

SCALING UP HIV
STIGMA REDUCTION IN
HEALTH FACILITIES

OUTCOMES OF A HEALTH POLICY
PROJECT EXPERT CONSULTATION

Brief

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Introduction

Stigma reduction is vital to the success of HIV prevention, care, and treatment efforts. HIV-related stigma and discrimination (S&D) continue to adversely affect the health and well-being of millions of people around the world—infringing upon the rights of those affected and undermining the effectiveness of HIV responses. Agencies, including the U.S. President’s Emergency Plan for AIDS Relief (PEPFAR), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), all acknowledge the central importance of addressing S&D, which remain significant barriers to progress at both the global and national levels. Ending S&D against people living with HIV (PLHIV) and key populations (KPs) and improving their access to and uptake of comprehensive HIV services remain cornerstones of PEPFAR’s human rights agenda (PEPFAR, 2014). Further, UNAIDS has identified S&D as a key challenge to achieving the global 90-90-90 targets.¹

S&D restrict the availability of HIV treatment, care, and support services and diminish the quality of those services that are available. S&D hamper HIV prevention efforts, as many effective prevention methods (such as condom use) are associated with assumed “immoral behavior” or a lack of trust. S&D also reach beyond health facilities, affecting lives and livelihoods in complex ways. Yet, health facilities remain central to eradicating HIV-related S&D.

In health facilities, people associated with HIV are often subject to negative attitudes and discriminatory actions at the hands of healthcare providers (see Box 1). S&D in health facilities discourage many from accessing services, disclosing information to providers, and adhering to appropriate medical advice and treatment. Healthcare providers themselves are also affected by S&D, which prevent many from learning or disclosing their HIV status and seeking out appropriate care. Those most likely to experience S&D in health facilities (and beyond) include PLHIV, men who have sex with men (MSM), sex workers, people who inject

Box 1. Common Manifestations of S&D in Healthcare Settings

- Denial of care
- Provision of substandard services
- Making care conditional (e.g., dependent on bringing in a partner, using family planning, etc.)
- Premature discharge
- HIV testing without consent
- Breaches of confidentiality
- Stigmatizing comments or behavior
- Use of excessive precautions against infection
- Referring clients unnecessarily to other providers
- Compulsory or forced treatment

drugs (PWID), transgender persons, and migrants. The need to reduce S&D in healthcare settings is widely recognized, yet programs to reduce S&D in health facilities have yet to be routinely institutionalized and scaled up.

General understanding of how to measure and reduce HIV-related S&D has advanced significantly over the past three decades. Despite these advances, there is a need to scale up and continue to refine effective approaches to stigma reduction.

Over the past five years, the USAID- and PEPFAR-funded Health Policy Project (HPP) has worked in collaboration with global and country-level institutions to advance understanding and approaches to measuring and addressing HIV-related stigma. At the global level, HPP led efforts to review, prioritize, adapt, test, and synthesize existing measures and programmatic tools for stigma reduction in health facilities. This resulted in the development of a comprehensive package for “stigma free” health facilities (HPP, 2015). The package was piloted in several Caribbean countries,² and offers a complete response to S&D in health facilities—from research to action. Its total facility approach targets all health facility staff, from doctors to cleaning staff.

HPP, in partnership with the Stigma Action Network and other global experts, has also worked to improve indicators for measuring and monitoring stigma. As a result, population and health facility level indicators have been adopted at the global level, which should increase the attention paid to stigma reduction:

- Indicators based on HPP’s measurement tool in health facilities added to the UNAIDS indicator registry (UNAIDS, n.d.)
- Population-level S&D indicator added to the Global AIDS Response Progress Reporting (UNAIDS, 2015)
- Revised stigma questions included in the latest demographic health survey core questionnaire (ICF International, 2015)
- Language on stigma incorporated into the State Department human rights reports (completed annually by U.S. Embassies) (USDOS, n.d.)
- Inclusion of three S&D indicators in the 2015 *WHO Consolidated Strategic Information Guidelines for HIV in the Health Sector* (WHO, 2015)

Despite this progress, there is a clear need to continue to refine and adopt standardized stigma monitoring indicators to support integration into existing systems and standards.

In an effort to facilitate further scale-up and refinement of these successful approaches, HPP convened an expert meeting in Washington, DC on June 3, 2015 to discuss and strategize a way forward to scale up S&D-reduction efforts in health facilities. Dr. Laura Nyblade, senior technical advisor on S&D at RTI International and HPP, articulated the goal of the consultation as exploring the question, “How do we take all that we have learned about stigma and discrimination-reduction over the past 30 years and integrate it in everything we do about HIV—as a core function, not as an add-on?”

The consultation was organized around six key themes central to adapting and scaling up (Yamey, 2011):

1. Implementation and service delivery strategies
2. Health sector governance and accountability
3. Leadership and political will

4. Stakeholder engagement
5. Research and evaluation
6. Attention to key populations

Panel presentations helped frame and provide context for group discussions. The presentations outlined developments achieved in the field of S&D, touched on the six key themes, and shared presenters' experiences addressing S&D in health facilities at the regional and country levels (see Annex for further details). Following the panel presentations, participants divided into roundtable discussion groups according to the key themes. These discussions yielded valuable insights and recommendations, which are presented below.

1. Implementation and Service Delivery Strategies

Integrate S&D reduction into existing programs, services, and systems

Participants emphasized the central importance of finding ways to integrate S&D reduction into existing systems—into the “business as usual” of health systems and health facilities. There was a strong consensus that successfully scaling up stigma-reduction interventions in health facilities will require integrating S&D reduction into the core functions of health facilities. Given the current restricted resource environment, persistent health worker shortages, and competing funding priorities, it is unlikely that S&D reduction can be successfully scaled up as an “add-on” to existing approaches and services. Participants recommended searching for opportunities to integrate S&D indicators and approaches into already funded initiatives. They argued that successful scale-up requires making better use of existing systems, including integrating S&D reduction into

- Pre-service and in-service training curricula for health workers
- Standards of care
- Supervisory standards, performance reviews, and codes of conduct
- Monitoring systems to enforce these codes of conduct

Participants placed particular emphasis on educating and sensitizing providers on the needs of KPs—preferably as early as possible in their training and education.

Focus on quality of care

Many participants saw S&D as a quality of care issue. Moreover, they felt that framing S&D as a quality of care issue presents an opportunity to generate resources, political will, and buy-in for scale-up efforts. Several participants noted that, in some contexts, identifying HIV-related S&D as a quality of care issue offers a more compelling case and gives it broader appeal than framing S&D as a human rights issue.

Ensure continuous quality monitoring

Participants pointed out the need for continuous quality monitoring that integrates S&D indicators. Joe Barker, senior technical advisor for program quality and quality improvement of the Office of the Global AIDS Coordinator and Health Diplomacy (OGAC), presented on the potential for including S&D in the PEPFAR Site Improvement through Monitoring System (SIMS). SIMS is OGAC's primary quality assurance system. As such, SIMS is a prime example of a mechanism with the potential to monitor S&D in relation to quality of care. PEPFAR is currently considering incorporating several items related to S&D into SIMS. Participants saw this as an important opportunity to improve monitoring of S&D in health facilities, build the evidence base, and strengthen support for S&D-reduction efforts.

Use integration to enhance accountability and improve quality of care

Quality of care is closely linked with issues of research, integration, stakeholder engagement, and accountability. The integration of S&D reduction and sensitization into in-service and pre-service/formation of health workers' curricula is vital to improving service quality. Codes of conduct, standards of care, and performance monitoring are also important tools in improving quality of care (see Section 2).

Educate and empower clients on quality of care and patients' rights

Ensuring stigma-free care requires more than training and incentivizing healthcare providers. It also requires educating and empowering clients to enable them to

hold providers accountable for offering high-quality, stigma-free health services.

Address quality of care among private sector and community-based service providers

Participants agreed that there is a need to extend the focus on quality of care beyond public health facilities. They argued that engaging private and community-based service providers is essential to ensuring the provision of high-quality, stigma-free health services. This is particularly clear when considering KPs, who often rely on private and community-based services. Participants noted that, in some contexts, private providers could serve as models for how to provide high-quality, stigma-free services.

Put in place and update standards for handling patient data and information

Standards for handling patient data and information are an important aspect of quality of care. Participants argued that there is a need to update standards for handling confidential data and information to account for the ease with which electronic data can be shared.

Identify a minimum package of essential S&D-reduction interventions

We are beginning to understand what works to reduce S&D in health facilities. However, research is needed to discover to what extent these interventions can be pared down before becoming ineffective. Participants highlighted the importance of identifying a bare minimum essential package of S&D-reduction interventions. Having such a package would make it easier to broadly disseminate these interventions and tailor them to different contexts. An essential minimum package could help make the most of limited resources by focusing investments on interventions that have the greatest impact. A clearly defined essential minimum package would also make it easier to estimate costs, and to advocate for the integration of S&D-reduction into existing programs and services.

Tailor S&D approaches to specific contexts and populations

Participants stressed the importance of tailoring interventions, materials, and services to specific populations and contexts. This point came out particularly strongly in relation to fostering political

will (see Section 3), identifying a minimum essential package of S&D-reduction interventions (see above), and attention to KPs. Failing to sufficiently tailor S&D-reduction efforts limits their impact. For example, participants argued that addressing S&D toward KPs requires tailoring not only to specific contexts, but also to specific KPs. Different KPs have diverse needs, attitudes, behaviors, and life experiences. Yet, participants pointed out that many S&D-reduction, clinical, and programmatic interventions continue to treat KPs as a single, homogeneous group.

Continue to refine and standardize stigma monitoring indicators

One of the main factors hindering efforts to focus attention and resources on S&D has been the lack of concrete indicators with which to measure the effects of S&D-reduction efforts. As described above, significant progress has been made in this area in recent years. Ongoing refinement and standardization of S&D-related indicators will be one of the keys to the successful scale-up of effective S&D-reduction interventions.

2. Health Sector Governance and Accountability

Integrate S&D into policies and plans at all levels—from national to facility

Participants argued that achieving accountability for S&D reduction throughout the health system requires action at multiple levels. S&D language and indicators need to be incorporated into strategic plans, operational policies, and standards at all policy levels—from the national down to the facility level. Participants noted the importance of such integration by pointing out that incorporating S&D into national strategic plans makes it far more likely that someone will be designated as responsible for addressing S&D, that funding will be allocated, and that action will be taken. In Thailand, for example, integrating an S&D-reduction target into the national strategic plan (National AIDS Committee Thailand, 2012) has resulted in the Ministry of Health (MOH) focusing on measuring and addressing S&D in health facilities and beyond (Siraprasasiri, 2014). Thailand has adapted and tested global tools for a national strategic information plan to measure S&D

(IHPP, 2014), which includes routine measurement at the health facility level, and ongoing efforts to incorporate S&D into other routine surveys with both the general population and KPs. Results from an initial round of data collection are being used to adapt and design programmatic tools and approaches for S&D reduction (Kingdom of Thailand, 2014).

Increase transparency of information and data

Participants emphasized the importance of transparency. Making data and information available and accessible is vital to accountability. Without access to information, civil society organizations and community members cannot hold healthcare providers

and governments accountable for providing stigma-free care. Transparency of data and information are also beneficial for healthcare providers and facilities. Transparency can help ensure a level playing field, and support the establishment and enforcement of clear expectations related to S&D. The importance of sharing information with health providers and facility management was illustrated by experiences in the Caribbean (see Box 2).

Incorporate S&D into the mandates of accountability mechanisms

There is a close linkage between quality assurance and accountability. The mechanisms for monitoring service quality described above are an important

Box 2. Political Will and S&D Reduction: The Case of St. Kitts and Nevis

S&D directed toward KPs and PLHIV is a political issue. Therefore, successful implementation and scale-up of S&D-reduction efforts requires political will and buy-in from key decisionmakers. Political will was central to the success of S&D-reduction efforts in the Caribbean. Presentations by Gardenia Destang-Richardson, coordinator of the National AIDS Programme at the MOH in St. Kitts and Nevis, and Roger McLean, lecturer and research fellow at the University of the West Indies, St. Augustine Campus in Trinidad, West Indies, demonstrated how the cycle of S&D can be broken by employing “top down” and “bottom up” approaches simultaneously.

When the MOH’s S&D reduction work began in St. Kitts and Nevis, with support from HPP, issues related to key populations were politically unpopular, and there was a general lack of human rights and S&D awareness. Destang-Richardson and her colleagues faced reluctant politicians, limited S&D-reduction policies within health facilities, and breaches of confidentiality and maltreatment by some healthcare providers. The MOH engaged decisionmakers at the national level, while also working at the community level to raise awareness and generate buy-in to support political leaders’ engagement on S&D issues.

The MOH and HPP used participatory approaches to gain the buy-in of key stakeholders from the earliest stages of research and design. This helped the project mobilize the political will needed to successfully implement the S&D-reduction package at health facilities. Participatory meetings with healthcare providers and decisionmakers afforded stakeholders the opportunity to grapple and come to terms with the findings of the facility-based survey. These findings were then used to develop context-specific interventions to address the problems identified.

Additionally, these efforts were bolstered by the Human Rights Campaign’s Equality for All initiative, which educated and engaged community members on human rights, helping to build a stronger popular base of support for political engagement on S&D issues.

The experience in St. Kitts and Nevis underscores the importance of political will and the involvement of key stakeholders at the national level in addressing HIV-related S&D.

aspect of ensuring that health providers and facilities are held accountable for providing stigma-free care. In addition, participants argued, S&D need to be incorporated into the mandate of health committees and other accountability mechanisms at all levels, from the national level down to health facilities. Health committees, for example, could initiate client surveys and other quality assurance tools. To be effective, these bodies need to have diverse memberships and the skills, will, and tools necessary to monitor and report on S&D-related issues; and they should involve a range of stakeholders from across different levels.

Participants saw a need to make better use of existing mechanisms, such as patient charters. They argued that often such charters focus on waiting times and other items that frustrate clients. There is a need to move beyond these issues to focus on quality of care more broadly. It is difficult for patients to hold health workers accountable for providing high-quality care when patients do not know their rights and/or do not feel empowered to ask for what they are entitled to.

Put enforcement mechanisms in place

Effective enforcement mechanisms are one of the keys to both accountability and quality of care. Participants highlighted monitoring and reporting systems as positive examples of S&D-reduction mechanisms with “teeth.” Specifically, participants pointed to experiences in Ghana (HPP, 2015b), where HPP partnered with the Commission on Human Rights and Administrative Justice (CHRAJ) to establish an online discrimination reporting and tracking system (CHRAJ, n.d.). They also noted that text and internet mechanisms for gathering information on patients’ experience provide new opportunities for holding providers accountable for meeting patient needs. For example, in Senegal programmers are exploring the creation of a Yelp-type system to enable clients to rate health facilities and providers.

3. Leadership and Political Will

Make engaging on S&D politically possible

Generating political will and leadership requires making engagement on S&D politically possible, and even beneficial, for political leaders and

decisionmakers. Participants advised planners, advocates, and implementers to keep hard political calculations in mind as they combat S&D. Participants identified three factors as the main keys to effectively generating political will: strategic messaging, community mobilization, and evidence.

To generate political will, messages and arguments must be framed in a way that motivates politicians, who are often risk averse. Many political leaders see supporting initiatives related to S&D or KPs as political suicide. Activists and implementers need to change the equation. As one participant put it (paraphrased), “No one is going to run a campaign on S&D reduction, but they can’t resist joining in an effort to end AIDS.” Participants suggested that reframing S&D as a quality of care issue could make engaging on S&D more politically palatable in some contexts (see Section 4). Community mobilization is another way to make engaging on S&D more attractive. Building community support for action gives politicians political “cover,” enabling them to speak out publicly in support of S&D reduction and meeting the health needs of KPs. A strong evidence base (and effective use of this evidence for advocacy) can also make engaging on S&D more attractive for politicians.

Use participatory approaches and continuous engagement to generate buy-in

Participants saw early and sustained engagement and involvement of key stakeholders and decisionmakers as vital to successfully scaling up S&D reduction in health facilities. They advocated for engaging and involving decisionmakers at all stages—from research planning and implementation to program and policy development and implementation, and onwards through monitoring and evaluation and the refinement of policies and approaches. Participants pointed out that you can’t plan for people without having them at the table; this applies to political leaders and decisionmakers as much as it does to KPs.

4. Stakeholder Engagement

Adopt a single unified and unifying message

A single message will facilitate coordination across systems, levels, countries, and issue areas. Participants asserted that using stigma-specific language and messages is not always the most effective strategy for stakeholder engagement. Instead, they suggested combining similar messages and mandates into a single banner message: respectful care. This message is broad enough to enable a wide variety of stakeholders to rally around it, enabling those working on S&D to coordinate and collaborate with those working on other issues, such as respectful maternity care, reproductive rights, or human rights. Taking what has worked (and what has not) from across these initiatives and applying it to a single message can help build a broad base of support for S&D reduction. Moreover, this type of unified effort is more easily mainstreamed as a common practice than fragmented issue-specific campaigns that are likely to be perceived (and funded) as “add-ons.”

Participants also described the central importance of evidence, data, and research in stakeholder engagement. There is a need for compelling data and evidence to persuade stakeholders of the need to act. Participants also reiterated the need to improve the dissemination and packaging of data and information—ensuring that they are useful, relevant, persuasive, clear, and appropriately targeted.

Use human rights-based approaches and language to give S&D reduction a broader appeal

Participants noted that human rights-based approaches are often used to give S&D reduction a broader appeal and form alliances that extend beyond the health sector. Participants saw human rights-based approaches as essential, yet cautioned that the usefulness of framing S&D reduction as a human rights issue is highly dependent on context. In many places, using human rights to appeal to healthcare providers and the community requires first educating and mobilizing the community about human rights (see Box 2). Framing S&D reduction as a human rights issue may be counterproductive in some places, where doing so may

cause S&D-reduction interventions to be perceived as being imposed by external actors.

Engage the private sector

Participants argued that, too often, policymakers, funders, and implementers lose sight of the private sector. They emphasized the importance of engaging the private sector and cited it not only as a potential source of much-needed resources, but also as a potential source of care for stigmatized groups. For example, participants suggested exploring the possibility of creating networks of KP-friendly providers to increase access to services for KPs (see “Focus on quality of care” on p. 3).

Engage faith-based organizations and faith leaders

Participants argued for the need to educate faith-based stakeholders, and to explore how to best support progressive faith leadership. Some participants suggested that the most effective approach is to identify centers of power (e.g., influential leaders), and to designate a point person for engaging faith-based stakeholders.

5. Research and Evaluation

During the expert consultation, participants touched on several aspects of research and program/policy evaluation that are vital to scaling up S&D-reduction interventions in health facilities. A primary challenge is data collection and analysis. Building the evidence base is vital to scaling up stigma reduction and sustaining ongoing stigma-reduction efforts.

Among other things, the evidence base

- Serves as the basis for advocacy and for directing scale-up
- Helps generate increased political commitment
- Encourages investment in combating S&D
- Informs program design
- Facilitates raising awareness and changing attitudes among health facility staff

Key components of the evidence base include

- Measuring and tracking S&D (the PEPFAR SIMS data could be a very useful set of health facility data)
- Documenting the negative impacts of S&D
- Linking stigma reduction to health outcomes
- Determining the effectiveness of stigma-reduction interventions

Invest in operational and implementation research

Developing an essential minimum package of interventions will require investment in further research, including implementation and operational research to help us understand how S&D-reduction interventions work and how these interventions can best be incorporated into health facilities' operations and procedures. Operational and implementation research can contribute to a more nuanced understanding of issues such as integrated vs. non-integrated and public vs. private care. Medium- and long-term evaluations are needed to understand how stigma-reduction interventions hold up over time. Participants argued that additional research is also needed to support the tailoring of S&D interventions to specific contexts and populations.

Expand the evidence base for KPs, especially transgender persons

The evidence base is particularly important for KPs, including sex workers, MSM, PWID, and transgender people. Without data and information, it can be difficult for these groups to advocate for improvements in healthcare and policies. The provision of appropriate services requires further research to ensure programs and services meet the distinct needs of different KPs. More research is needed to enable providers to offer high-quality services for KPs. Participants highlighted the lack of evidence-based approaches and services for transgender people as a particular area of need, pointing out that behavioral interventions and clinical guidance for transgender persons continue to be based on guidance for MSM, rather than on research into the specific (and likely quite different) needs of transgender persons. Participants also highlighted a

need for additional research on layered or intersectional stigma—stigma experienced by individuals and populations who are stigmatized for multiple identities, behaviors, or associations.

Research positive factors, such as resilience, coping, and resistance to stigma

Much research on S&D has focused on the negative impacts of S&D, and how to reduce it. Relatively little research has explored positive and protective factors. Participants pointed out the need for greater investigation into the supportive factors that allow people to be resilient, to cope with S&D, and to resist the adoption of stigmatizing attitudes and behaviors. Understanding how these positive factors operate and what can be done to support their development may prove vital to long-term solutions and social change.

Conduct modeling, costing, and cost-effectiveness research

Participants saw a need for the increased use of modeling to project the potential impacts of S&D, or of S&D-reduction interventions, and to convey this information to health workers and decisionmakers. Cost and cost-effectiveness research were also identified as important areas for future research. Some participants highlighted performance-based financing to reduce S&D toward KPs as an area in need of further exploration, while emphasizing the importance of safeguarding against potential violations of KPs' rights.

Improve dissemination, information sharing, and use of research

Participants argued that improved dissemination, information sharing, and use of research findings are needed. This includes ensuring that consideration of how findings will be disseminated and used is a routine part of research design.

6. Attention to Key Populations

HIV prevalence rates among certain KPs—including MSM, PWID, sex workers, and transgender persons—are significantly higher than those of the general population. These populations also experience high

levels of S&D, which affects their ability to access health services. Attention to KPs is needed both from an equity standpoint and an epidemiological standpoint.

Meet immediate needs, but focus on long-term goals

Participants emphasized the need to combine short- and long-term approaches. Some strategies and approaches, such as stand-alone services for KPs, may be necessary to meet immediate needs in the short term. However, these need to be carried out in tandem with longer-term approaches designed to both mainstream KPs to avoid isolation and support broader social change. Several participants felt that, even in the short term, stand-alone services are not necessarily the answer. While these services work well in some places, in others they may result in further stigmatization and isolation. Some participants argued that there was a need for KP-friendly (and well-trained) service providers, not necessarily KP-specific clinics.

Provide appropriate services

Participants argued that KPs' most urgent need is for appropriate services, not just "friendly" services. Whether a service is "friendly" says little about the quality of clinical care being provided, and whether this care meets clients' health needs. Without appropriate clinical skills, even the most sensitive, supportive health providers may be unable to provide high-quality services for KPs.

Promote meaningful engagement, cultivate leadership skills

Participants saw meaningful engagement and involvement of KPs as central to successfully reducing S&D in healthcare settings, and emphasized the need to further cultivate KPs' leadership skills. Participants pointed out that this requires support on multiple levels, as many KPs also have restricted access to education. They identified HPP's approach in the Caribbean as a positive example. KPs' involvement as trainers on S&D for healthcare providers in the Caribbean helped dispel myths and stigma, and also empowered KPs to see themselves as leaders and experts.

Recognize community-based services and forge connections between community-based organizations and health facilities

Many services for KPs are community- rather than facility-based. Participants emphasized the need to incorporate non-facility-based services into S&D-reduction approaches. They saw forging connections between communities and facilities as central to improving service quality.

Participants highlighted several examples of creative collaborations between government health facilities and community-based organizations that are already happening around the world. In Cameroon, CHAMPS trains health facilities to be connected with community organizations. In the Philippines, COLORS (a trans organization) successfully advocated to secure a desk in the public health clinic. This type of hybrid approach can offer the best of both worlds—appropriate services with the added security, access, and mainstreaming benefits of services based in a government health facility. In Thailand, the transgender HIV prevention program "Sisters" has also successfully partnered with the public sector. As a result, a nurse from the public health facility comes to the drop-in center every two weeks to offer services. Even in Uganda, where the legal environment is particularly challenging, participants noted that some mainstreaming of services for KPs is happening as a result of relationships built by community-based organizations.

Support networking and information sharing among organizations that serve key populations

While good work is being done to reduce S&D and improve the health status of KPs, many innovative and positive experiences happening at the community level are not reaching the global level. This is because organizations serving KPs remain isolated and under-resourced. Out of necessity, many of these organizations operate under the radar, restricting their access to resources, training, and support. Participants argued that efforts to reach, support, and connect these organizations need to be intensified.

Address the security needs of key populations in healthcare settings

Participants identified security as an important area of need for KPs. Depending on the context, KPs experience threats to their security on multiple levels, from physical threats and intimidation to the risk of unauthorized disclosure and dissemination of personal and medical information. Participants argued that donors and implementing partners need to pay more attention to security needs when designing programs and services for KPs.

Security concerns affect both clients and providers. Fear for their personal safety may discourage clients from accessing health services. Providers may be reluctant to provide services to KPs for fear of harassment or prosecution. Participants found that involving the government and engaging high-level officials can significantly enhance security and neutralize security threats, particularly in places with hostile policy environments. They encouraged collaboration between nongovernmental organizations and government health facilities, noting that government health facilities often have some level of protection, whereas non-government health facilities that are known to serve KPs may face greater security risks. This underscores the importance of working toward integration rather than stand-alone services for KPs. Participants felt that engaging high-level government officials is often a worthwhile strategy, as public statements by such officials may help ease security concerns among providers related to the legal environment.

Conclusion

As HPP draws to a close, the expert consultation on scaling up HIV stigma reduction in health facilities offered an opportunity to pause and reflect on progress and to inform future action. The outcomes of this consultation underscore the importance of sustaining efforts to scale up S&D-reduction efforts in health facilities.

Integration of S&D into existing systems, services, and approaches emerged as a top priority. Development of a minimum package of essential interventions was seen as crucial to this integration effort. Participants

also focused on the importance of strategic messaging and positioning. Framing S&D reduction as a quality of care issue, and more specifically “respectful care,” was suggested as a way to mobilize a unified response spanning multiple issue areas. This emphasis was also seen as a way to generate greater political will for S&D reduction by making engagement on S&D reduction a less risky political proposition. Attention to KPs was also seen as essential to scale-up. Participants placed a particular emphasis on the need to target interventions and approaches to meet the needs of specific KPs, rather than treating KPs as a homogeneous group. Participants saw improved accountability as essential, and stronger monitoring systems and community engagement as vital to improving accountability.

Research was identified repeatedly as a key ingredient to success. Development of a minimum package of interventions, better targeting of KPs, and generating political will all require continued efforts to address existing data gaps and build the evidence base for S&D reduction. As programmers, donors, and decisionmakers look to the future, HPP urges them to consider the recommendations presented above as a starting point for strengthening the scale-up of S&D reduction in health facilities.

References

- CHRAJ. n.d. “Discrimination Reporting System.” Available at <http://drs.system.chrajghana.com>.
- HPP. 2015a. “Comprehensive Package for Reducing Stigma and Discrimination in Health Facilities.” Washington, DC: Futures Group, Health Policy Project. Available at <http://www.healthpolicyproject.com/index.cfm?id=stigmapackage>.
- HPP. 2015b. “How Can People Living with HIV and Key Populations Access Justice in Ghana?” Available at <http://www.healthpolicyproject.com/index.cfm?ID=CHRAJupdate>.
- ICF International. 2015. “DHS Model Questionnaire—Phase 7.” Available at <http://dhsprogram.com/publications/publication-dhsq7-dhs-questionnaires-and-manuals.cfm>
- International Health Policy Program (IHPP), Ministry of Public Health, Thailand. 2014. *Report of a Pilot: Developing Tools and Methods to Measure HIV-related Stigma and Discrimination in Health Care Settings in Thailand*. Bangkok: IHPP, Ministry of Public Health, Thailand.
- Kingdom of Thailand. 2014. *National Operational Plan Accelerating Ending AIDS 2015–2019*.
- National AIDS Committee Thailand. 2012. *Thailand National AIDS Strategy 2014–2016*. Bangkok: National AIDS Committee Thailand.
- PEPFAR. 2014. *PEPFAR 3.0: Controlling the Epidemic: Delivering on the Promise of an AIDS-free Generation*. Available at <http://www.pepfar.gov/documents/organization/234744.pdf>.

Siraprasiri, Taweasap. 2014. "Evidence-based Responses for Stigma Reduction in Thailand: Experiences and the Way Forward." Presentation at the satellite meeting Stigma Research and Prevention 2.0 at The 20th International AIDS Conference, Melbourne, Australia.

UNAIDS. n.d. "Indicator Registry." Available at <http://www.indicatorregistry.org>.

UNAIDS. 2015. Global AIDS Response Reporting 2015. Geneva: UNAIDS. Available at http://www.unaids.org/en/resources/documents/2015/GARPR_2015_guidelines.

U.S. Department of State (USDOS). n.d. "Human Rights Reports." Available at <http://www.state.gov/j/drl/rls/hrrpt/>.

WHO. 2015. *Consolidated Strategic Information Guidelines for HIV in the Health Sector*. Geneva: WHO. Available at <http://www.who.int/hiv/pub/guidelines/strategic-information-guidelines/en/>.

Yamey, G. 2011. "Scaling Up Global Health Interventions: A Proposed Framework for Success." *PLoS Medicine*, 8(6), e1001049. doi:10.1371/journal.pmed.1001049.

Notes

¹ The UNAIDS goals aim to ensure that by 2020, 90 percent of PLHIV will know their HIV status, 90 percent of all people diagnosed with HIV infection will receive sustained antiretroviral therapy, and 90 percent of all people receiving antiretroviral therapy will have viral suppression.

² Completed in St. Christopher (St. Kitts) and Nevis and Dominica; ongoing in Antigua and Barbuda, Barbados, St. Lucia, and Grenada. Portions of the package have also been modified and used to support stigma-reduction efforts in Jamaica and the Dominican Republic.

Annex 1: Program

Scaling Up HIV Stigma Reduction in Health Facilities: An HPP Expert Consultation

2:30 P.M.	Presentations/Panel Discussion: <i>Breaking Barriers: Scaling Up HIV Stigma Reduction in Health Facilities</i>
3:30 P.M.	Break
3:40 P.M.	Roundtable Working Group Discussion
4:45 P.M.	Report-back & Wrap-up
5:00 P.M.	Reception

Panel Details

OPENING REMARKS

Kendra Phillips, Deputy Director
Office of HIV/AIDS, Bureau for Global Health United States Agency for International Development

Angela Davis, Senior HIV/AIDS Technical Advisor
USAID/Eastern & Southern Caribbean

MODERATOR

Ron MacInnis, Deputy Director
Health Policy Project, Futures Group

PANELISTS

Laura Nyblade, Senior Technical Advisor,
Stigma and Discrimination
Health Policy Project, Global Health Division, RTI International

Roger McLean, Lecturer and Research Fellow
Centre for Health Economics, University of the West Indies, St. Augustine Campus, Trinidad West Indies

Gardenia Destang-Richardson,
National AIDS Programme Coordinator
Ministry of Health, St. Kitts & Nevis

Pepe Julian Onziema, Reagan-Fascell Fellow
International Forum for Democratic Studies National Endowment for Democracy

Joseph Barker, Senior Technical Advisory for
Program Quality and Quality Improvement
Office of the Global AIDS Coordinator and Health Diplomacy, Site Improvement through Monitoring System (SIMS), Lead; U.S. Department of State, U.S. President's Emergency Plan for AIDS Relief

ROUNDTABLE WORKING GROUP DISCUSSION—TABLE FACILITATORS

Health Governance and Accountability

Jeffrey S. Crowley, Program Director &
Distinguished Scholar
National HIV/AIDS Initiative, O'Neill Institute for National and Global Health Law

Taylor Williamson, Health Governance Specialist
Health Policy Project, Global Health Division, RTI International

Implementation/Delivery Strategies for Integration

Bruce Agins, Director
HEALTHQUAL International
Medical Director
AIDS Institute, New York State Department of Health

Aparna Jain, Associate
The Evidence Project, Population Council

Debbie Kaliel, Country Ownership Advisor
Office of HIV/AIDS, U.S. Agency for International Development

Laura Nyblade, Senior Technical Advisor, Stigma and Discrimination
Health Policy Project, Global Health Division, RTI International

Key Populations

Hua Boonyapisomparn, Consultant
Health Policy Project, Futures Group

Ashley Grosso, Research Program Manager, Key Populations Program
Center for Public Health and Human Rights, Department of Epidemiology, Johns Hopkins Bloomberg School of Public Health | Johns Hopkins University

Britt Herstad, Regional HIV Advisor
Office of HIV/AIDS, U.S. Agency for International Development

Pepe Julian Onziema, Reagan-Fascell Fellow
International Forum for Democratic Studies, National Endowment for Democracy

Leadership and Political Will

Warren (Buck) Buckingham
Buckingham Global Health LLC

Maeve McKean, Senior Advisor for Human Rights
Office of the Global AIDS Coordinator and Health Diplomacy, U.S. Department of State

Research and Evaluation: Addressing Data Gaps

Tonia Poteat, Assistant Professor
Department of Epidemiology, Center for Public Health and Human Rights, Center for AIDS Research, Johns Hopkins Bloomberg School of Public Health

Julie Pulerwitz, Director, Social and Operations Research, HIV and AIDS
Population Council

Anne L. Stangl, Senior Behavioral Scientist
International Center for Research on Women

Janet M. Turan, Associate Professor
Department of Health Care Organization and Policy, Maternal and Child Health Concentration, School of Public Health, University of Alabama at Birmingham

Stakeholder Engagement

Linda Scruggs, Co-Owner/Director
Ribbon Consulting Group

Ron MacInnis, Deputy Director
Health Policy Project, Futures Group

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