Eliminating Stigma & Discrimination in Health Settings Delivering HIV Services
GOALS OF THIS e-COURSE

01
To provide a simple, user-friendly, narrated & self-guided online resource for training health facility staff

02
To draw on existing field-tested & validated anti-stigma resources
LEARNING OBJECTIVES

- Define stigma & discrimination
- Identify causes & consequences of stigma & discrimination
- Describe what stigma & discrimination looks like in health facilities
- Identify ways to reduce stigma & discrimination in health facilities
- Describe in practical terms how health care providers can reduce stigma in their day-to-day work
- Describe how a facility can develop, implement, enforce & monitor an anti-stigma code of conduct & action plan
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MODULE 1

Human Rights in Health Settings
SECTION 1

STIGMA & DISCRIMINATION
DECLARATION OF GENEVA

• Adopted by the General Assembly of the World Medical Association (WMA) in 1948
• Declared the medical profession’s dedication to humanitarianism
• Intended as an update of the Oath of Hippocrates
• The Declaration of Geneva requires medical professionals make the following pledges, among others:
  – “The health of my patient will be my first consideration.”
  – “I will not permit considerations of religion, nationality, race, party politics, or social standing to intervene between my duty and my patient.”
Human rights violations are common in health settings
- In many parts of the world
- Limiting accessing to quality health services

Health care workers also face discrimination
- From co-workers & employers
- Work in environments where their rights, responsibilities & roles are not recognized

Some examples of human rights violations
- Coercion of patients
- Substandard quality of care
- Breaches of confidentiality

HUMAN RIGHTS & HEALTH
**HIV, HUMAN RIGHTS & HEALTH**

- People who experience stigma & discrimination are marginalized & made more vulnerable to HIV
- People living with HIV are more vulnerable to stigma & discrimination
- Myths & misinformation increase stigma surrounding HIV
- One in eight people living with HIV is being denied access to health services because of stigma & discrimination
- Adopting a human rights-based approach is critical to maximizing individual health outcomes & achieving HIV epidemic control

Source: HIV Stigma and Discrimination, AVERT
WHAT IS STIGMA?

“Stigma is a social process of devaluing a person, beginning with marking or labeling someone’s differences, then attributing negative values to those differences.”
WHAT IS DISCRIMINATION?

• “Discrimination is unfair & unjust treatment of an individual on the basis of a real or perceived characteristic.”
  • HIV status
  • Age
  • Race & ethnicity
  • Gender identity
  • Sexual orientation
  • Housing situation
  • Immigration status
  • Criminal record

• Discrimination can be experienced at individual, facility, community, or national levels

National laws, policies & practices perpetuate discrimination in health care settings, prohibiting or discouraging people from seeking health care services they may need.

– UNAIDS
DISCRIMINATION

- Discrimination affects both users of health care services & health care providers
- Serves as a barrier to accessing health services & affects the quality of health services
- Reinforces exclusion from society for both individuals & groups
STIGMA ↔ DISCRIMINATION

• Stigma is a belief or attitude
• Discrimination is the action resulting from stigma
  – For example:
    • People living with HIV being refused treatment in a health facility
    • A patient’s HIV status or sexual identity being revealed publicly
• Discrimination takes many forms
  – Denial of services
  – Physical or verbal abuse
  – Involuntary treatment
    • Forced contraception or abortion

As health workers, we sometimes automatically make judgments about people without realizing how these will affect them or the health services they receive.

Source: Health Policy Project
CYCLE OF IGNORANCE

Stigma & Discrimination

Silence

Fear

Inaction

SECTION 2

STIGMA & DISCRIMINATION IN REAL-LIFE
In 2018, IAPAC asked people living with HIV in 29 Fast-Track Cities regarding their quality of life (QoL).

Survey included questions about:
- Stigma in their communities
- Stigma in health facilities
IAPAC QoL SURVEY INTERIM RESULTS

Have you experienced stigma or discrimination in your community in the past 12 months?
31% said “Yes”

Have you experienced stigma or discrimination in your healthcare facility in the past 12 months?
19% said “Yes”

If yes, by whom?
75% said by “Health Worker”
PUNITIVE PRACTICES, POLICIES & LAWS

In many countries, policies & laws marginalize those most at risk of acquiring HIV infection.

Laws may require health providers to report certain groups to law enforcement.

Same-sex activity is outlawed in around 80 countries. Penalties ranging from jail sentences to execution.

More than 100 countries criminalize some aspect of sex work & many outlaw it entirely.

In many countries, transgender people are denied acknowledgement as “legal persons.”

Harsh or illegal police practices force sex workers, LGBT people & people who use drugs to go underground & avoid health services.

Migrants & refugees may be denied access to HIV prevention & treatment.

People who use drugs may be detained in rehabilitation centers for many years:
- Systematic abuse of human rights
- Forced labor
- No treatment for drug dependence
- Increased mortality
HIV STIGMA TAKES MANY FORMS

Self-stigma
- Negative self-judgement resulting in shame, worthlessness & isolation
- Mental health issues (i.e., depression)
- Mental health generally is stigmatized
  • Often unrecognized & untreated in many settings

Societal stigma
- Laws that criminalize the conduct of people living with HIV or exert punitive legal measures against HIV-vulnerable populations
  • Aliens people living with & at risk of HIV infection
  • Deters people from seeking HIV testing & treatment
HIV STIGMA TAKES MANY FORMS (CONTINUED)

Employment stigma
- In the workplace, marginalized groups such as people living with HIV & migrants may be:
  - Stigmatized by co-workers & employers
  - Subject to termination or refusal of employment
  - Receive substandard pay

Household-level stigma
- Can result in family rejection
  - May force people to leave their homes
- Increases vulnerability, financial & housing insecurity & risk for transactional sex
DRIVERS OF HIV-RELATED STIGMA

Lack of awareness
Health workers may be unaware that their attitudes, words & actions are stigmatizing

Moral judgement
Health workers may make negative judgments about people who are “different”
May not understand the lives, identities & sexuality of key populations vulnerable to HIV
MSM, transgender individuals, sex workers & PWUD may be seen as sinful or immoral, thus deserving of shame & blame

Fear & ignorance
Health workers may lack knowledge about & have misconceptions about HIV transmission & fear acquiring HIV through casual contact or medical procedures
Such fear & ignorance drives stigma
KEY POPULATIONS MOST AT RISK OF DENIAL OF CARE

- Adolescents & young people
  - Particularly adolescent girls & young women
- People living with HIV
- Men who have sex with men
- Transgender individuals
- Sex workers
- People who use drugs
- Migrants & internally displaced persons
- Ethnic minorities
HIV disproportionately affects key populations:

- Young women 15-24 years old in sub-Saharan Africa are twice as likely as young men to be living with HIV.
- Men who have sex with men are 19 times more likely to be living with HIV than the general population.
- HIV prevalence among sex workers is 12 times greater than among the general population.
- Of the estimated 13.7 million people who use drugs worldwide, 13% are living with HIV.
VALUES & BELIEFS

• Our values & beliefs are the root cause of much stigma
  – Stem from our cultural & social upbringing
  – Learned behavior from our families, communities, & traditions
  – Affect the way we relate to other people
• We may be unaware how these values & beliefs affect our behavior
• What we learn as “normal” leads us to judge those who behave differently
• Much stigma around HIV is related to values & beliefs about sex & morality

The following case study about Alejandro, an adolescent gay male, helps to illustrate how our values & beliefs can drive stigma within a health facility setting & deny patients their right to health.
SECTION 3

CASE STUDIES
Values & Beliefs

- Alejandro is an 18-year-old sexually active Latino gay male.
- He moved from his family home in a small town to study at an urban college where he received an academic scholarship. He chats with other young people on a social media app & meets up for sex. Alejandro & his sex partners do not talk about HIV.
- He read about pre-exposure prophylaxis (PrEP), & thought it would be a good option for him because he does not consistently use condoms when he has sex.
- Alejandro spoke with the campus physician about starting PrEP, however the physician did not feel comfortable prescribing PrEP for Alejandro. The physician referred Alejandro to his family physician for an HIV test, & counseled him that PrEP promoted “promiscuity.”
Beyond the shame of having been labeled “promiscuous,” Alejandro subsequently did not ask his family physician to prescribe PrEP, fearing the physician might disclose the PrEP request to Alejandro’s parents. Alejandro is still dating on-line & using condoms ~80% of the time.
Young sexually active gay men at significant risk for acquiring HIV infection have a human right to PrEP

Much stigma is related to issues surrounding morality, sex & religion
Physician’s personal beliefs are stigmatizing, but also feed into patient’s internal stigma

The campus physician is providing substandard care
Refusal to prescribe PrEP to high-risk populations runs counter to evidence
Referral to another physician to conduct HIV test (& prescribe PrEP) promotes loss to follow-up

Alejandro’s fear that his family will learn about his PrEP request
Feelings of shame contribute to unwillingness to further request PrEP
Shame contributes to anxiety, depression & other mental health conditions

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ALEJANDRO’S CASE

Adapted from www.avac.org
WHAT CAN WE LEARN FROM ALEJANDRO’S CASE?

• Alejandro’s campus physician should have:
  – Refrained from making a stigmatizing statement about PrEP users
    • Language matters always, but particularly with already stigmatized people
  – Offered evidence-based information about PrEP
    • Within the context of combination HIV prevention
  – Recommended an immediate HIV test at the campus clinic
    • Referral for HIV testing can be a missed public health opportunity
The following case study about Dakota, a transgender woman, illustrates the consequences of intersectional stigma in health settings.
CASE STUDY

Disclosure

- Dakota is a transgender woman aged 21.
- Dakota lives with her cousin & has been supporting herself with casual work in a local bar where she meets men & offers them sex for pay to supplement her income.
- She takes amphetamines before sex & most days. Her drug use eats up quite a bit of her available money. She has one regular client who pays her double every week not to use a condom.
CASE STUDY (continued)

Disclosure

• One night, the bar was offering free HIV testing & she took a test. The test came back positive. Dakota went to a nearby clinic but the staff were unfriendly to her. She was prescribed antiretroviral therapy but no one asked her about her drug use or sex work. She was not counseled about disclosing her HIV status to her sexual partners or family.
• Dakota did not return to the clinic. When her antiretrovirals ran out, she stopped her HIV treatment. She continued to have unprotected sex with clients.
• A year later, Dakota was admitted to the emergency room with dehydration, following a month of persistent diarrhea. She was diagnosed with cryptosporidiosis & AIDS.
In Dakota’s instance, stigmatizing behavior contributed to:

- Inability to disclose HIV status to her sexual partners & family
- Loss to follow up & no substance use or case management referral
- Continued exposure of her sexual partners to HIV
- Presenting to care with advanced HIV disease
WHAT CAN WE LEARN FROM DAKOTA’S CASE?

• Dakota’s clinician should have:
  – Taken a thorough medical history, including in relation to drug use
  – Referred Dakota to harm reduction & social services
    • Drug counseling, case management
  – Advised Dakota about importance of disclosing her HIV status to intimate partners & the need for a social support network
  – Developed an HIV treatment plan to ensure successful outcomes
    • Support for antiretroviral therapy adherence to achieve viral suppression
  – Discussed the importance of maintaining viral suppression
    • Undetectable=Untransmittable (U=U)
Zero stigma & non-discrimination are core human rights principles & obligation
- Within health care settings they remain widespread & take many forms

Stigma & discrimination are barriers to accessing health services & prevents the attainment of universal health coverage

Stigma & discrimination lead to poor health outcomes & hampers efforts to achieve healthy lives for all
SECTION 4
SUMMARY
Eliminating Stigma & Discrimination in Health Settings Delivering HIV Services

SUMMARY OF KEY PRINCIPLES

- Accessible & high quality services for everyone
- Non-discrimination & equality
- Privacy & confidentiality
- Respect for personal dignity & autonomy
- Meaningful participation of patients in their care
- Accountability by addressing stigma & discrimination at all levels
REFLECTION POINTS

• Let’s reflect upon the content from Module 1:
  – What is the link between health & human rights?
  – How does stigma & enacted stigma (discrimination) violate the human right to health? Act as a barrier to accessing & utilizing HIV services?
  – What is your obligation as a health workers in delivering stigma-free care, treatment & support services to people living with HIV?
  – How will you integrate what you have learned in this module into your daily HIV clinical practice?
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