chief among the reasons for depression among older people living with HIV (54).

Given the heightened stigma and discrimination faced by key and vulnerable populations, it is critical that countries foster supportive legal environments and develop appropriate programmes and strategies to reach and engage key populations, women, girls and other vulnerable populations in HIV prevention, care and treatment services. When planning their HIV responses, including the response to HIV-related stigma and discrimination, countries should identify (based on evidence, surveillance data, consultations, and in partnership with women, girls and other vulnerable communities) the specific populations that are critical to their epidemic and HIV response based on the epidemiological and social context.

## **How the stigmatization process works in the context of HIV**

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A critical first step in developing an appropriate response to HIV-related stigma and discrimination is understanding how the stigmatization process works. Such understanding will enable countries to target programmes to either halt the process or lessen the negative impacts of stigma experienced by people living with HIV, key populations, women, girls and other vulnerable populations. The process can be broken down into three main components: drivers and facilitators, "stigma marking" and stigma manifestations (Figure 2).

Drivers or causes of stigma are negative (13); they include fear of infection through contact that holds no risk of HIV transmission (e.g. touching, kissing), concerns about productivity due to poor health, and social judgement and blame. Facilitators may be positive or negative (55). For example, the presence or absence of protective supplies and occupational safety standards in health facilities can minimize or worsen stigmatizing avoidance behaviours (e.g. double-gloving) by health workers towards people living with HIV (56).

Drivers and facilitators influence whether a stigma is applied to people or groups (stigma marking) related to their HIV status or other perceived difference, such as race, class, socioeconomic status, gender, sexual orientation or occupation. Intersecting stigma occurs when people are "marked" with multiple stigmas. Once a stigma is applied, it manifests in a range of stigma experiences (lived realities) and practices (beliefs, attitudes, actions).



Stigma experiences include discrimination, which refers to stigmatizing actions or omissions (e.g. failure to include ramps for people with disabilities) that are prohibited under international human rights law (e.g. losing housing or a job because of one's HIV status, or a woman being physically assaulted by her partner because of her HIV status). Experienced stigma refers to stigmatizing behaviours that fall outside the purview of international human rights law, such as double-gloving or avoiding frequenting someone's business.

Another stigma experience is internalized stigma (self-stigma), which occurs when a person living with HIV agrees with the negative attitudes associated with HIV and accepts them as applicable to themselves. Perceived stigma, which refers to perceptions about how stigmatized groups are treated in a given context, and anticipated stigma, which refers to expectations of bias being perpetrated by others if their health condition becomes known, are also stigma experiences.

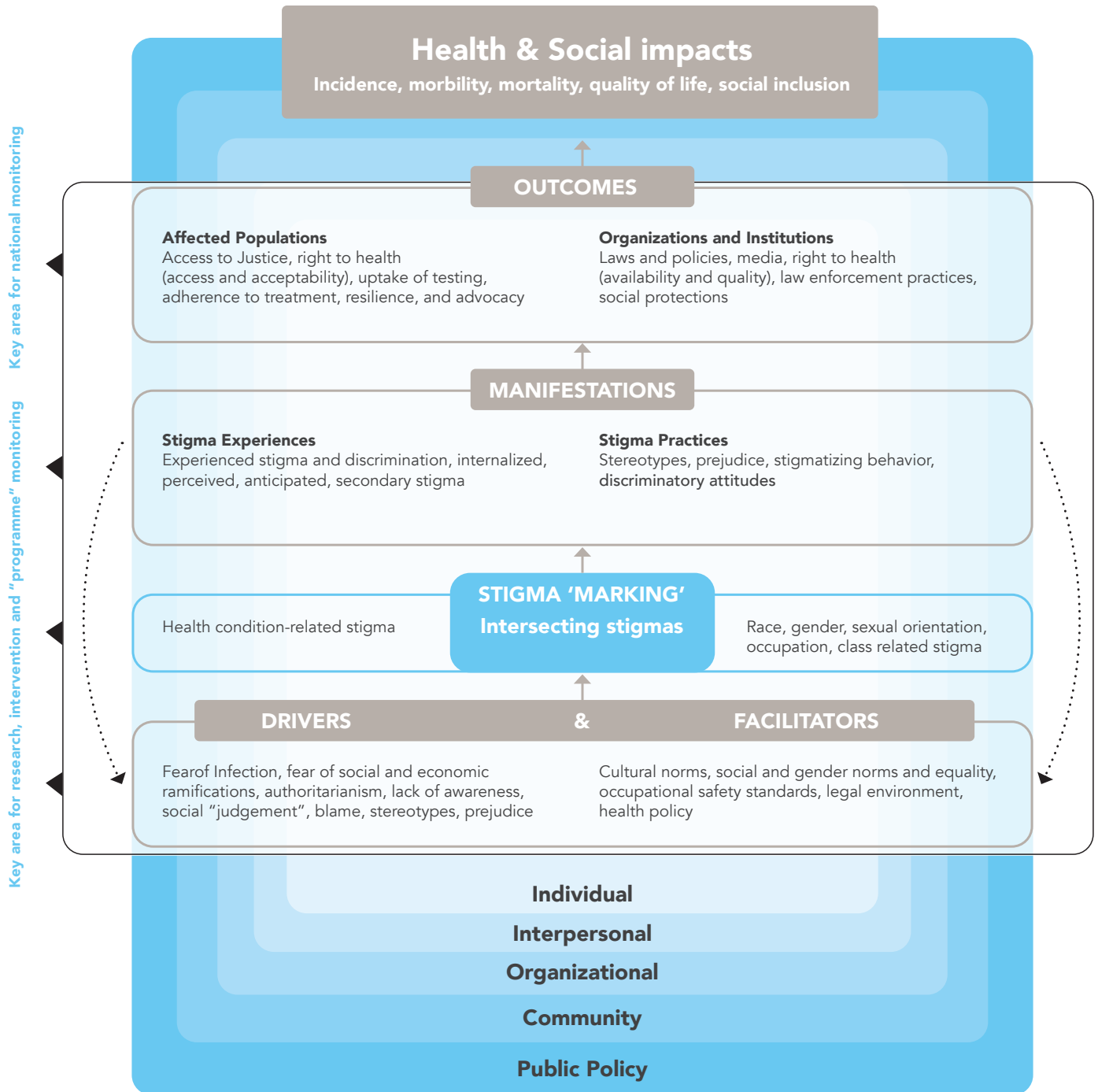
Secondary stigma refers to the experience of stigma by family or friends of members of stigmatized groups, or among health-care providers who give care to members of stigmatized groups (14).

Stigma practices include stereotyping, prejudice, and stigmatizing attitudes and behaviours. Stereotyping and prejudice act as both drivers and manifestations, as they fuel and are reinforced by the stigmatization process.

These manifestations (stigma experiences and practices) influence a number of outcomes for affected populations, including access to justice, access to and acceptability of health-care services and other support (e.g. food assistance, social protection measures), uptake of testing, adherence to treatment, resilience (or the power to challenge stigma), and advocacy. Stigma manifestations also influence outcomes for organizations and institutions, including laws and policies, the availability and quality of health services, law-enforcement practices, and social protections (14).

HIV-related stigma and discrimination can occur at many different levels, including among individuals, between family members and peers (interpersonal), within organizations (e.g. health facilities, workplace, schools, police stations) and communities, and in public policy (e.g. discriminatory laws and policies) (see Figure 2). This means that national responses to stigma and discrimination must target the drivers, facilitators and manifestations of stigma at multiple levels and with multiple actors, such as people living with HIV, key populations, families, community members, health workers, employers, law-enforcement agents and policy-makers (10, 55, 57, 58).

Figure 2. The Health Stigma and Discrimination Framework.



Reprinted from Stangl AL, Earnshaw VA, Logie CH, Van Brakel W, Simbayi LC, Barré I, et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Med. 2019;17:31.

## Using the Health Stigma and Discrimination Framework

The Health Stigma and Discrimination Framework can be used to inform intervention development. Ideally, we want to stop stigma marking from occurring, so interventions often focus on the drivers and facilitators of stigma. For example, mass communication efforts may be used to help populations better understand a health condition and dispel myths about how a disease is transmitted and who is at risk. Similarly, new policies could be developed and implemented in health-care facilities to ensure people living with HIV are not identified in any way, such as through the use of certain-coloured files. While we would like to prevent stigma from being applied, we also need to be prepared to deal with the manifestations of stigma. This could include psychosocial support for people living with HIV or legal aid to cope with discrimination. Interventions could also focus on specific key or vulnerable populations that face heightened stigma and discrimination in a given context, such as women and girls. Efforts could include training for health-care providers, community workers or police officers to overcome stereotypes and stigmatizing attitudes, or developing new laws or policies to protect against discrimination.

The Framework can also point to areas where clinicians, programme implementers and policy-makers can focus greater attention to better meet the needs of and improve health outcomes among their clients, communities and societies more broadly. Implementation science approaches can advance how we tailor and apply the framework to guide HIV-related stigma- and discrimination-reduction interventions and policies—for example, in defining who the focal audience is for change, which specific drivers and facilitators of HIV-related stigma and discrimination should be addressed, which intervention or policy components are appropriate to address them, and how to measure change in specific outcomes over time.

## Designing interventions

While interventions need to be adapted for specific settings and populations, there is a wealth of evidence on what works to reduce HIV-related stigma and discrimination, from which a few stigma-reduction principles have emerged (55, 59–61). These principles are detailed in Table 3 and reviewed briefly here. First, it is critical that all efforts are led by, or meaningfully involve, people living with HIV, key populations, women, girls and other vulnerable populations. Addressing the root causes or drivers of stigma and the key concerns of affected populations is also important. Where possible, interventions should address the multiple, intersecting stigmas that people living with or at risk of HIV face. A number of tools are available that can be adapted for use in multiple contexts. The Understanding and Challenging HIV Stigma Toolkit is one such example (62); others can be found in Annexes 1–5. When working with groups to shift underlying norms, stereotypes and taboos, it is critical to use participatory methods that allow a safe space for sharing and discussing. To be most impactful, a package of interventions should be used with multiple stakeholders across levels (e.g. individual, interpersonal, organizational), designed in conjunction with the populations in question. Sufficient planning is needed to allow time to engage with and garner the support of key gatekeepers (e.g. religious and community leaders, government stakeholders). Special care should be taken when planning interventions to reduce stigma and discrimination to ensure the intervention and its components do not unintentionally increase stigma and discrimination. For example, in some contexts, promoting HIV-specific food assistance actually increased stigma, as people carrying food rations were labelled as “HIV-positive” and stigmatized by community members (63).

**Table 3.**

Stigma and discrimination-reduction principles

Stigma-reduction principle	Description
<b>People living with HIV, key populations, women, girls and other vulnerable populations should lead or be meaningfully engaged</b>	Stigma- and discrimination-reduction efforts work best when interventions are led by or actively involve members of affected communities, including people living with HIV, key populations, women, girls and other vulnerable populations. Community members are best positioned to drive programming that is informed by their lived experiences and challenges with HIV-related stigma and discrimination.
<b>Use or promote approaches that address the drivers, facilitators and manifestations of stigma and discrimination and the key concerns of affected populations</b>	Interventions should directly address the drivers and facilitators, ideally in combination, to halt the stigmatization process. Interventions to mitigate the manifestations of stigma and discrimination and address the needs and concerns of affected populations are also necessary to effectively reduce HIV-related stigma and discrimination. Intervention approaches may be combined into one intervention or multiple interventions may be implemented, but all of these aspects of the stigmatization process need to be addressed. Examples of drivers include lack of awareness and knowledge of HIV, including stigma and discrimination and their harmful effects, or fears and misconceptions of acquiring HIV. Facilitators may include laws that criminalize HIV transmission, specific behaviours or key population identities. Manifestations may include experienced and internalized stigma and discrimination.
<b>Address intersectional stigma and discrimination</b>	Key populations such as men who have sex with men, transgender people, people who use drugs, and sex workers often face stigma and discrimination in addition to that related to HIV. Race, gender, economic status and other health issues, such as living with TB or a disability, can compound and amplify the stigma experienced by people living with HIV. For example, interventions to reduce HIV stigma in contexts where drug use is the main driver of transmission need to address the stigma associated with drug use, as these stigmas are so interlinked.
<b>Take advantage of existing tools</b>	There are a number of useful tools and resources for mitigating or monitoring HIV-related stigma and discrimination that are adaptable to different contexts and settings; many of these tools are referenced throughout this document.
<b>Use participatory methods</b>	Participatory methods (e.g. games, role plays, discussions) are optimal in reducing HIV-related stigma and discrimination, as they improve knowledge and attitudes in a non-judgemental and approachable manner.
<b>Use multiple intervention strategies with multiple stakeholders across multiple socioecological levels (individual, interpersonal, community, organizational, public policy)</b>	A range of activities (e.g. empowerment of people living with HIV, training for health workers, mass communication, law and policy reform) are often necessary to meaningfully and sustainably address HIV-related stigma and discrimination. Stakeholders are encouraged to work together, taking on the stigma- and discrimination-reduction approaches most suitable for their organization; for example, national governments may lead on revising laws and policies, while civil society may support these revisions with evidence-based advocacy and inputs from the community. Simultaneously, community-based organizations can take the lead on implementing mass media campaigns to shift harmful social norms, implementing stigma-reduction and human rights-based training for educators and health workers, or providing empowerment and social support services for people living with HIV and key populations to overcome anticipated and internalized stigma.
<b>Allow time for planning to ensure success (e.g. six months)</b>	The most promising approaches require time before starting to engage gatekeepers and opinion leaders, conduct formative assessments on difference audiences, train teams, and form new partnerships. Activities increase buy-in and inspire cooperation; allowing time for these activities is critical to the success of stigma- and discrimination-reduction interventions.

Sources:  
 Reducing HIV stigma and discrimination: a critical part of national AIDS programmes—a resource for national stakeholders in the HIV response. Geneva: Joint United Nations Programme on HIV/AIDS; 2007.  
 Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? J Int AIDS Soc. 2009;12:15.  
 Stangl A, Carr D, Eckhaus T, Brady L, Nyblade L, Claeson M. Tackling HIV-related stigma and discrimination in South Asia. Washington, DC: World Bank; 2010.

Six approaches to stigma- and discrimination-reduction are commonly used, often in combination with one another (55). These include information-based, skills-building, counselling and support, contact, structural interventions and biomedical interventions (see Table 4).

**Table 4.**

Overview of intervention approaches

Intervention approach (key stigma domain addressed)	Description	Example
<b>Information-based (drivers)</b>	Providing information on HIV and HIV-related stigma	Brochures delivered by community leaders containing information about how HIV is and is not transmitted and what stigma is and why it is harmful (64)
<b>Skills-building (drivers and facilitators)</b>	Activities to enhance skills of communities affected by HIV and duty-bearers (e.g. police officers, health workers, educators)	Participatory learning sessions with health workers, police officers and teachers on stigma, human rights and current HIV science, and how to provide culturally competent services for people living with HIV and key populations (65–69) Empowering communities to design and implement stigma-reduction programmes (70)
<b>Counselling, support (manifestations)</b>	Supportive services for people living with HIV and key populations	Peer-led support groups with women living with HIV to overcome internalized and anticipated stigma (71) One-to-one counselling services for young people living with HIV (72)
<b>Contact (drivers and manifestations)</b>	Interactions between people living with HIV and the general public or key duty-bearers (e.g. health-care workers, police officers)	Networks of sex workers living with HIV giving roses to health-care providers and police officers who treated them kindly to thank them and encourage continued support (70) Young people living with HIV co-facilitating a training session with educators on how to approach sexuality education in a sensitive manner for young people living with HIV (68)
<b>Structural (facilitators)</b>	Activities aimed at removing, reducing or improving structural factors that influence the stigmatization process, such as laws that criminalize HIV, hospital or workplace policies that institutionalize discrimination of people living with HIV; or lack of supplies to allow health-care workers to practice universal precautions	Strategic litigation to expand jurisprudence around discriminatory practices in the context of HIV (61) Revising or removing harmful laws (e.g. decriminalizing HIV transmission) (61) Developing protective laws (e.g. legalizing syringe-exchange programmes) (61)
<b>Biomedical (facilitators)</b>	Universal testing and treatment approaches, free access to pre-exposure prophylaxis, and other interventions	Making access to antiretroviral therapy free and universal to all people living with HIV, including in humanitarian and emergency settings (73–75)

Based on Stangl AL, Lloyd JK, Brady LM, Holland CE, Baral S. A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? J Int AIDS Soc. 2013;6(3 Suppl. 2):18 734.

# Tackling HIV-related stigma and discrimination in six settings

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HIV-related stigma and discrimination can manifest differently across settings and may require different approaches and considerations when intervening (76, 77). This guidance document includes setting-specific discussions, interventions, case studies and recommendations for eliminating HIV-related stigma and discrimination.

## **Basis for recommendations in each setting**

The interventions recommended under each setting were drawn from the latest evidence on successful interventions and programmes for reducing HIV stigma and discrimination as reported in recent systematic reviews, including a review of interventions to reduce HIV stigma and discrimination (55); a review of intervention to address self-stigma or internalized stigma (78); a review of multilevel stigma-reduction interventions (60); and a review of selected human rights programmes to improve HIV outcomes (61). Evidence on the impact of changes in laws and policies on the HIV epidemic was also considered. Additional evidence from peer-reviewed and grey literature was gathered through a targeted literature search by setting. The successful interventions identified are included in Annexes 1–5. It should be noted that the intervention examples presented in this report are not an exhaustive representation of intervention options but rather options that reflect current knowledge and best practice. In addition, the literature reviewed focused mainly on interventions to reduce HIV stigma and discrimination. While intersecting stigma and discrimination were considered in each setting, the recommendations are based mainly on evidence for reducing HIV stigma and discrimination. For all settings, including those for which the evidence base was lacking or less robust (workplace, justice, emergency), input on best practices was provided by technical experts working in those settings.

# Community settings

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In this document community settings are made up of people and households within a shared geographical area. Communities are also home to institutions such as workplaces, schools and health facilities. Shared environments are common sources and facilitators of social norms and practices, including HIV-related stigma and discrimination. In community settings, HIV-related stigma and discrimination can manifest through subtle gestures (e.g. refusing to share food or utensils with people living with HIV) or more overt actions (e.g. verbal abuse towards, gossip about, rejecting or shunning a person living with HIV). The social judgement of household and community members can result in internalized stigma among people living with HIV or anticipated stigma among people who think they may be living with HIV. Such experiences may prompt self-isolation and deter disclosure and engagement with HIV testing, care and treatment services, which in turn can result in harm to a person's mental and physical health and well-being (79–82).

Families and households may be subject to HIV-related stigma and discrimination through association. This is particularly relevant in contexts where a family with a member living with HIV is held accountable for the behaviour of its members and is collectively met with HIV-related stigma and discrimination. As such, a family may be less supportive of a member disclosing their HIV-positive status and seeking health-care services (79, 83, 84). Stigma and discrimination in community settings can be related to HIV as well as key and vulnerable population identities, including gender. This intersecting stigma and discrimination can present key populations, women, girls and other vulnerable populations with additional challenges and barriers to maintaining their health and well-being (84). For example, among communities of men who have sex with men, those living with HIV may be ostracized and isolated from those who are not HIV-positive (84).

On the other hand, a non-stigmatizing, non-discriminatory community environment can allow opportunities for HIV-related services and support systems to be more available and accessible to people living with or at risk of HIV. For example, household members may serve as caregivers or treatment supporters, taking an active role in ensuring treatment success. This support can help mitigate an individual's internalized and anticipated stigma (79–82, 85).

Community-level interventions should be implemented not only broadly but also directly within specific communities that are influential in reinforcing or shifting norms and practices (e.g. faith-based, spiritual, women's groups, youth groups) and among influential community leaders. For example, faith-based and spiritual organizations often influence social norms, including how people living with or thought to be living with HIV are treated in communities (85).

## **Intervention examples and recommendations**

Annex 1 presents 28 studies that assessed interventions to reduce HIV-related stigma and discrimination in community settings. Box 3 presents a case study of one of these intervention studies. The majority of interventions focused on people living with HIV or members of the general public; other interventions focused on community leaders, members of key populations, and caregivers of people living HIV.

The majority of interventions were information-based or skills-building in nature; other interventions involved contact with people living with HIV, counselling and support, biomedical considerations, and structural components. All interventions were found to reduce HIV-related stigma. In some cases, reduction of stigma was exhibited through reductions in internalized stigma or through improved attitudes, behaviours or knowledge.

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## **Box 2**

### **Community-based intervention to reduce HIV stigma in South Africa**

A study evaluated a community-based intervention to reduce experience of stigma among people living with HIV and perpetration of stigma by people close to people living with HIV in North West Province, South Africa (86). The five-month intervention entailed three different components:

- A two-day workshop with people living with HIV, which included presentations and activities on understanding HIV stigma, assessing personal strengths, and managing disclosure.
- A series of three-day workshops for each of the following groups: partners, older children, family members, friends, spiritual leaders and community members. These workshops were led by one person living with HIV and one person not living with HIV and focused on understanding HIV stigma and the relationships of people living with HIV and people living close to them.
- Empowering participants to design and implement an HIV stigma-reduction programme within their community, with support from facilitators.

One pre-test survey and four post-test surveys were completed over the course of the year with people living with HIV and people living close to people living with HIV in urban and rural settings. Significant reductions in experienced stigma and perpetration of stigma were observed in both settings. The evaluation team concluded that this intervention was a useful HIV stigma-reduction tool for communities and encouraged future application of this approach while maintaining the basic tenets and incorporating several recommendations.

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**Table 5.**

Recommendations for community settings

Level (focus populations)	Recommendations
<b>Individual (people living with HIV, members of key populations)</b>	<p>Increase number and accessibility of support and peer groups as a fundamental part of HIV service provision to address internalized and experienced stigma.</p> <p>Provide mental health services to reduce internalized stigma and increase self-esteem, self-efficacy, coping skills and quality of life.</p> <p>Train key populations, women, girls and other vulnerable populations to know what constitutes discrimination so they can assert their rights (e.g. to housing and employment) and access justice when needed.</p>
<b>Interpersonal (family members, peers, partners)</b>	<p>Raise awareness and knowledge among families of adults and young people living with HIV about how HIV is and is not transmitted in order to reduce stigmatizing avoidance behaviours, and about non-stigmatizing ways to support family members living with HIV (e.g. adherence support strategies, supported disclosure to trusted family members and peers).</p>
<b>Organizational (advocacy organizations, networks of people living with HIV, health facilities, community-based organizations, nongovernmental organizations)</b>	<p>Implement programmes to strengthen skills and create spaces for key populations, women, girls and other vulnerable populations to meaningfully engage, influence, advocate and participate in decision-making for programme development.</p> <p>Mobilize key populations, women, girls and other vulnerable populations to develop, implement and evaluate strategies for promoting health, well-being and human rights among key and vulnerable populations.</p> <p>Ensure good-quality support services for people who experience stigma manifestations (e.g. gender-based violence, discrimination, experienced stigma) are available, acceptable and accessible through developing sufficient infrastructure, training staff, and addressing barriers to services uptake (e.g. location of services, concerns around confidentiality, welcoming staff).</p>
<b>Community (general public, opinion leaders, families of people living with HIV)</b>	<p>Implement programmes that challenge drivers of stigma and discrimination among the public and foster supportive communities.</p> <p>Use mass communication strategies, social media campaigns, advertising campaigns, and education-entertainment (“edutainment”).</p> <p>Work with community and opinion leaders (e.g. faith leaders, women’s groups, local leaders, celebrities).</p> <p>Use contact strategies that allow for interaction between key populations, women and girls and other vulnerable populations and members of the broader community.</p> <p>Implement stigma-reduction programmes that use cultural and religious mediums delivered through large public events, combined with advocacy and engagement led by key populations.</p> <p>Implement programmes to reduce harmful gender norms that put women, girls, men and boys at risk of HIV infection, including capacity development of civil society groups working for women’s rights and gender equality.</p>
<b>Public policy (local and national duty-bearers)</b>	<p>Routinely review and revise policies and practices in the community to ensure they protect against discrimination of key populations, women, girls and other vulnerable populations.</p> <p>Routinely measure HIV-related stigma in the community using qualitative assessments (e.g. focus-group discussions with representatives of people living with HIV and the broader community) and quantitative data collection (e.g. Demographic and Health Survey, People Living with HIV Stigma Index) to guide development and implementation of programmes to reduce stigma and discrimination.</p> <p>Establish a national-level monitoring system to capture stigma, discrimination and rights violations experienced by people living with HIV and key populations for support and redress.</p>

# Workplace settings

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The majority of people living with HIV globally are of working age (15 years and older) and, with proper care and support, have the potential to be valuable members of the workforce for the duration of their working lives (87, 88). Workplace settings comprise all settings in which workers work, including formal (traditional wage employment) and informal (e.g. street vending, sex work, house cleaning) economies. The formal economy includes employment in both the private and public sectors. People living with HIV are three times as likely to be unemployed as people in the general population (89). Likewise, some key populations, women and other vulnerable populations (e.g. transgender people, poor women, migrants) are excluded from work in the formal economy and must often engage in sex work to survive. This is due in part to HIV-related and intersecting stigma and discrimination related to race, gender and poverty persisting in many formal workplace settings around the globe. Experiences of workplace stigma and discrimination may take the form of refusal to hire a person living with HIV, harassment, bullying, forced testing or disclosure, denial of work opportunities or promotion, pressure to resign, or wrongful termination of employment (90–92). A 2018 report based on the People Living with HIV Stigma Index from 10 countries<sup>3</sup> noted that on average 40% of recently unemployed respondents living with HIV had lost their job or an income opportunity as a direct result of their HIV status (93).

Efforts to reduce HIV-related stigma and discrimination in the workplace are of high importance. Working free of any HIV-related stigma is a right. Access to and experience of the workplace has immeasurable implications for the livelihood and well-being of a person living with or thought to be living with HIV, their family and their community. Further, in many contexts the workplace can be the site of public health programmes to support HIV prevention, testing and treatment. The presence of stigma and discrimination in the workplace can undermine the effect of these programmes, which has implications for public health efforts focused on HIV.

HIV-related stigma and discrimination in formal workplace settings may negatively affect the health of employees living with HIV through discouraging testing, linkages with care, treatment adherence and routine health-care visits (12, 31, 57, 87, 88, 90–92, 94). There are numerous examples of such impacts among employees in educational and health-care settings, where HIV-related stigma and discrimination can be particularly pervasive. Surveys of discriminatory attitudes towards people living with HIV held among the general public often ask whether educators living with HIV should be allowed to teach (95, 96).

Some workplaces require mandatory HIV testing. Mandatory, compulsory or coerced testing is never appropriate, regardless of where the coercion comes from (e.g. health-care providers, partners, family members, employers, law-enforcement officials). Its ramifications in the workplace include potential denial of employment and loss of livelihood (97). For some groups of workers the consequences can also be more serious; for example, migrant workers can lose their livelihoods and face deportation if they test positive for HIV (98).

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3 Belize, Costa Rica, Fiji, Greece, Honduras, Malawi, Nicaragua, Republic of Korea, Timor-Leste, Ukraine.

Mandatory HIV testing can limit the employment options of people living with HIV and of members of key populations, women and other vulnerable people. This may lead to the choice or need to work in the informal sector, which is typically associated with lower earnings, less job security, lower social protection and higher vulnerability. The informal sector is not without its challenges, however: if a person's HIV-positive status is made known within a community, the person's livelihood may be affected due to HIV-related stigma and discrimination (e.g. food sellers and sex workers may lose customers) (34).

Workers who are not living with HIV can also be subject to HIV stigma and discrimination by association. For example, health workers may face social and professional consequences for the care they provide to people living with HIV (94, 99).

Certain forms of work present higher risk of occupational exposure to HIV and related stigmatized health conditions such as TB. For example, health workers and sex workers are more occupationally likely to come into direct contact with blood and fluids carrying HIV (94, 100). Transgender people, who as a result of intersectional stigma are often limited in their employment options to sex work, faced a heightened risk of experiencing violence and exposure to HIV (101). The conditions surrounding some forms of work and workplace settings can contribute indirectly to HIV infection, as demonstrated in the mining industry in sub-Saharan Africa and other industries that rely on seasonal migrant labour (102–104). Exploitative and inhumane conditions can increase the risk of HIV through prompting engagement in high-risk sexual behaviours or drug use, or increasing vulnerability to sexual violence (98, 102–104). Ensuring access to HIV prevention, care and treatment in a confidential and stigma-free manner in these workplace settings is particularly important. Occupational health programmes are not always comprehensive or rights-based; moreover, their guidelines may not align with national or international minimum standards.

Employees and employers have significant roles to play in addressing HIV and key and vulnerable population stigma and discrimination in the workplace and in fostering a safe and supportive work environment for all. Employers can shape organizational policies and practices, while co-workers' behaviours can influence social norms within the workplace (92, 105–107).

## **Intervention examples and recommendations**

Annex 2 outlines two interventions relevant to workplace settings that sought to reduce HIV-related stigma and discrimination. Beyond interventions focused on duty-bearers in the education, health-care and justice settings, there are few formally evaluated interventions specific to workplace settings or that directly support access to employment for people living with HIV, key populations, women and other vulnerable populations. This underscores the need for countries to prioritize research to develop and test stigma- and discrimination-reduction interventions for people living with HIV, key populations, women and other vulnerable populations in different types of formal and informal workplaces to expand the evidence on what works in these settings.

The interventions identified were information-based and skills-building in nature and focused on employees in workplace settings. One of these interventions sought to improve attitudes and knowledge about HIV and HIV-related stigma and discrimination; it appeared to be successful at achieving these outcomes based on the evaluation conducted. The intervention is described in Box 4 (108). The other intervention, a 1-day gender and sexual diversity training session carried out with 2825 employees of the United States President's Emergency Plan for AIDS Relief across 38 countries (109), addressed some of the intersecting stigmas in the context of HIV. The training included four modules that addressed (a) health and policy considerations for gender and sexual minorities; (b) gender and sexuality concepts; (c) the experiences and insights of members of and advocates for the lesbian, gay, bisexual and transgender community; and (d) discussion of meaningful engagement. A range of pedagogical approaches and activities were used to support the goal of improving attitudes towards and meeting the needs of people from gender and sexual minorities in the workplace. The intervention improved "self-efficacy for reducing (gender and sexual minorities) stigma and discrimination in the workplace" by 30%.

While there are few published evaluations of workplace interventions outside the education, health-care and law-enforcement sectors, notable consideration has been given to this topic, especially in the context of South Africa. Two case studies focusing on workplace HIV programmes in South Africa highlighted the importance of involving stakeholders and unions as a critical way to build trust. Further, it is believed that workplace confidentiality policies would have greater effect in abating concerns of HIV-related stigma and discrimination if these policies were communicated more clearly to employees. It was recommended that workplaces provide employees with access to medical services outside the company to encourage employees to access health services and offer greater assurance of confidentiality.

Another assessment in Durban, South Africa focused on eight construction firms with policies that aimed to reduce HIV-related stigma and discrimination. These policies entailed such provisions as prohibiting compulsory testing before or during employment and specifying redress procedures for workers who discriminate against a colleague because of their real or perceived HIV status. Overall, the inclusion of such policies was beneficial, and employees no longer feared losing their jobs due to their HIV status. However, employees living with HIV were still afraid of experiencing stigma and discrimination from their co-workers. This highlights the importance of workplace policies that address HIV-related stigma and discrimination at all levels of the workplace. This includes not only the broader workplace staff, who may require HIV specific education and training, but also employees living with HIV, who may require support to cope with and address internalized and anticipated stigma (105).

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### **Box 3**

#### **Multicountry workplace intervention and evaluation in sub-Saharan Africa**

An evaluation of the ExxonMobil StopAIDS workplace intervention in Angola, Cameroon, Chad, Côte D'Ivoire, Equatorial Guinea, Kenya and Nigeria was published in 2010 (108). The initiative, which commenced in 2005 across ExxonMobil worksites in sub-Saharan Africa, entailed the following:

- Peer education component developed by Population Services International: in addition to improving knowledge of HIV and self-efficacy to prevent HIV infection and transmission, the objectives of this component included reducing HIV-related stigma and discrimination in this setting and beyond, and positively supporting people living with HIV. As part of this intervention, peer groups of about 15 employees were formed. From each group, 3 peer educators were selected to facilitate 15 half-hour sessions over the course of 12–18 months. These peer educators were given three days of training before commencement of the intervention and two days of refresher training six months into the intervention. Near the completion of the intervention, peer educators were selected to serve as trainers in order to sustain the programme.
- Medical benefit plan: ExxonMobil took action to ensure local country medical plans removed exclusions regarding coverage and treatment for HIV and AIDS-related illnesses. As part of this intervention, appropriate local HIV testing and treatment centres were identified and promoted to ExxonMobil staff.

The evaluation focused on the 7 largest of the 21 sites. A quasi-experimental assessment with no control group was carried out, collecting data using self-administered surveys from 993 employees exposed to the intervention. The intervention was well received, with the only constructive feedback being related to increasing the frequency and expanding audience (e.g. to include staff family members) of the educational sessions. The assessment observed some significant improvements in several knowledge indicators (methods of HIV prevention, gender-relevant symptoms of sexually transmitted infections, modes of mother-to-child-transmission of HIV) but not others (modes of HIV transmission, myths regarding HIV transmission). Significant improvements in attitudes were observed; most notably, respondents were “twice as likely to express no discriminatory attitudes toward people living with HIV/AIDS” (108). Following the intervention, respondents were more likely to have sought an HIV test. Participants were also more likely to have engaged in risky sexual behaviours (e.g. multiple partners, sex in exchange for money, inconsistent condom use), but this “increase” was possibly attributed to an increased willingness to discuss and report such behaviours.

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**Table 6.**

## Recommendations for workplace settings

Level (focus populations)	Recommendations
<b>Individual (workers)</b>	<p>Educate staff on opportunities to seek redress.</p> <p>Make workers aware of opportunities to claim their rights.</p> <p>Provide information about linkages to external partners, such as national hotlines and legal services providers (e.g. nongovernmental organizations) in the informal economy as appropriate.</p> <p>Provide training on human rights and gender equality competencies for all workers, including information on existing workplace policies related to HIV and non-discrimination.</p>
<b>Organizational (employers)</b>	<p>Base HIV workplace policies and practices on the principles of non-discrimination, gender equality, healthy work environment, social dialogue, non-screening for the purpose of employment, confidentiality, continuing employment relationship, prevention, care and support; these policies and practice should be integrated into other existing policies such as occupational health and safety policies.</p> <p>Where possible, ensure upstream and downstream supply chains have such policies and practices in place</p> <p>Policies and practices may include the following:</p> <ul style="list-style-type: none"> <li>• Provide employees access to HIV services or developing partnerships with HIV service providers to help reduce the stigma surrounding HIV testing and treatment.</li> <li>• Promote HIV testing and “know your status” initiatives in the workplace, alone or through multi-disease testing.</li> <li>• Provide access to or linkages with HIV treatment services to reduce stigma surrounding HIV testing and treatment.</li> <li>• Provide flexible leave policies to allow for medical visits or offer insurance plans that meet the needs of people living with HIV and members of key populations.</li> <li>• Ensure key populations, women and other vulnerable populations are not denied reasonable accommodation; that they are free from violence and harassment in the workplace; and that there are measures in place to ensure confidentiality of data (including personal and medical data).</li> <li>• Ensure there is no discrimination on the basis of real or perceived HIV status in recruitment, continued employment, pursuit of equal opportunities or termination of contract.</li> <li>• Disseminate information on existing HIV workplace policies and provisions to all staff members so they understand their rights and ways to address any policy violations; this includes training peer educators from all levels of the workplace to disseminate information.</li> <li>• Routinely review and revise policies and practices in the workplace to ensure they protect against discrimination of people living with HIV, key populations, women and other vulnerable populations.</li> <li>• Integrate training on gender and sexuality diversity for duty-bearers (e.g. doctors, nurses, lawyers, judges, law-enforcement agents) to reduce discrimination against women in the context of HIV.</li> <li>• Routinely measure knowledge, attitudes and behaviours of educators and school staff to inform the scope of in-service training on HIV and human rights.</li> </ul>
<b>Community (workers, families, community members)</b>	<p>Provide education, training and outreach to workers, their families and members of surrounding communities with accurate, up-to-date, relevant, evidence-informed information on HIV, comorbidities and legal literacy.</p>
<b>Public policy (national government, lawmakers)</b>	<p>Establish a national-level monitoring system to capture stigma, discrimination and rights violations experienced by people living with HIV and key populations in workplace settings for support and redress.</p> <p>Build support for protective and non-discriminatory workplace policies by engaging lawmakers and other decision-makers to increase their capacity to understand and develop non-discriminatory policies.</p>

# Education settings

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In education settings, HIV-related stigma and discrimination are influenced by factors ranging from school policies, to teachers' attitudes, to the comprehensiveness of the sexuality education curriculum. Students and educators living with HIV may anticipate or experience HIV stigma and discrimination in schools, including bullying and violence; neglect, avoidance and isolation; breaches in confidentiality; and denial of enrolment of students or loss of employment for educators (95, 96, 110–113). These manifestations of stigma and discrimination can have serious repercussions on the health and well-being of students and educators living with HIV.

The strain of living in fear of accidental disclosure, having insufficient social and structural support, or dealing with HIV-related stigma and discrimination may result in students and educators living with HIV having poor mental health (112, 114, 115). Adolescence is a particularly challenging time to experience HIV-related stigma and discrimination. Children in this transitional period are not always equipped with the knowledge and social skills to respond to HIV-related stigma and discrimination (110). Further, youth and adolescents living with HIV may be struggling with intersecting and compounding vulnerabilities related to their HIV status, such as socioeconomic status, gender and sexuality, and exposure to violence in their home, community or school (53, 114, 116). Youth affected by HIV through association or loss can face related challenges and have unique support needs as they cope. These collective factors contributing to poor mental health are particularly important to address, as they can lead to depression and suicidal thoughts (116).

Students and educators living with HIV may have poor physical health if they do not feel comfortable with prioritizing their health in education or workplace settings. Students and educators living with HIV face challenges with treatment adherence, which can inhibit viral suppression and lead to physical symptoms and drug resistance. Students living with HIV may avoid taking their medicines at school or in the presence of classmates (117–119). Treatment adherence can be particularly problematic for students at boarding school or university, as they may lack private space to store and take their medicines. Students and teachers living with HIV may avoid health-care appointments or picking up their prescriptions in order to avoid suspicion or punishment for missing school or work or for being seen in settings associated with HIV (95, 96, 118–120). For educators, the impacts of stigma on physical and mental well-being, combined with social exclusion and lack of support, may combine to impede their ability to perform their tasks at optimal levels (115).

The academic performance of students living with HIV may suffer as a result of HIV-related stigma and discrimination and related poor mental and physical health (112). Some students living with HIV may need to switch schools or drop out of school as a result of HIV-related stigma and discrimination or intimate or gender-based violence following intentional or accidental disclosure (117–119). These experiences can compromise their education, which in turn can compromise their future livelihood and well-being (112, 117–119).

Thanks to improvements in testing, treatment and coverage, more and more children born with HIV are surviving into adolescence. This means that more than ever before, it is important that schools serve as supportive environments for students living with HIV

(121). Students living with HIV, like all students with chronic health conditions, require an enabling and supportive educational environment in order to thrive. According to the International Technical Guidance on Sexuality Education, schools are important settings for supporting youth to live happy and healthy lives through encouraging engagement with health services and reducing community stigma and discrimination (122). Unfortunately, many schools lack the policies, structures and trained staff required to support students living with HIV with their education and the management of their health. Programmatic and policy efforts in the education sector must focus on creating a supportive environment for all students, including students living with HIV, girls, and members of key and vulnerable populations, regardless of whether their health status or identity has been disclosed. Such efforts in education settings will need to be mindful of the accessibility of services, especially regarding age of consent. For example, the Government of South Africa has an integrated school health policy that enables HIV services, including access to HIV testing and condoms, to be made available to students aged 12 years and older without parental consent (123).

Adolescence is a period in which people start to explore their sexuality (124). Adolescents living with HIV need support to navigate safe and consensual sex, but layers of stigma around discussing sexuality with adolescents living with HIV can inhibit appropriate dissemination of such information (118, 119, 124–127). Great strides have been made in this area by international agencies such as the United Nations Educational, Scientific and Cultural Organization and the United Nations Population Fund through improving access to comprehensive sexuality education in and out of schools. However, in many settings, additional support is needed to fully and effectively implement this curriculum, and provisions for students living with HIV need to be included and prioritized, particularly in high-prevalence settings (122, 128).

Educators serve as role models for their students and the broader community. As such, the way that educators discuss matters related to HIV and treat people living with HIV, key populations, women and girls and other vulnerable populations is highly influential (68, 129). Educators may discuss HIV and sexuality with strong moralistic undertones that are judgemental of girls or members of key and vulnerable populations and behaviours that put people at risk of HIV infection (68, 118, 119). Such discussions are not necessarily intended with malice—rather, educators may be unaware of the latest culturally sensitive messaging on HIV prevention, care and treatment; may be influenced by cultural, religious or traditional norms that support such messaging; or may use judgemental language out of a strong desire to ensure students do not engage in behaviours that may result in HIV infection. In some cases, the sexual and reproductive health curricula and policies from which they draw their lessons may have stigmatizing and discriminatory tones and may neglect the needs of students who identify as a gender or sexual minority. These messages are neither accurate, sensitive nor supportive of students living with HIV or who identify as a gender or sexual minority (68, 118, 119, 129). It is important that educators and educational institutions address the specific needs of young people living with HIV, women, girls, and members of key and vulnerable populations, alongside protecting their rights to confidentiality, freedom from stigma and discrimination, and equal treatment (130).

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#### **Box 4** Disclosure

School-aged youth living with HIV may have complicated feelings and experiences around matters of disclosure. People of this age



group often receive conflicting messages around disclosure. Family members or caregivers may expressly forbid disclosure to protect a young person or the wider household from the real or perceived repercussions of HIV stigma and discrimination (118). At the same time, it is not uncommon for caregivers to disclose a young person's HIV status to school or other family members without the person's consent. Health-care providers may encourage limited disclosure to support treatment adherence or to prevent potential transmission to current or future sexual partners of the adolescent. Youth living with HIV may feel they do not have autonomy around disclosure, which can be a source of distress and discontent. Youth may want to share their HIV-positive status with a close peer to help them process and cope with the fact that they are living with HIV. Such disclosure can be met with variable success. Disclosure of one's serostatus should not be a measure of success for any stigma-reduction intervention and may not be advisable for youth living with HIV in educational settings.

Disclosure is an ongoing consideration and decision-making process for all people living with HIV. Youth living with HIV require support and guidance as they navigate such decisions and the process of disclosure, particularly as they begin to engage in sexual relationships (131).

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While some educators may perpetuate HIV-related stigma and discrimination in schools, many are also key sources of support for students living with HIV. For example, educators may discreetly remind students living with HIV to take their medicines or excuse them from class for clinic appointments in order to keep their status confidential (119). Providing this type of practical, social and emotional support to students is of great importance and should be promoted in all education settings. It is important that educators receive sufficient training and resources to equip them to be sources of support. A study in Zimbabwe underscored that educators often feel ill-prepared and unsure of how best to support youth living with HIV (129).

## **Intervention examples and recommendations**

Annex 3 outlines 13 interventions relevant to education settings that sought to reduce HIV-related stigma and discrimination. A case study of one of these intervention studies is presented in Box 6. The majority of interventions were information-based or skills-building in nature. A few interventions also included contact with groups affected by HIV and counselling support. Reductions in HIV-related stigma and discrimination were primarily in the form of improvements to attitudes and knowledge regarding HIV. Other notable results included increased willingness to support people living with HIV when necessary, an interest in learning more about HIV, improvements in personal risk and health behaviours as related to HIV (e.g. seeking testing, use of condoms), and improvements in self-efficacy and intention to perform such behaviours.

Although not referenced in Annex 3, in a number of countries there are laws and policies at national and school levels to ensure students living with HIV are able to access education (132, 133)—but these policies may not always be adequately enforced

(134). In some cases, administrators may face pressures from families of children at school to deny admittance to students living with HIV. In others, school staff may not be made aware of such policies. This highlights how policies to reduce HIV-related stigma and discrimination in education settings may not succeed alone without intervention components that consider or operate at multiple socioecological levels (64).

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### **Box 5**

#### **School-based programme in Zambia to support HIV prevention and reproductive health among students**

A 2012 study evaluated the Restless Development school HIV education programme youth-led model through a non-randomized quasi-experimental design in 15 intervention and 15 control schools across Zambia (135). The programme comprised two strategies:

- Instituting pairs of trained volunteer peer educators at schools for an academic year: volunteers are generally aged 18–25 years and have earned at least a high-school degree. They receive a monthly stipend of US\$ 80–90 and monthly supervision.
- Offering a comprehensive life skills and sexual health programme through weekly 40-minute participatory lessons in the classroom: this programme extends beyond the classroom by offering students access to a youth resource centre with a library and counselling, and extracurricular activities coordinated by the volunteer peer educators; organizing community educational events on specific topics (e.g. preventing early marriage); and capacity-building for teachers through periodic workshops on specific topics.

Quantitative survey data were analysed from a total of 2133 eighth- and ninth-grade students (1088 students from intervention schools, 1045 students from control schools). The programme appeared to have a positive influence on students' knowledge and behaviour. It was observed that students at intervention schools had greater knowledge of HIV and reproductive health matters, held less stigma, and had greater self-efficacy regarding sex (using a condom, refusing unwanted sex). The thoughtful engagement of young adults, duration of the intervention and multilevel components contributed to the success of the programme. The costs were modest, at about US\$ 21 per beneficiary reached.

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**Table 7.**

Recommendations for education settings.

Level (focus populations)	Recommendations
<b>Individual (students living with HIV)</b>	Implement programmes (e.g. peer mentor programmes, support groups, adherence clubs) outside school settings for students living with HIV (e.g. at health facilities or community centres) to provide skills and confidence necessary to manage living with HIV and reduce internalized stigma.
<b>Organizational (schools, health facilities)</b>	<p>Provide adolescents with access to youth-friendly HIV services that ensure confidentiality and an environment free of stigma and discrimination.</p> <p>Ensure comprehensive sexuality education is provided in all schools, starting from primary education level. Such education should provide learners with the knowledge, skills and values they need to eliminate misconceptions related to HIV, sexuality and gender; to promote gender equality, non-discrimination, inclusiveness and human rights; and to reduce intersecting stigmas regarding HIV, sexuality and sexual behaviour.</p> <p>Implement in-service training to enable educators to deliver comprehensive sexuality education, including training educators so they are confident and empowered in communicating with learners about HIV testing, treatment, care and prevention; the rights of people living with HIV; and issues related to preventing gender-based violence and stigma and discrimination against key populations, women, girls and other vulnerable populations.</p> <p>Implement HIV workplace programmes for educators and staff that provide training on HIV and non-discriminatory practices, access to services and benefits for staff living with or affected by HIV, and policies to prevent stigma and discrimination and ensure confidentiality.</p> <p>Use contact strategies in educational settings (e.g. inviting people living with HIV to present at schools or teacher training sessions) to raise awareness about stigma and its harmful effects and to reduce negative attitudes towards key populations, women, girls and other vulnerable populations.</p> <p>Implement and uphold policies to prevent and address all forms of school violence, bullying and cyber-bullying, including on the basis of HIV status, gender or gender-nonconforming behaviour.</p> <p>Establish mechanisms for reporting and responding to incidents of stigma and discrimination and for providing psychosocial care and support.</p> <p>Routinely review and revise policies and practices in the education setting to ensure they protect against discrimination of key populations, women, girls and other vulnerable populations.</p>
<b>Community (parents, community leaders, faith-based and other religious communities)</b>	<p>Implement community programmes to support students and educators living with HIV in order to reduce internalized stigma and support HIV management, such as support networks and peer mentorship.</p> <p>Engage parents and the broader community in stigma reduction (e.g. community meetings, contact strategies, sensitization through cultural mediums) to address drivers of stigma in education settings</p> <p>Implement programmes to increase access to education opportunities for adolescent girls and young women living with or vulnerable to HIV infection.</p>
<b>Public policy (education ministries, social protections ministries, teacher training colleges)</b>	<p>Integrate HIV sensitization, gender sensitization, reduction of stigma and discrimination, and human rights sensitization into curricula at teacher training colleges.</p> <p>Implement preservice teacher training to enable educators to deliver comprehensive sexuality education, including training educators so they are confident and empowered in communicating with learners about HIV testing, treatment, care and prevention; the rights of people living with HIV; and issues related to preventing gender-based violence and stigma and discrimination against key populations, women, girls and other vulnerable populations.</p> <p>Develop and enforce an education sector-wide zero-tolerance policy on HIV-related stigma and discrimination; in low-prevalence settings, integrating HIV into a general non-discrimination policy may be more appropriate.</p> <p>Revise national education-sector guidelines to promote treatment adherence, support school health programmes and linkages with health services, and ensure young people living with HIV have access to safe and confidential support for treatment adherence.</p> <p>Adapt, adopt or implement laws to ensure adolescents have legal access to HIV testing and services by removing age restrictions.</p> <p>Ensure education and social protection policies are concordant with and sensitive to the special needs of young people affected by HIV, including orphans and other children who experience intersecting stigmas and vulnerabilities; this includes ensuring access to subsidies for school fees and school feeding programmes that are HIV-sensitive.</p> <p>Routinely review and revise policies and practices in the education sector to ensure they protect against discrimination of key populations, women, girls and other vulnerable populations.</p>

# Health-care settings

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Health-care settings can be a source of stigma and discrimination, as well as care and treatment, for people living with HIV (12, 30, 136, 137). Examples include unnecessary delays in treatment, differential care (e.g. avoiding physical contact, inadequate management of pain, separation of prevention of mother-to-child transmission services from other maternal and child health services), conditional care (e.g. granting access to antiretroviral therapy only on the condition of condom or contraception use), neglect (e.g. withholding food, water or hygiene), or refusal of service—all of which directly obstruct access to appropriate health care. Stigma may be exhibited through health workers using judgemental language, testing for HIV without consent, taking unnecessary precautions (e.g. double-gloving, wearing masks, burning bedsheets), or breaching confidentiality (e.g. gossiping, disclosing to family members without permission). Such displays of stigma and discrimination can impede access to health care through discouraging people living with (or who suspect they may be living with) HIV from seeking necessary testing and treatment (12, 30, 31, 57, 136–141). The recent scale-up of index HIV testing and partner notification, especially among adolescent girls, in high-prevalence settings may increase stigma, discrimination and violence among women and girls and other vulnerable populations and deter health-seeking behaviours (142).

HIV-related stigma and discrimination in health-care settings as a human rights infringement itself may negatively impact the health, well-being and quality of life of people living with HIV and key and vulnerable populations and hamper efforts to halt HIV transmission (136, 143, 144). People concerned about contracting HIV may be less likely to seek information about HIV or discuss safe sexual practices with a provider due to fear of stigma (57, 140). Unfriendly health-care staff and lack of confidentiality have been cited by people unsure of their HIV status as a reason for not accessing HIV testing services (145). People who experience stigma and discrimination in health-care settings are more likely to have breaks in care or poor treatment adherence, increasing the likelihood of drug resistance and making it harder to manage the epidemic (140, 141).

When health-care providers and workers exhibit HIV-related stigma and discrimination, it is often attributed to prejudice towards “marginalized behaviours” (141), fear of HIV transmission, and misconceptions about HIV and how it is and is not spread (30, 57, 141).

Adolescents living with HIV face many of their own challenges with HIV-related stigma and discrimination in terms of accessing health care and receiving good-quality health services. Adolescents may avoid HIV testing in some settings because parental consent is required to receive testing (113). Confidentiality is a particular concern among adolescents seeking care and information about HIV and sexual health, and they may not seek such care and information from health-care settings if their privacy cannot be maintained (113). In some settings, health providers and other adults may give adolescents living with HIV incomplete, judgemental or simplistic information about HIV management and sexual health. For example, a study in Zambia found that adolescents living with HIV were told by health providers and family members not to engage in sexual activity, not to get married and not to start a family. Not only does such advice violate the rights of adolescents living with HIV, but it may also harm their mental and emotional health (118, 119). These collective concerns are heightened for adolescents and youth who identify as a gender or sexual minority due to intersectional

stigma and health services that often neglect the specific needs of gender and sexual minorities (44, 72).

## **Intervention examples and recommendations**

Annex 4 presents 20 successful interventions to reduce HIV-related stigma and discrimination in health-care settings. One of these studies is elaborated in Box 7.

These interventions predominantly engaged health-care providers (physicians, nurses, laboratory technicians) or health workers (all staff employed at a health facility). A few of the interventions focused on nursing or medical students, people living with HIV, or people seeking HIV-related services. The majority of interventions were information-based or skills-building in nature, while others included contact with groups affected by HIV, and structural approaches that encompass activities aimed at addressing structural factors that influence manifestations of HIV-related stigma and discrimination, such as policies in health-care settings.

Reductions in stigma and discrimination were primarily in the form of improved attitudes towards people living with or thought to be living with HIV, increased knowledge of HIV, and reduced fear of infection. A few of the interventions were also found to have the added benefit of improving health workers' personal behaviours regarding HIV testing and risk reduction (94, 127).

Notably lacking from Annex 4 are interventions at the policy and institutional level. This is due in part to the effects of these initiatives being challenging to evaluate thoroughly, but their importance has been established in the literature (146). There are notable examples of policy interventions to this end. In Thailand the Ministry of Public Health is seeking to institute training for all health workers in order to reduce HIV-related stigma and discrimination. The pilot study of this programme showed positive results in the participating hospital and 30 health workers. These results have prompted the expansion of this programme to hospitals in four provinces in Thailand (147, 148).

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### **Box 6**

#### **Training student nurses in China, Hong Kong Special Administrative Region**

A study in 2008 assessed whether a knowledge–contact programme would be more effective than a knowledge-only programme in reducing HIV-related stigma among undergraduate student nurses (149). The programmes were differentiated as follows:

- Knowledge-only programme: 50-minute informational lecture, with a question-and-answer session, on HIV transmission, progression and prevention. This lecture was given by a retired nurse with experience in disseminating information about HIV in community settings.
- Knowledge–contact programme: the same 50-minute informational lecture was given as above, followed immediately

by a 50-minute contact session, with a question-and-answer session. The contact session was with two men living with HIV (one who identified as heterosexual and one who identified as a man who has sex with men) and a female moderator. These three people were trained in facilitating HIV-related stigma- and discrimination-reduction activities. During the contact session, the men living with HIV emphasized (a) their past positive and negative interactions with nurses to bring out the powerful impact of nurses' attitudes and behaviours on the well-being of people living with HIV; (b) the physical changes and psychological struggles they had dealt with before they could live with HIV to elicit empathy from the nursing students; and (c) their hopes and wishes to widen the nursing students' perspectives of people living with HIV (149). A total of 89 student nurses from 2 universities participated in the study (39 in the knowledge-only programme, 50 in the knowledge-contact programme). Both programmes observed significant improvements in HIV knowledge, stigmatizing attitudes, fear of infection, willingness to treat, and emotional well-being. Compared with the knowledge-only programme, the knowledge-contact programme was found to have significantly greater short-term benefits in improving stigmatizing attitudes. This study offers insights into the components of an effective training programme to reduce HIV-related stigma among nursing students. The benefit of facilitating contact with people living with HIV, and of providing knowledge about HIV, was demonstrated.

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**Table 8.**

Recommendations for health-care settings

Level (focus population)	Recommendations
<b>Individual (people living with HIV and key populations)</b>	<p>Integrate paralegals into health facilities to provide on-site guidance and awareness-raising for key populations, women, girls and other vulnerable populations about their rights and quality standards in accessing services and discrimination-free health care.</p> <p>Paralegals could support clients to seek redress as needed.</p>
<b>Organizational (health-care administrators, health facility staff, key populations, women, girls and other vulnerable populations)</b>	<p>Provide routine in-service training sessions on HIV, human rights, key populations, stigma reduction, non-discrimination, gender-sensitization and medical ethics for all health facility staff, including non-health-care staff such as receptionists and data clerks.</p> <p>Engage administrators and identify champions within the health sector or facilities for sustainability and follow-up.</p> <p>Engage key populations, women, girls and other vulnerable populations in the design, implementation and evaluation of services to ensure in-service training sessions are acceptable, accessible, of good quality, and based on the principles of medical ethics.</p> <p>Ensure universal precaution supplies and post-exposure prophylaxis are always stocked to reduce providers' fears around occupational exposure to HIV, which will in turn reduce avoidance behaviours with people living with HIV.</p> <p>Develop and uphold non-discriminatory policies to support and protect the rights of key populations, women, girls and other vulnerable populations who work in health-care settings</p> <p>Routinely review and revise policies and practices in health-care settings to ensure they protect against discrimination of key populations, women, girls and other vulnerable populations.</p> <p>Establish a facility-level monitoring system to capture stigma, discrimination and rights violations experienced by people living with HIV and key populations for support and redress; this could include anonymous feedback on users' experiences at the health facility, or a formal system for reporting and resolving rights violations.</p> <p>Routinely assess knowledge, attitudes and practices of health-care workers towards people living with HIV and other key populations to support health facility administrators to identify and address any issues</p> <p>Integrate health services with a well-functioning referral system, including care for survivors of rape and post-exposure prophylaxis.</p>
<b>Public policy (ministries of education and health, medical and nursing schools)</b>	<p>Integrate HIV sensitization, reduction of stigma and discrimination, and human rights approaches into curricula of health provider training schools (e.g. medical and nursing schools).</p> <p>Routinely review and revise policies and practices across the health-care sector to ensure they protect against discrimination of key populations, women, girls and other vulnerable populations.</p>

## Justice settings

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People living with HIV often face a number of challenges in accessing justice due to HIV-related stigma and discrimination. In particular, stigma and discrimination can manifest as discriminatory laws, policies and practices regarding HIV (travel restrictions and bans, prosecutions for HIV non-disclosure and potential or perceived exposure or transmission), harassment and mistreatment on the part of law-enforcement agents, and wrongful arrest and imprisonment of people living with HIV and key populations (17, 19–21, 48, 150). Such discriminatory legal practices are not only harmful but also an infringement of human rights, a tacit validation of HIV-related stigma and discrimination in other spheres, and counterproductive to efforts to reduce HIV incidence (151). The enforcement of such laws and practices increases a person's vulnerability to HIV by obstructing access to and discouraging use of HIV-related services (17, 19–21).

HIV criminalization laws can impact on uptake of HIV services, as knowledge of a person's HIV status can be used against them in legal settings (19). In some settings, police officers position themselves in the vicinity of needle–syringe programmes and arrest people who inject drugs when they access the programmes; this counterproductive activity discourages people who inject drugs from engaging with harm-reduction services (22). Conversely, when people who use drugs are assured legal access to needle–syringe programmes, they are more likely to use such services (23).

Criminalization prevents key populations from seeking justice when harassed, physically harmed or discriminated against in other ways. For example, sex workers often do not report abuse from clients to avoid further mistreatment or abuse from the police due to their stigmatized occupation (152). Wrongful arrest of people living with HIV can have direct health consequences for people living with HIV and for the wider community due to treatment disruption. When a person living with HIV is arrested, their medicine may be withheld, resulting in drug resistance and undermining the success of their treatment (19).

Emerging evidence suggests that decriminalizing occupations and behaviours that heighten a person's risk of being exposed to HIV, including sex work, same-sex behaviour and drug use, is critical to halting the HIV epidemic. For example, recent modelling efforts suggest that decriminalizing sex work would avert 33–46% of HIV infections among female sex workers in the next decade across all settings (153). Similarly, decriminalizing and reducing incarceration may avert new HIV infections in people who use drugs. Modelling data from Mexico suggest that implementing law reform would reduce incarceration in people who inject drugs by 80% from 2018, averting 9% of new HIV infections between 2018 and 2030, with 21% averted if people who inject drugs were referred for opioid agonist treatment<sup>4</sup> instead of being incarcerated (154). Decriminalizing same-sex behaviour is also likely to have an impact on HIV incidence. A systematic review and meta-analysis of pooled data on HIV testing and engagement with the HIV treatment cascade among African men who have sex with men revealed that levels of testing ever, in the past 12 months and status awareness were significantly lower in countries with the most severe legislation against

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<sup>4</sup> Opioid agonist therapy is an effective treatment for addiction to opioid drugs. Therapy involves taking an opioid agonist (methadone or buprenorphine) to prevent withdrawal and reduce cravings for opioid drugs. People with opioid addiction can use opioid agonist therapy to stabilize their lives and reduce the harms related to their drug use.



lesbian, gay, bisexual and transgender people, compared with countries with the least severe legislation (155).

Restricting or banning travel for people living with HIV is another challenge in justice settings. In 2019 around 48 countries and territories still maintain some form of HIV-related travel restriction. UNAIDS opposes mandatory HIV testing and restrictions that limit or restrict movement based on HIV-positive status. There is no evidence that HIV-related travel restrictions protect public health; rather, they are likely to impede efforts to protect public health by creating barriers to access to services for people living with HIV and people at higher risk of HIV. Travel restrictions based on HIV status fuel stigma and create a misleading public impression that HIV is a “foreign” problem, which interferes with the efficacy of public health messages on the prevention of HIV (150).

There is mounting recognition that an effective national HIV response must include non-discriminatory laws. A number of international commitments are in place to support such laws. Since 1979 United Nations Member States have agreed to uphold the Convention on the Elimination of all Forms of Discrimination Against Women. Since 2001 countries have committed to remove discriminatory laws pertaining to HIV and to facilitate access to justice for people living with HIV and key populations (18–20, 120, 156); SDGs 5, 10 and 16 call for non-discriminatory laws. In addition, the human rights situation in all 193 United Nations Member States is reviewed every 5 years under the universal periodic review in order to improve human rights on the ground.

To ensure people living with HIV, key populations, women, girls and other vulnerable populations are able to access justice in the event that their rights are not upheld (157, 158), the public must be aware of their rights and be able to access redressal mechanisms if necessary. Such mechanisms can serve as an additional tool for accountability and for enforcement of anti-discriminatory HIV laws and policies (159). In many countries there are initiatives and agencies in place to this end (157, 158). In Jamaica the national HIV-related discrimination reporting and redress system “collects cases of HIV-related discrimination and refers them to a redress partner to investigate, mediate, or provide damages to people who have experienced discrimination” (158). Such mechanisms must be made available and accessible, regardless of barriers such as socioeconomic status (157–160). However, just because reporting systems exist does not mean key populations, women, girls and other vulnerable populations will use them, especially in contexts with high levels of stigma and discrimination.

There are also examples of justice being accessed through informal structures. For example, in Kenya the Luo Council of Elders has mitigated 500 cases that restored rightful inheritance to widows and their children in the context of HIV (161).

Duty-bearers (e.g. politicians, lawmakers, police officers, lawyers) are in a position to be positive agents of change with regard to HIV-related stigma and discrimination and access to justice. In countries with a discriminatory legal environment, however, duty-bearers at multiple levels of influence may be in need of education and sensitization (regarding HIV, stigma and discrimination, human rights, and current laws and policies regarding these subjects) in order to coherently and effectively support the national HIV response (17–21). There are examples of judges lacking knowledge of HIV and treating people living with HIV in a stigmatizing manner (e.g. making them wear masks or keeping them at a distance in the court room) (19).

Although 123 countries have laws against HIV-related discrimination, the enforcement of these laws is often lacking, which negates the effect of the laws and undermines public health efforts regarding HIV (20, 21).

Duty-bearers must be engaged at multiple levels to better ensure that non-discriminatory laws and practices are fully enforced (17, 19, 21, 162). A study in Kyrgyzstan noted that although senior police officers were appraised and aware of such laws and practices, junior police officers, who tend to be active in the field, were not. This example highlights the importance of direct engagement and adds a cautionary note that a trickle-down effect may not always be reliable (162).

People living with HIV, members of key populations, women, girls and members of other vulnerable populations may not fully understand, be aware of, or be confident in their rights or duties under the law for a number of reasons. People living with HIV would benefit from services to foster their legal literacy and empower them and provide legal support to seek redress if their human and legal rights are not met (19, 163).

Refugees, displaced people and migrants living with HIV may require special considerations. In addition to being subject to restrictive laws and policies related to entry, stay and residence, these uprooted people can face additional barriers (e.g. language, financial) in accessing redress mechanisms (98).

## **Intervention examples and recommendations**

Annex 5 presents studies that assess interventions to improve access to justice by way of reducing HIV-related stigma and discrimination. Box 9 presents a case study of one of these studies.

The majority of the included interventions focused on lawmakers, law-enforcement agents or members of key populations. Health workers, people living with HIV, journalists and the general population were also included in the study populations for some studies. Intervention approaches were primarily skills-building and structural. Other approaches included those that were information-based, provided counselling support, or facilitated contact with people living with HIV or members of key populations. Most of these interventions served to improve attitudes towards key populations and HIV harm-reduction efforts and to reduce discriminatory practices on the part of law-enforcement agents. Other notable results included empowering people living with HIV and members of key populations and improving other key stakeholders' knowledge and ability to support people living with HIV.

It is important to revise not only laws and policies specific to HIV, key populations, women, girls and other vulnerable populations, but also laws and policies that may contradict or otherwise infringe upon these efforts (19, 21). Further, it is recommended to include multiple stakeholders (e.g. lawmakers, law-enforcement agents, people living with HIV, key populations, women, girls, other vulnerable populations) in discussions and collaborative efforts to revise existing harmful laws and ensure enforcement of non-discriminatory laws and policies. These different stakeholders can provide valuable perspectives to better maximize the effectiveness of legal reform and other interventions to improve the legal environment (17, 19).

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## Box 7

### Programmes to improve access to justice in Kenya

A 2013 study offered an assessment of three legal integration programmes in Kenya (164):

- The Legal AID Centre of Eldoret provides legal aid and services to people with limited access to justice, such as people living with HIV.
- The Coalition on Violence Against Women offers services including direct legal aid payments and referrals, and training on human rights, gender-based violence and related topics for clients and service providers.
- The Christian Health Association of Kenya offers HIV-related services, legal services and rights awareness.

These programmes operate within different health facilities and centres. The Christian Health Association of Kenya programme is active in over 435 locations.

The study evaluated the programmes using survey data collected from programme staff, existing programme records and data, semi-structured interviews, and focus-group discussions with clients and service providers. The programmes were observed to improve clients' knowledge, awareness and self-efficacy regarding their rights and access to legal aid, health care and justice. All three programmes were found to improve service providers' knowledge of discriminatory practices and human rights violations, and their ability to inform, serve and refer clients. It is important to note that the existence of these legal aid centres has allowed people living with HIV and members of key populations to access justice, which previously may not have been so accessible using only standard legal support.

Some external factors limited the effectiveness of these programmes, including (a) real and perceived corruption on the part of law officials and law-enforcement agents and retaliation from legal opponents, and (b) logistical challenges regarding staff turnover and linkage with health facilities. Regardless, the programmes were still identified to have great potential. This study demonstrates that integrating legal and health services can offer greater access to both health and justice for people living with HIV, women, girls and other vulnerable populations.

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**Table 9.**

Recommendations for justice settings

Level (focus population)	Recommendations
<p><b>Individual (key populations, women, girls and other vulnerable populations)</b></p>	<p>Empower key populations, women, girls and other vulnerable populations with knowledge of their legal rights—and, where appropriate, their responsibilities under the law—and how they can access legal support and redress.</p>
<p><b>Community (general public, key populations, women, girls and other vulnerable populations, community-based organizations, key population networks)</b></p>	<p>Expand paralegal officer system to all prisons in the country by training people in prison on HIV and human rights and to work as paralegals; after training, these people can provide support to their peers, including making referrals for HIV testing and other health services.</p> <p>Expand provision of legal advice and assistance, awareness-raising and “know your rights” campaigns to each district among key populations, adolescent girls and young women, and in health-care facilities.</p> <p>Efforts should include provision of legal information and referrals; legal advice and representation; alternative and community forms of dispute resolution; engaging religious or traditional leaders and traditional legal systems (e.g. village courts) with a view to resolving disputes and changing harmful traditional norms; and strategic litigation.</p> <p>Deliver legal literacy programmes such as awareness-raising campaigns that provide information about rights and laws related to HIV through media (e.g. television, radio, print, internet), community mobilization and education, peer outreach and telephone hotlines.</p> <p>Mentor and strengthen the capacity of community service organizations working with people living with HIV, sex workers, men who have sex with men, people who inject drugs, and transgender people to continue to involve them in HIV service programming.</p> <p>Conduct routine assessments of access to justice for people living with or vulnerable to HIV as part of the People Living with HIV Stigma Index surveys and other surveys specific to sex workers, men who have sex with men, and people who inject drugs.</p> <p>Enable local networks of people living with HIV, key populations, women, girls and other vulnerable populations to monitor the impact of problematic laws (civil and penal codes) that impede HIV services—and any changes in policies and laws—and advocate for change as needed.</p> <p>Fund advocacy groups to support the legal reform process and advocate for and monitor the implementation of supportive policies and laws and advocate for changes, such as greater government funding to increase quality of counselling availability of HIV and TB services by well-trained professionals in prison health facilities.</p>
<p><b>Organizational (police and prison administrators, members of the judiciary, key and vulnerable populations, civil society organizations)</b></p>	<p>Provide in-service training for police officers, judiciary members and prison staff on HIV policies, gender-based violence and key populations, and responsible and supportive policing in the context of HIV.</p> <p>Training should cover the latest science on HIV; the importance of reaching out to populations at risk; the importance of appropriately addressing all violence, including domestic and sexual violence, and including in the context of HIV and for members of key populations; and the negative consequences of illegal police activity on justice and on the HIV response.</p> <p>Expand the training for prison personnel to include information on HIV prevention and health-care needs and human rights of people living with or at risk of HIV.</p> <p>Routinely measure knowledge, attitudes and behaviours of police officers, correctional officers and members of the judiciary to inform the scope of in-service training.</p> <p>Facilitate key populations, women, girls and other vulnerable populations to engage with law enforcement (e.g. through training and sensitization meetings) to prevent harmful policing practices, such as arresting sex workers and peer educators for carrying condoms and incarcerating people who inject drugs on criminal drug charges rather than referring them to harm-reduction programmes.</p> <p>Expand legal support so all community service organizations working with adolescent girls and young women, key populations and people living with HIV have access to affordable or pro bono lawyers for casework, legal defence and strategic litigation, where necessary.</p> <p>Implement programmes to prevent violence against women and key populations and to address stigma and discrimination in partnership with women-led and key population-led organizations; all violence against women and people from key populations should be monitored and reported, and redress mechanisms should be established to provide justice.</p>

<p>Public policy (government ministries, parliamentarians)</p>	<p>Laws and policies should be derived from human rights standards to eliminate stigma, discrimination and violence against key populations, women, girls and other vulnerable populations.</p> <p>Remove laws criminalizing drug use or possession for personal use, sexual orientation, gender identity and HIV exposure, non-disclosure and transmission.</p> <p>Strengthen the legal and policy environment to ensure laws protect women and girls from gender inequality and violence—for example, reform domestic relations and domestic violence laws and law enforcement where these fail to protect women or create barriers to HIV services; and reform property, inheritance and custody laws to ensure equal rights for women, children and caregivers affected by HIV.</p> <p>Integrate HIV sensitization, stigma and discrimination reduction, and human rights and gender sensitization into curricula at police academies and law schools.</p> <p>Routinely inform and sensitize duty-bearers (e.g. parliamentarians, personnel of ministries of justice and interior, judges, prosecutors, lawyers, law-enforcement agents, traditional and religious leaders) on the legal, health and human rights aspects of HIV and on relevant national laws and the implications for enforcement, investigations and court proceedings.</p> <p>Routinely review existing laws, regulations and policies relating to HIV, TB and hepatitis C, and compare against global commitments.</p> <p>Address laws and policies that are discriminatory towards members of key populations, women, girls and other vulnerable populations as part of the national response to HIV; specifically:</p> <ul style="list-style-type: none"> <li>• Assess access to justice for people living with or vulnerable to HIV, and advocate and lobby for law reform.</li> <li>• Engage parliamentarians and ministers of justice, interior, corrections, finance, industry, labour, women’s affairs, education, immigration, housing, defence, health and trade, and religious and traditional leaders, among others.</li> <li>• Promote enactment and implementation of laws, regulations and guidelines that prohibit discrimination; support access to HIV prevention, treatment, care and support; uphold the rights of key populations, women and girls and other vulnerable populations (e.g. through ensuring access to safe housing to people in prison).</li> </ul>
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# Emergency settings

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In 2016 the United Nations High Commission for Refugees estimated 479 million people were affected by emergencies in 2016, up from 314 million people in 2013 (165). During this period the number of people living with HIV affected by humanitarian emergencies increased from 1.71 million to 2.57 million, and the ratio of people living with HIV affected by a humanitarian emergency increased from 1 in 20 to 1 in 14 (165). The magnitude and frequency of emergencies are increasing: 2017 was a record year for complex crises, food insecurity, climate-change events and escalating conflicts and prompted the largest humanitarian appeal ever launched (166, 167). Conflict and crisis can greatly add to the complexities of the HIV epidemic through the disturbances and challenges these events present. In the wake of the increasing occurrence and impact of such events, emergency and humanitarian settings must be considered in efforts to reach the global target of ending AIDS as a public health threat and to achieving universal health coverage by 2030 (168, 169).

Emergency and humanitarian circumstances can increase vulnerability to acquiring HIV infection. Prevention commodities such as condoms may become inaccessible; this is pertinent, as crisis-affected populations may fall back on negative coping mechanisms, such as turning to transactional sex or sex work to survive. In some contexts, women and children may face increased vulnerability to sexual violence. For example, conflict may require people to walk longer distances to fetch water or firewood or to access vital supplies, and these extended trips can increase risk of sexual violence (170, 171). Gender-based violence in crisis situations remains alarming in many contexts, with 7 in 10 women in such situations being exposed to gender-based violence (172). Young men and boys can also be subject to such forms of violence, but their needs are often underreported and overlooked (173).

The health of people living with HIV can be compromised in emergency and humanitarian settings. Conflicts and crises often cause interruptions in HIV prevention, care and treatment, specifically disrupting health systems and medical supply chains. Additionally, food and nutrition insecurity, lack of access to appropriate shelter and clean water, and overall disruption of social services during emergencies makes it harder to adhere to treatment (168, 174). HIV criminalization laws or travel restrictions may exacerbate access to HIV care and treatment services, as refugees living with HIV may fear expulsion from the host country or prosecution if they disclose their HIV status.

The ongoing political, economic, social and humanitarian crisis in the Bolivarian Republic of Venezuela demonstrates these challenges. In 2017, 77% of the 77 000 people living with HIV in the country had insufficient access to HIV treatment. The situation has forced many people, both living with and without HIV, to flee the country in order to access food, medical care and other basic necessities and rights, placing refugees at risk of acquiring HIV or treatment interruption (175).

HIV-related stigma and discrimination notably add to the challenges faced by people living with HIV as they seek safety and stability in emergency and humanitarian settings. For example, if a person living with HIV lacks social support due to HIV stigma and discrimination, it is much more difficult for them to navigate access to food sources or shelter (176, 177). There are many reports of people living with HIV being ostracized in formal and informal refugee settlements.

A number of humanitarian contexts have persistently high or increased incidence of HIV among key populations disadvantaged by structural inequalities, including stigma and discrimination. It is not uncommon for marginalized populations, including people living with HIV, to experience increased stigma and discrimination in emergency and humanitarian settings in the wake of the deepening of structural inequalities that conflict and crisis can present (176). Marginalized populations, who are often neglected and overlooked in periods of stability due to stigma and discrimination, also typically lack appropriate support and resources during times of conflict and crises (176–178). For example, during the 2014–2016 Ebola virus outbreak in Sierra Leone, HIV-related stigma-reduction training and services decreased, negatively affecting people living with HIV in this area (179).

Refugees, migrants and displaced people face notable challenges related to HIV stigma and discrimination as they transition to a new host country or area in their own country. These populations may experience xenophobia, as host communities' fears of the unknown can compound in times of crisis, with suspicions that outsiders may take scarce resources or otherwise inflict harm. Refugees, migrants and displaced people are often incorrectly thought to bring HIV to their host community and may experience stigma and discrimination as a result, despite evidence to the contrary from multiple studies (168, 177, 178). These misconceptions are important, largely because of the mistreatment that refugees and migrants may experience. There are still over 40 countries where a person's HIV status can affect their ability to seek asylum or migrate there (178, 180).

Existing stigma and discrimination against people living with HIV and key populations can interfere with efforts to provide support in emergency and humanitarian settings to people living with HIV and members of key populations. This can be particularly pertinent in countries where HIV transmission or same-sex relations are criminalized. Relief teams may be unable to safely offer services to support people living with HIV and in some cases may be sources of harm themselves (181–183). In settings where the human rights of people living with HIV are not upheld, people living with HIV may face arrest or other consequences from local authorities and the general public if they are identified as living with HIV. The safety of workers and officials implementing these support services is also a consideration: there have been cases where people carrying out or supporting relief services for people living with HIV have faced punitive measures. Such restrictive circumstances underscore the importance of working to uphold the rights and dignity of people living with HIV. In the interim, this may require innovation on the part of workers and officials on the ground—for example, supplying multiple months' supplies of antiretroviral medicines at a time or not directly branding HIV services as being HIV-specific.

Among the magnitude of public health needs in emergency and humanitarian settings, HIV-specific services and considerations often lack prioritization. There tend to be more visible priorities driving funding, resources and efforts (176–178). Provision of HIV services and reducing HIV-related stigma and discrimination in emergency and humanitarian settings, however, is critical to stem the HIV epidemic.

Resources and assistance for people living with HIV in emergency and humanitarian settings must be provided in a safe and confidential manner so that stigma and discrimination are not heightened through unwanted disclosure (176). Refugees, migrants and displaced people may face intersecting stigmas based on their legal status, ethnicity, race, economic status or health status, which may require special attention by humanitarian agencies and governments overseeing service provision during humanitarian and emergency settings to protect their rights to health and other critical services. Continued activism and persistence are often necessary in emergency

and humanitarian settings to ensure such initiatives successfully meet their objectives, as observed in the Bolivarian Republic of Venezuela (175).

## Intervention examples and recommendations

The evidence on interventions to reduce HIV stigma and discrimination in emergency and humanitarian settings is very limited, with no published evaluations of such programmes. This highlights the current programming gap and the need to add to the evidence base in this area. As a global community, we will not be able to reach the 90–90–90 targets or the target of universal health coverage if we fail to address HIV in emergencies. It is important to expand implementation science research efforts to improve the evidence base and programmes to reduce HIV-related stigma and discrimination in emergency and humanitarian settings.

We are not without insight and expertise in the field.<sup>5</sup> One intervention implemented in Ukraine during the ongoing armed conflict identified that cash transfers decreased stigma and discrimination in health-care settings and among individuals (e.g. reduced internalized stigma) (see Box 10). A sum of US\$ 25 a month enabled people living with HIV to travel to health facilities to receive antiretroviral therapy, purchase nutritious food, and enhance their self-value and feeling that people cared for them. Additionally, the programme improved attitudes among health workers towards people living with HIV.

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### Box 8

#### Food for Life cash transfer programme in Ukraine during period of armed conflict

The ongoing armed conflict in Ukraine has created numerous challenges for people living with HIV that infringe on their health and human rights. Notably this conflict disrupted access to antiretroviral therapy, as it became cost- and time-prohibitive to travel to clinics, and it was further aggravated by the fact that many people living with HIV who were internally displaced by the conflict were unable to access employment due to stigma and discrimination. With factories closing in conflict-affected regions, competition for jobs grew in the communities where people living with HIV and other internally displaced people moved. People living with HIV reported that potential employers assumed they would be less productive and need more time off, which made it difficult for them to find employment in a competitive job market with limited opportunities.

To ensure continued access to antiretroviral therapy over an eight-month period in 2017, the All-Ukrainian Network of People Living with HIV/AIDS and the World Food Programme sought to ensure people living with HIV had access to treatment and support through use of a conditional cash transfer programme (184).

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<sup>5</sup> Members of the Inter-agency Task Team to Address HIV in Humanitarian Settings, the International Organization for Migration and the United States Centers for Disease Control and Prevention reviewed and provided guidance on the emergency and humanitarian section of this report.



The programme offered US\$ 25 per month via electronic transfer for transport or food supplements. These transfers were conditional on participants visiting a participating hospital to start or restart their HIV treatment.

The programme was successful on a number of fronts. First, it was highly effective at improving treatment adherence. Programme monitoring data showed 90% viral suppression was achieved among people living with HIV who initiated or restarted treatment during the programme. Further, 34% of beneficiaries improved their level of adherence to treatment. This outcome demonstrates it is possible to achieve the 90–90–90 goals even in emergency settings when adequate resources are available.

Second, the programme reduced stigma and improved attitudes and behaviours of health-care providers and social workers towards people living with HIV through increased contact with people living with HIV, which led to increased understanding of the experiences and challenges of living with HIV. In addition, the programme reduced internalized stigma, as interaction with and provision of support services reminded them they are people of value.

Although successful at meeting its objectives, the programme ended in 2018 after the conflict in Ukraine was downgraded to a “prolonged crisis” and World Food Programme funding ceased. The conflict in Ukraine persists, however, and the economic hardships have returned for people living with HIV in conflict-affected areas. This case study demonstrates the need for both immediate and longer-term support programmes in emergency settings to ensure people living with HIV can continue to access treatment and nutritional services during heightened periods of vulnerability.

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**Table 10.**

Recommendations for states and humanitarian organizations in emergency settings

Level	Recommendations
<b>Individual (key populations, women, girls and other vulnerable populations)</b>	Implement programmes and services to reduce internalized stigma and support the needs of key populations, women, girls and other vulnerable populations in conflict and crisis through providing safe access to care and treatment.
<b>Community (community health workers)</b>	Strengthen capacity of community health workers by ensuring appropriate linkages between communities and formal health systems in emergency settings.
<b>Organizational (community-based and humanitarian organizations, multilateral organizations)</b>	<p>Engage key populations, women, girls, other vulnerable populations and community-based organizations in development and implementation of interventions to reduce HIV-related stigma and discrimination in emergency and humanitarian settings.</p> <p>Integrate stigma- and discrimination-reduction training into existing workforce capacity development and service performance monitoring for employees involved in emergency service delivery and planning; this may include members of health-care and justice workplaces.</p> <p>Educate humanitarian actors, including the Office for the Coordination of Humanitarian Affairs, cluster leads and cluster partners in addressing discrimination, working with people living with HIV and key populations in emergency settings on HIV-related stigma and discrimination.</p> <p>Implement programmes to prevent, address, monitor and report violence against key populations, women, girls and other vulnerable populations in emergency settings.</p> <p>Monitor levels of stigma and discrimination using globally agreed indicators in emergency settings, including the experiences of internally displaced people and refugees, and the attitudes and practices of humanitarian personnel.</p>
<b>Public policy (national governments, national duty-bearers)</b>	<p>Include provisions for key populations, women, girls and other vulnerable populations in national emergency plans; this includes ensuring procedures are in place to protect women and girls from gender-based and intimate partner violence.</p> <p>Ensure key populations, women, girls and other vulnerable populations have access to legal assistance in host and affected communities, camps for internally displaced people and refugees, and border settings.</p> <p>Routinely review and revise policies and practices regarding emergency settings to ensure they protect against discrimination of key populations, women, girls and other vulnerable populations.</p>

# Considerations relevant across settings

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There are a number of cross-cutting issues that are important to consider in the context of HIV-related stigma and discrimination reduction efforts. The consideration of these issues may indicate a need for layering on additional programmes outside those targeted to address stigma and discrimination, as progress on stigma and discrimination may be limited without these additional programmes.

## **Laws and policies**

Across countries there are different laws and policies related to HIV-related stigma and discrimination that may influence each of the settings described. Examples include national laws regarding criminalization of HIV transmission or criminal laws affecting key populations, anti-discrimination laws, and policies in organizational settings that dictate how a person living with or thought to be living with HIV should be treated. These laws and policies can serve as either barriers to or effective tools for reducing HIV-related stigma and discrimination, depending on whether they are protective or punitive. A thorough understanding of laws and policies specific to the country context will be important for ensuring the inclusion of appropriate structural interventions to support the elimination of HIV-related stigma and discrimination programmes (19, 21).

## **Social protection and services**

HIV-related stigma and discrimination can present challenges regarding access to different social protections and services. For example, in some settings key populations, women, girls and other vulnerable populations may be denied housing or use of public transportation. Similarly, access to welfare programmes or social security may be contingent on passing a drug test. This can impact on a person's health by leaving them unstably housed or without a means to travel to a health facility or to their place of employment (185, 186). Additionally, key populations, women, girls and other vulnerable populations may not be able to access life insurance, which in some settings may preclude them from accessing financial loans or a pension. Further, health insurance programmes can discriminate against people living with HIV by treating HIV as a pre-existing condition; this may obstruct a person living with HIV from accessing care and restrict their mobility (e.g. changing jobs or location), as they may not be confident that their health coverage will be maintained (187, 188). As social protections and services are important supporting components of interventions to uphold the health and well-being of key populations, women, girls and other vulnerable populations, it is important that these protections and services are well understood and amended as necessary to support HIV-related stigma and discrimination interventions.

## **Social and economic inequalities**

Social and economic inequalities can intersect with and compound the stigma and discrimination that people living with HIV and key populations experience. They can also increase risks for HIV, for example by rendering clean needles unaffordable. Such inequalities limit the agency and options a person living with or thought to be living with HIV and members of key populations have to circumvent or respond to HIV-related stigma and discrimination. This may include possessing legal literacy and understanding how to navigate insurance and other forms of social protections and services. HIV stigma and discrimination may also be the source of social and economic inequality—for example, if a person loses their social standing or livelihood as a result of their HIV-positive status (189). A person's social or economic status may also be a source of stigma and discrimination, intersecting with HIV stigma and posing an additional barrier to seeking HIV-related services (190).

## **Gender inequality and gender norms**

Inequalities between women and men exacerbate HIV-related stigma and discrimination in many contexts. Both trans and cis women living with HIV often struggle with gender discrimination and the comparatively lower status that women are afforded as a result of gender inequalities. A widowed woman living with HIV may face property disputes with her deceased husband's family, complicated by limited access to justice to uphold her rights. The burden of care for people living with HIV often falls on women, regardless of whether they themselves are living with HIV, limiting their prospects for education and employment (191).

Gender inequality and harmful gender norms can also fuel stigma, which can negatively affect sexually active young women and sex workers in particular. Homophobia and the stigmatization of men who have sex with men are reinforced by notions of masculinity that place value on men's dominance over women and may increase internalized stigma among gender-nonconforming people (192). Further, rigid gender-binary ideas and notions that biological sex and gender expression must always align marginalize people who do not conform.

Gender norms can also present distinct challenges in HIV prevention, testing and treatment. For example, men are often socialized to not seek assistance or emotional support, which may increase internalized stigma among men living with HIV or inhibit their willingness to seek health services and social support if stigmatized.

## **Social and cultural norms**

Social and cultural norms can contribute to HIV-related stigma and discrimination and to stigma and discrimination towards key populations and people at risk of HIV transmission. Thus, people perceived to be living with HIV or engaging in stigmatized activities may be met with stigma and discrimination for going against social and cultural norms. Such harmful social and cultural norms can be reinforced and experienced across settings. It is important to positively shift these norms to reduce HIV-related and other intersecting stigmas that impede access to HIV services and impact negatively on quality of life (193).

## **Communication and media**

Communication and media platforms are important to consider in efforts to reduce HIV-related stigma and discrimination as they can shape public opinion. For example, such platforms can fuel HIV-related stigma and discrimination through the use of stigmatizing language regarding HIV (e.g. use of the term “HIV-infected person” or “AIDS patient” instead of “person living with HIV”) or sensationalizing stories regarding HIV or key populations, fuelling fear and misconceptions. On the other hand, these platforms can also be important tools to reduce HIV-related stigma and discrimination by providing accurate information about HIV and people living with or vulnerable to HIV and normalizing engagement with HIV testing and treatment services (34, 194).

## **Sexual and gender-based violence**

Sexual and gender-based violence is a form of discrimination. People living with HIV, women, girls and members of key and vulnerable populations may be subject to this type of violence across settings. For example, a woman may be physically harmed by her male partner if he learns of her HIV status (50, 52). HIV-related and other intersecting stigmas may also influence the care or support received by a survivor of sexual or gender-based violence. For example, a sex worker attempting to report sexual violence may not be given post-exposure prophylaxis and may be subject to additional sexual violence by law-enforcement agents (152).

# Monitoring and evaluating progress to eliminate all forms of HIV-related stigma and discrimination

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Key to our success in achieving zero discrimination are the active monitoring and evaluation of efforts implemented to reduce HIV-related stigma and discrimination across socioecological levels in each country. Both programme- and impact-level assessments are required to inform real-time programme adaptation and improvement and ascertain whether the combination and level of the interventions implemented are achieving the desired effects. Monitoring the implementation of programmes will also be critical to identify any challenges and inform mid-course correction as needed. The Health Stigma and Discrimination Framework shown in Figure 2 should guide monitoring and evaluation efforts.

All monitoring and evaluation efforts should apply rights-based and rights-sensitive approaches to the monitoring and evaluation of HIV programmes and activities, and should include communities and civil society organizations in the design and implementation of evaluation efforts, as articulated in the UNAIDS publication *Rights-based Monitoring and Evaluation of National HIV Responses (195)*.

When determining what measures to use in monitoring and evaluation efforts to assess stigma- and discrimination-reduction programmes, consider the following questions:

- What inputs are needed to implement the planned programme?
- What aspects of stigma are the programme components trying to shift?
- What socioecological levels will the stigma- and discrimination-reduction programme address?
- Who will be exposed to the programme?
- Who are the intended beneficiaries of the programme?
- What are the expected outputs of the programme?
- What are the expected outcomes of the programme?
- What are the expected impacts of the programme?

Answers to these questions will determine which inputs and outputs should be tracked throughout programme implementation, and which domains of stigma should be measured (e.g. drivers, facilitators, manifestations), with which populations, and in which parts of the country. We examine two examples to see how these questions could be applied to determine how best to monitor the outcomes of programmes implemented to reduce stigma and discrimination.

## Example 1

Country A implements a nationwide mass media campaign for three months followed by linked community discussions led by people living with HIV and key opinion leaders to shift negative attitudes of the general public about people living with HIV.

- Inputs needed: television airtime, radio airtime, billboards, scripts and messaging for campaign adverts and edutainment developed by and with people living with HIV, trained community facilitators, and venues for hosting community events.

- Aspect of stigma to be shifted: driver—negative public attitudes towards people living with HIV.
- Levels addressed by programme: multilevel (community, individual).
- Exposed: general public, community opinion leaders, and people living with HIV.
- Intended beneficiaries: general public and people living with HIV.
- Expected outputs: 420 radio spots, 252 television spots, 100 billboards, 50 trained community facilitators, and 200 community meetings.
- Expected outcome: reduced negative attitudes towards people living with HIV.
- Expected impact: reduced experienced stigma and discrimination among people living with HIV.

Given these responses, a monitoring system could be developed to track the various inputs needed and to determine whether the expected outputs of the programme are achieved. The outcome of the programme could be assessed using questions asked of the general public in the Demographic and Health Survey and Multiple Indicator Cluster Survey, which assess negative attitudes towards people living with HIV. The impact of the programme could be assessed using qualitative assessments such as focus-group discussions, with representatives of people living with HIV and opinion leaders in a sample of communities exposed to the programme to see how the programme influenced behaviours towards people living with HIV. In addition, quantitative data on experiences of HIV-related stigma and discrimination can be assessed using the People Living with HIV Stigma Index and the 2018–2023 standard questionnaire of the Demographic and Health Survey.

## Example 2

In addition to the mass media intervention, Country A decided to scale up training in 10 regional-level health facilities for all employees, using a total-facility approach to raise awareness about the harmful impacts of stigma in the health facility setting, increase knowledge on the latest HIV science and human rights and medical ethics in the context of HIV, and develop policies to support stigma-free health facilities. The programme will also ensure supplies are readily available to support universal precautions and minimize workplace exposure to HIV, including access to post-exposure prophylaxis.

- Inputs needed: adapted training curriculum, trained facilitators, training supplies, and universal precaution supplies.
- Aspects of stigma to be shifted: drivers—lack of awareness of stigma and its harmful impacts, and negative public attitudes towards people living with HIV among health-care workers; facilitators—workplace policies and availability of universal precaution supplies.
- Levels addressed by programme: multilevel (organizational, individual).
- Exposed: all staff working at regional health facilities.
- Intended beneficiaries: health workers, people living with HIV and key populations.
- Expected outputs: 20 trained facilitators, 4000 trained health workers, new or updated policies in each facility, and 10 regional facilities fully stocked with universal precaution supplies.
- Expected outcome: increased awareness of stigma, increased understanding of human rights and medical ethics in the context of HIV, reduced negative attitudes towards people living with HIV, and reduced stigmatizing behaviours towards people living with HIV and key populations.
- Expected impact: reduced experienced stigma and discrimination among people living with HIV and key populations attending health facilities in Country A.

Similar to the previous example, a monitoring system could track inputs and outputs of the programme. Responses to the questions indicate that the programme outcome could be assessed by surveying a sample of health-care workers in each regional health facility before and after the programme is implemented using a tool that captures the specific drivers intended to be shifted. The facilitators could be assessed through observations at health facilities to determine whether a policy is in place to protect people living with HIV and key populations from being discriminated against, and whether there is sufficient stock of universal precaution supplies and post-exposure prophylaxis. The impact of the programme could be assessed using qualitative assessments such as focus-group discussions, with representatives of people living with HIV and key populations who attend the health facilities, or quantitatively by implementing routine surveys such as the People Living with HIV Stigma Index to assess the manifestations of stigma among people living with HIV and assessing whether experiences of stigma decreased following the programme. The 2018–2023 standard questionnaire of the Demographic and Health Survey also includes two questions to assess experienced stigma in health-care settings.

### **Monitoring and evaluation best practices**

Where possible, validated measures of HIV-related stigma and discrimination should be used. Validated measures are those that have been demonstrated to capture the intended domain of stigma consistently over time through previous research. Ideally, evaluations should make use of existing data and ongoing data-collection efforts, both quantitative and qualitative. Such efforts include the People Living with HIV Stigma Index, the Demographic and Health Survey, the Integrated Bio-Behavioural Survey, legal environment assessments, the Global Fund baseline assessments conducted in 20 countries, the National Commitments and Policy Instrument of the Global AIDS Monitoring process, and other qualitative sources of information available, such as focus-group discussions with representatives of affected communities.

A separate guidance document providing greater detail on how to measure the outcomes and impacts of programmes to reduce HIV-related stigma and discrimination will be released in 2020.



# Conclusion

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Recommendations for reducing HIV-related stigma and discrimination for a range of settings have been presented, including those specific to key populations, women, girls and other vulnerable populations. Although setting- and population-specific needs have been identified, consistent themes have emerged as well.

Institutionalizing preservice training (e.g. focused on HIV-related stigma and discrimination and human rights) for professionals and duty-bearers would be a valuable intervention strategy. Preservice training offers an opportunity for greater longevity and impact of HIV-related stigma and discrimination reduction efforts, as new and incoming staff and employees across these settings would be appropriately informed and trained before starting their careers. Such training would also be a more economical option over the longer term, compared with in-service training sessions that need to be implemented routinely as staff enter and leave the workplace. The development of preservice curricula and training implementation should be led by or fully engage people living with HIV, key populations, women, girls and other vulnerable populations to enhance programme effectiveness.

It is clear that across each of these settings and populations, no one intervention approach will fully address HIV-related stigma and discrimination or improve access to HIV services. Therefore, a multipronged approach that works across socioecological levels is necessary to create a more enabling environment for people living with or at risk of HIV. This may include the collective use of such intervention strategies as implementing and enforcing non-discriminatory policies; instituting HIV-related stigma and discrimination education and sensitivity training curriculums across different organizational settings; establishing community resources (e.g. legal aid centres) to support people living with HIV in accessing their rights; and offering support and empowerment programmes aimed at people living with HIV and members of key populations.

The importance of engaging multiple stakeholders and people at different levels of training, from junior to senior staff, is essential for efforts to reduce HIV-related stigma and discrimination, as all employees may engage with people living with or thought to be living with HIV seeking services or participating in education or the workplace. Likewise, people outside a specific setting (e.g. family and community members) can influence experiences of HIV-related stigma and discrimination. Further, interventions that directly support people living with HIV must not be overlooked. Key populations, women, girls and other vulnerable populations may require support and information to address internalized and anticipated stigma, and encouragement to access available health and legal services, including redressal mechanisms.

As HIV-related stigma- and discrimination-reduction interventions are implemented, it is important that the needs of women, girls, and key and vulnerable populations are considered. These populations can face unique challenges with both HIV itself and with HIV-related stigma and discrimination across settings (e.g. social disadvantage, violence, economic vulnerability) and may require special provisions, such as to facilitate equitable gender norms or reduce key population stigma.

Further, when designing and implementing such interventions, it is important to ensure they do not inadvertently add to the stigma, discrimination or vulnerability experienced by these populations in the context of HIV.

In honour of the late Dr Jonathan Mann, who first identified stigma and discrimination as the second, "silent" epidemic, let us "include, not exclude" (1986). Let us come together in a Global Partnership and take action to eliminate all forms of HIV-related stigma and discrimination. We have the tools. We have the resources. It is time to act.



# Annexes

## Annex 1 Interventions to reduce HIV stigma and discrimination in community settings

Reference	Country	Study population	Intervention	Duration	Results
Apinudecha et al., 2007 (1)	Thailand	People living with HIV Caregivers Community leaders	Skills-building, contact, structural	8 months	Improved knowledge Reduced stigma
Boulay et al., 2008 (2)	Ghana	Community members	Information-based, skills-building	2 months	Improved attitudes and willingness to care for a relative living with HIV
Rimal and Creel, 2008 (3)	Malawi	Community members	Information-based, contact	2 years	Stigma decreased for people with high efficacy only No change for people with low efficacy
Nyblade et al., 2008 (4)	Viet Nam	Community members	Information-based, skills-building, contact, structural	20 months	Improved awareness and attitudes Reduced fear and discriminatory behaviours
Fakolade et al., 2010 (5)	Nigeria	Community members	Information-based, contact	4 years	Improved attitudes
Young et al., 2010 (6)	Peru	Community members	Information-based, skills-building	2 years	Stigma decreased for men, but not for socially marginalized women
Adam et al., 2011 (7)	Canadian web-based	Men who have sex with men	Information-based	4 months	Improved attitudes and knowledge Reduced discriminatory behaviours
Nambiar et al., 2011 (8)	India	People living with HIV	Information-based	14 days	Reduced enacted stigma No change in felt or disclosure stigma
Tshabalala and Visser, 2011 (9)	South Africa	Women living with HIV	Information-based, skills-building	8 sessions	Internalized stigma decreased No change in enacted stigma
Nuwaha et al., 2012 (10)	Uganda	Community members	Information-based, counselling support, biomedical	2 years	Improved attitudes towards people living with HIV, disclosure beliefs and practices, and personal risk behaviours Increased likelihood of HIV testing
Rao et al., 2012 (11)	United States of America	Women living with HIV	Information-based, skills-building, counselling support, contact	2 days	Reduced internalized stigma
Smith Fawzi et al., 2012 (12)	Haiti	Youth living with HIV and their caregivers	Information-based, skills-building	1 year	Improved social support and reduced psychological distress for study population Reduced stigma among caregivers

Catalani et al., 2013 (13)	India	Female sex workers Men who have sex with men Young married women Married men	Information-based	1.5 hours	Reduced negative judgements about people living with HIV and fears of contracting HIV from casual contact
Jain et al., 2013 (14)	Thailand	Community members	Information-based, contact	1 year	Improved HIV transmission knowledge Reduced fear of HIV Reduced internalized stigma
Jürgensen et al., 2013 (15)	Zambia	Community members	Information-based, contact	4 years	Reduced stigma Improved attitudes No changes in perceived stigma
Low et al., 2013 (16)	Kenya	Individuals Community leaders	Counselling and support, biomedical	18 months	Reduced stigma among community leaders
Lakshmi and Sampathkumar, 2013 (17)	India	People living with HIV	Information-based, skills-building, counselling support	Six 1-hour sessions	Improved attitudes
Mall et al., 2013 (18)	South Africa	Community members	Information-based, skills-building, biomedical	2 years	Improved knowledge, attitudes and behaviours Increased uptake of HIV testing
Nyamanthi et al., 2013 (19)	India	Women living with HIV	Skills-building, counselling support	Six 45-minute sessions	Reduced internal stigma and avoidant coping
Barroso et al., 2014 (20)	United States	Women living with HIV	Information-based and skills-building through video and journaling	4 weeks	Reduced internal stigma and stereotypes Improved self-esteem, coping self-efficacy and social relationships
Rivera et al., 2014 (21)	United States	People who inject drugs People who are underinsured or uninsured	Information-based	1 viewing session	Reduced HIV blame and HIV shame
Elamin et al., 2015 (22)	Sudan	People living with HIV	Information-based	6 months	Increased HIV knowledge Completely reduced negative perceptions of AIDS as a health problem
Rios-Ellis et al., 2015 (23)	United States	Community members (underserved Latinos)	Information-based	One 60- to 90-minute session	Reduced HIV stigma Improved knowledge, willingness to test, and understanding of HIV risk
Bhatta and Liabsuetrakul, 2016 (24)	Nepal	People living with HIV and on antiretroviral therapy	Information-based, counselling and support, contact	Six 1.5-hour sessions	Reduced stigma Improved feelings of empowerment, social support and quality of life
Chidrawi et al., 2016 (25)	South Africa	People living with HIV and their family members, partners, friends, community members and spiritual leaders	Information-based, counselling and support, contact	5 months	Decline of HIV stigma experiences for people living with HIV Improved behaviour towards people living with HIV from people who live close to this population
Payne-Foster et al., 2017 (26)	United States	Community members (church)	Information-based	Eight 1-hour modules	Reduced individual-level stigma
Li et al., 2017 (27)	Canada	People living with HIV Ethno-racial leaders from racialized diasporic communities	Information-based, contact, collaborative learning	12 months	Reduced HIV stigma, increased readiness to "take action towards positive social change"
France et al., 2019, (28)	Zimbabwe	People living with HIV	Information-based, counselling and support	12 weeks	Reduced self-stigma and depression

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## Annex 2 Interventions to reduce HIV stigma and discrimination in workplace settings

Reference	Country	Study population	Intervention	Duration	Results
Richter et al., 2012 (1)	Angola, Cameroon, Chad, Côte D'Ivoire, Equatorial Guinea, Kenya, Nigeria	Employees in workplace settings	Information-based, skills-building	15 half-hour sessions over 12–18 months	Improved attitudes and increased knowledge about HIV and HIV-related stigma and discrimination
Poteat et al., 2017 (2)	38 countries	2825 participants, including PEPFAR staff and programme implementers, United States Government staff, and local stakeholders	Information-based, skills-building, contact	1-day training	Improved attitudes towards people from gender and sexual minorities Increased self-efficacy to take action to reduce stigma and discrimination Increased knowledge of organizations that support health and human rights of gender and sexual minorities in the country

PEPFAR, United States President's Emergency Plan for AIDS Relief.

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### Annex 3 Interventions to reduce HIV stigma and discrimination in education settings

Reference	Country	Study population	Intervention	Duration	Results
Paxton, 2002 (1)	Australia	Students (secondary)	Contact	12 talks; 3-month follow-up	Improved attitudes (although this was found to be have reduced at follow-up)
Lau et al., 2005 (2)	China, Hong Kong Special Administrative Region	Students (grade 9–10)	Information-based, contact	2 weeks	Improved knowledge Reduced discriminatory attitudes towards and negative perceptions of people living with HIV
Deutsch, 2007 (3)	United States of America	Students (university)	Information-based, skills-building video		Improved attitudes Reduced stigma
Norr et al., 2007 (4)	Malawi	Educators	Information-based, skills-building, use of peer groups	Six 2-hour sessions	Improved knowledge, attitudes, self-efficacy, intention to change, and personal HIV risk behaviour Some measures of stigmatization remained unchanged
Bell et al., 2008 (5)	South Africa	Students (primary) Caregivers	Skills-building	Ten 90-minute sessions	Improved knowledge and reduced stigma among students
Bekele and Ali, 2008 (6)	Ethiopia	Students (high school)	Information-based, skills-building	8 hours	Reduced stigma
Sorcar, 2009 (7)	India	Students (high school and college)	Information-based	3 stages, 1 year	Improved knowledge and attitudes Reduced fear Increased likelihood of independently seeking HIV-related information
Brown, 2009 (8)	South Africa	Students (university)	Information-based, contact	3 weeks	Improved attitudes towards people living with HIV Increased interest to learn more about HIV and willingness to support people living with HIV when needed
Chao et al., 2010 (9)	South Africa	Educators	Information-based, skills-building, contact, counselling support	Interactive computer course or 2-day care and support workshop	Reduced stigmatizing attitudes Improved knowledge
Li et al., 2011 (10)	China	Students (high school)	Information-based	Eight 90-minute sessions	Improved knowledge Reduced stigmatizing attitudes
Denison et al., 2012 (11)	Zambia	Students (grade 8–9)	Information-based, skills building	1 month	Improved knowledge, attitudes, self-efficacy, and personal risk behaviour
Harper et al., 2014 (12)	United States	Youth (age 16–24 years) newly diagnosed with HIV <sup>1</sup>	Information-based, skills-building, counselling support	Two individual sessions and nine weekly 2-hour group sessions; 3-month follow-up	Improved personalized stigma, disclosure concerns, and self-image post-intervention No positive change in concern with public attitudes Gender-specific analysis shows positive results for male youth post-intervention and at follow-up
Kerr et al., 2015 (13)	United States	African American adolescents	Information-based	12 months	Increased HIV knowledge Reduced stigma

<sup>1</sup> 60% of study participants were enrolled in school.

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## Annex 4 Interventions to reduce HIV stigma and discrimination in health-care settings

Reference	Country	Study population	Intervention	Duration	Results
Ezedinachi, 2002 (1)	Nigeria	Health workers	Information-based, skills-building	30 workshops, 1-year follow-up	Improved attitudes Reduced fear Increased understanding of rights of people living with HIV Improved treatment climate
Al-Mazrou et al., 2005 (2)	Saudi Arabia	Students (paramedical)	Information-based	1 year	Improved knowledge and attitudes Increased preference for confidentiality
Williams et al., 2006 (3)	China	Nurses	Information-based, skills-building	5-day workshop	Improved knowledge and attitudes towards and willingness to treat people living with HIV
Pisal et al., 2007 (4)	India	Nurses	Information-based, skills-building, contact	4 days	Increased knowledge Reduced fear and stigma (except for comfort with cleaning up stool and urine of people living with HIV)
Khuat Thi Hai et al., 2008 (5)	Viet Nam	Health workers	Information-based, skills-building, contact, structural	1-day workshop, 1.5-day training (Arm A), 2-day training (Arm B)	Reduced fear- and value-based stigma Reduced discriminatory behaviours and practices
Wu et al., 2008 (6)	China	Health providers	Information-based, skills-building	4-hour-session; 3- and 6-month follow-up	Improved knowledge and attitudes Increased likelihood of protecting patients' confidentiality and rights
Kaponda et al., 2009 (7)	Malawi	Health workers	Information-based, skills-building		Improved knowledge and attitudes Reduced stigma Increased self-efficacy
Uys et al., 2009 (8)	Lesotho, Malawi, South Africa, Swaziland, United Republic of Tanzania	Setting nurses, team nurses, people living with HIV	Information-based, skills-building, contact	5 days, 10 workshops	Reduced experienced stigma Increased self-esteem among people living with HIV No reduction in experienced stigma Improved personal HIV testing behaviours among nurses
Wang et al., 2009 (9)	China	Physicians	Skills-building	10-day training programme on HIV-related knowledge and risk-reduction counselling	Increased knowledge Reduced stigma
Yiu et al., 2010 (10)	China, Hong Kong Special Administrative Region	Students (nursing)	Information-based, contact	50-minute lecture, 6-week follow-up	Improved knowledge and willingness to treat Reduced stigmatizing attitudes and fear of infection decreased
Neema et al., 2012 (11)	Uganda	People seeking HIV-related services	Skills-building	18 months	Reduced self-stigma Improved knowledge, self-esteem and communication
Norr et al., 2012 (12)	Chile	Health Workers	Information-based peer-group intervention	8 sessions, 3-month follow-up	Improved knowledge, attitudes and personal HIV risk behaviours
Li et al., 2013 (13)	China	Health providers	Information-based, skills-building, structural	14 months	Reduced stigmatizing attitudes and behaviours Increased institutional support in hospital
Li et al., 2013 (14)	China	Health providers	Information-based, skills-building	4 weekly group sessions over 1 month	Improved attitudes and behaviours towards people living with HIV
Arora et al., 2014 (15)	India	Student nurses	Information-based, skills-building	5 days	Increasing understanding of HIV and AIDS Improved beliefs regarding HIV and AIDS

Li et al., 2015 (16)	China	Health workers	Information-based, skills-building, structural	12 months	Improved attitudes and behaviours (adherence to universal precaution protocol)
Pulerwitz et al., 2015 (17)	Viet Nam	Health workers	Information-based, skills-building, structural, contact	6 months	Reduced stigmatizing attitudes and discriminatory behaviours
Lohiniva et al., 2016 (18)	Egypt	Health workers	Information-based, skills-building, contact	4 months	Reduced value- and fear-based stigma
Batey et al., 2016 (19)	United States of America	Health workers People living with HIV	Information-based skills-building, contact	1.5-day workshop (12 hours total)	Increased awareness of stigma among health workers Decreased concerns among people living with HIV
Geibel et al., 2016 (20)	Bangladesh	Health providers	Information-based, skills-building	Three 90-minute sessions	Reduced stigmatizing attitudes Improved experience of young people

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## Annex 5 Interventions to reduce HIV stigma and discrimination in justice settings

Reference	Country	Study population	Intervention	Duration	Results
Argento et al., 2011 (1)	India	Sex workers Lesbian, bisexual, gay and transgender people Police General population	Community-level structural	4 years at time of assessment	Reduced violence on the part of police officers towards sex workers
Gurnani et al., 2011 (2)	India <sup>1</sup>	Female sex workers Government officials Police Journalists Health workers	Skills-building, counselling support, contact, structural	4 years	Empowered female sex workers Improved engagement with health services and response from policy-makers Increased number of non-stigmatizing media stories Reduced stigma on the part of police officers
Beletsky et al., 2012 (3)	Kyrgyzstan	Police	Information-based, skills building, structural (national-level policy)	About 2 years at time of assessment	Improved knowledge and attitudes regarding harm reduction and policies regarding sex workers
Beletsky et al., 2013 (4)	Kyrgyzstan	Police	Information-based, skills building, structural	46 hours of training	Improved knowledge of policies regarding sex workers and likelihood of referral to harm-reduction services Reduced intent to confiscate syringes
Gruskin et al., 2013 (5)	Kenya	People living with HIV Survivors of gender-based violence Service providers	Information-based, skills-building, contact, structural (improved access to legal services) <sup>2</sup>		Improved legal literacy, ability to communicate with health-care providers, and access to health care and justice of people living with HIV Improved health providers' knowledge of discriminatory practices and human rights violations

<sup>1</sup> Assessment of evaluation includes a pre- and post-test.

<sup>2</sup> Three legal interventions were evaluated in this assessment and have variable duration periods.

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