SCOTLAND'S HIV ANTI-STIGMA STRATEGY

ROAD MAP TO ZERO

HIV-related stigma is still a major challenge for Scotland.

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THE HIV ANTI-STIGMA CONSORTIUM

The HIV Anti-Stigma Strategy: Road Map to Zero and Action Plan were developed through a collaborative multi sector approach. Formed by HIV Scotland to create a shared ownership over eliminating stigma, the Consortium brought together people living with HIV, people from key populations, and other experts to create a unified approach for Scotland. This work was funded by the MACAIDS Fund.

ABOUT

SCOTLAND'S HIV ANTI-STIGMA STRATEGY:

ROAD MAP TO ZERO

The purpose of Scotland's HIV Anti-Stigma Strategy: Road Map to Zero is to highlight available research and best practice to guide a strategic approach in fulfilling targets set by UNAIDS and the Scottish Government's Sexual Health and Blood Borne Virus Framework. This document will specifically address how HIV-related stigma influences the effectiveness of Scotland's response to the challenges raised by HIV.

The Road Map to Zero was prepared over a year-long consultative process that brought together people living with and affected by HIV, third sector, academics, and the National Health Service (NHS) to chart the way forward to achieving zero HIV-related stigma. Focus groups, case study reviews and an online consultation were also conducted with people living with and affected by HIV to develop key elements of the document. Much of their feedback is presented as quotes throughout.

The Road Map to Zero defines HIV-related stigma, identifies causes and outlines the ways to address them. It sets out the context for HIV stigma in Scotland and the significant impact it can have on people living with and affected by HIV. This document should be viewed alongside 'NAT's (National AIDS Trust) Tackling HIV Stigma: What works?'[1] which outlines best practices for reducing HIV-related stigma and is supported by evidence from global approaches.

Scotland's HIV Anti-Stigma Strategy: Road Map to Zero aims to provide the foundations for Scotland's HIV Anti-Stigma Strategy Action Plan 2018 – 2027 which will be published in 2018.

To create significant progress in Scotland's response to HIV, a concerted effort must be made to challenge inequalities across the country. We must engage civil, political, social and cultural spheres to influence positive health outcomes for all demographics and populations affected by HIV.

BACKGROUND

There has been a renewed and reinvigorated international effort to eliminating HIV. In December 2013, the UNAIDS established new country and region-led targets for HIV treatment scale-up beyond 2015. Through global stakeholder consultations, new and ambitious targets have been set. UNAIDS 2016-2021 Strategy[2] sets the scene to address the '90-90-90' targets worldwide:

Target 1:

- **By 2020, 90% of all people living with HIV will know their HIV status;**
- **By 2020, 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy;**
- **By 2020, 90% of all people receiving antiretroviral therapy will have viral suppression.**

According to the UN, when this three-part target is achieved, "at least 73% of all people living with HIV worldwide will be virally suppressed or living with an undetectable viral load – a two- to three-fold increase over current rough estimates of viral suppression."[3] Achieving this '90-90-90' target by 2020 will enable the world to end the AIDS epidemic by 2030, which in turn will generate profound health and economic benefits.[4] The only way to achieve this ambitious target is through approaches grounded in principles of human rights, mutual respect and inclusion.

The Fast-Track Cities global initiative grew out of the need to achieve the ambitious targets.

Fast-Track Cities is a partnership between the City of Paris, International Association of Providers of AIDS Care (IAPAC), the Joint United Nations Programme on HIV/AIDS (UNAIDS), and the United Nations Human Settlements Programme (UN-Habitat), in collaboration with local, national, regional, and international partners and stakeholders. The initiative was launched in 2014 in Paris where 27 cities signed the Paris Declaration on Fast-Track Cities committing to accelerating and scaling up their local HIV response. The aim of the Fast-Track Cities Initiative is to build on existing HIV programs to attain the '90-90-90' targets and achieve zero HIV stigma and discrimination. While this is an ambitious initiative, 70 cities worldwide have already signed up to achieving this by 2020.

In 2011, the Scottish Government published the first Sexual Health and Blood Borne Virus Framework[5] that outlined key outcomes for sexual health and the transmission of blood borne viruses and sexually transmitted infections. The Framework brought together policy on sexual health and wellbeing, HIV and viral hepatitis for the first time. Setting out five outcomes, which the Government wished to see delivered, the Framework sought to strengthen and improve the way in which the NHS, the third sector and local authorities supported and worked with individuals at risk of poor sexual health or blood borne viruses. The Framework was updated in 2015 to report on progress made on the outcomes and what still needed to be done. The update further emphasised the Scottish Government's commitment to reducing stigma.

To address global and national targets, Scotland's priorities should be on significantly reducing HIV-related stigma, as it is one of the biggest barriers to testing, treatment and support.[6] Programmes to reduce HIV-related stigma and to respect the human rights of affected populations are integral and essential to every national response to HIV, and fundamental to successfully achieving the goals and activities set out in HIV strategies.[7]

By taking a strong position on eliminating stigma, inequality and social exclusion, we can make real strides in reaching global targets. The success of the '90-90-90' strategy and the Sexual Health and Blood Borne Virus Framework will be based on Scotland's capacity to inform, empower, mobilise and engage people living with and affected by HIV who are currently being left behind and to fast-track HIV-related legislation and prevention programmes.

HIV IN SCOTLAND

HIV is still a major public health challenge for Scotland. HIV diagnoses in Scotland continue to rise with an annual average of 350 new diagnoses over the past five years since 2016.[8] There is evidence that fear of a positive HIV diagnosis can discourage individuals from getting tested and engaging with health services. It is estimated that 13% of people living with HIV in Scotland are unaware of their status,[9] making the total number of people living with HIV in Scotland approximately 5,901. Increased efforts are needed to scale up access and adherence to treatment coupled with HIV prevention strategies including condom programming, treatment as prevention, Undetectable=Untransmissable (U=U), pre-exposure prophylaxis (PrEP), post-exposure prophylaxis (PEP), harm reduction services for people who inject drugs, and focused prevention programming for other people living with and affected by HIV.[10,11]

HIV is most prevalent among groups already stigmatised in Scotland, including gay, bisexual and other men who have sex with men (MSM), black, Asian and minority ethnic groups (BAME), people who inject drugs, sex workers,[12] and transgender people.[13] While currently there is no data in Scotland measuring HIV prevalence in transgender people and sex workers, the HIV Anti-Stigma Consortium has included these groups as key populations based on data from the UNAIDS 2016-2021 Strategy,[14] and the HIV-related stigma that these two population groups face.

The public health response to HIV in Scotland is changing with new advancements in treatment and prevention. Biomedical advancements present significant opportunities for Scotland to address the rates of HIV transmission. To realise global and national goals, a multi-pronged approach is necessary. We need to approach HIV by addressing the science of HIV and transmission, but also by tackling social inequalities that obstruct the efficacy of prevention and treatment programmes.

While there have been advances in supporting the rights of people living with and affected by HIV in Scotland, there is still a significant amount of work to be done to address social, educational, economic and health disparities that prevent people from accessing and engaging in services. People living with HIV should be supported and empowered from the point of diagnosis. This requires a non-punitive, non-criminal HIV prevention approach centred within communities, where expertise about and understanding of, HIV issues is best found.[15] Strategies addressing HIV-related stigma should complement and be seen as a component of wider strategies addressing inequalities. It is crucial that interventions include specific provisions that address existing social inequalities, prejudices and stigma experienced by HIV-vulnerable populations.[16] The recent outbreak of HIV among people who inject drugs in Glasgow was exacerbated by these social inequalities and the multiple stigmas attached to both HIV and drug use. As the number of people living with HIV continues to grow each year in Scotland, we must look towards eliminating the negative experiences people living with and affected by HIV continue to encounter.

WHAT IS HIV-RELATED STIGMA?

Stigma refers to extreme disapproval of (or discontent with) a person or group based on a characteristic that serves to distinguish them from other members of society and outside the norm.[17] It is described as a "spoiled identity."[18]

HIV carries its own stigma. It is defined as the negative beliefs, feelings and attitudes towards people who are living with or are affected by HIV.[19] Often, dated and inaccurate views of HIV as an untreatable disease and lack of knowledge have contributed to stigma and criminalisation of people with or affected by HIV, as does the fact that transmission often involves taboo topics – sex, gender identity and drug use.

HIV-related stigma is a harmful societal phenomenon, enabled by underlying social, political and economic powers that begins when a difference is labelled and then linked to negative stereotypes. It is a process where power inequalities are maintained through the devaluation and disempowerment of people living with, or perceived to be living with HIV, key populations most affected, and activities linked to transmission.[20]

There is significant evidence that suggests that stigma undermines prevention efforts, leads to increased risk, non-disclosure, and poorer adherence to treatment. This can lead to increases in late diagnosis which can negatively impact on a person's quality of life and life expectancy.

Fear of stigma and discrimination is a leading contributor to poor health outcomes for people living with or affected by HIV. For example, the fear of stigma and discrimination may keep people from revealing their status to family, friends and sexual partners. It is also associated with increased levels of mental ill-health, including increased levels of anxiety, loneliness, depression, engaging in avoidant coping strategies, and suicidal feelings.[27,28] Research suggests that fear of being perceived as having HIV, being promiscuous, or merely being a member of a population known to be associated with HIV discourages people from seeking information and resources, and makes them less likely to be tested for HIV.[29,30] These barriers undermine prevention and treatment programmes and weaken a person's ability to seek and access health care services. By improving our understanding of stigma and by identifying factors that can impact on stigma, we can improve and accelerate efforts to address the challenges of HIV in Scotland.

"My ex-partner who I just split up from, I told him about my HIV status, this is a gay man, this is a professional and he said that I was diseased, I was rotten, I was riddled, and I found that really difficult to take. But again, that didn't surprise me cos [sic] I know what the gay scene is like."

Man living with HIV, Edinburgh

"The moment you say you're HIV positive, your relationships change, and the language people use changes. You feel isolated."

Woman living with HIV, Glasgow

Stigma can be separated into three categories: discrimination, perceived stigma, and self-stigma.[21][22]

Discrimination is the enactment of stigma. It occurs when a person is treated less favourably than another who is in a similar situation and when this treatment cannot be justified.[23] An example of discrimination is being denied access to medical treatment based on HIV status, race, gender or sexuality. People can face multiple levels of discrimination at once, which is commonly known as intersecting stigma.

Perceived stigma is a result of social attitudes and language used towards people living with or assumed to be living with HIV. Perceived stigma is an expectation of negative treatment amongst people living with and affected by HIV. This is commonly based on past experiences of stigma. Perceived stigma is often linked with key risk populations based on assumptions about sexual practices, drug use or immigration status.[24]

Self-stigma occurs when an individual believes and internalises negative attitudes and stereotypes about themselves and their HIV status or perceived risk to HIV due to their work, drug use or gender identity. It affects the way individuals feel about themselves as well as how they perceive and manage other experiences of stigma or discrimination. Feelings of self-stigma include blame, internalised shame and a feeling that HIV is a punishment.[25][26]

WHAT IS HOLDING US BACK?

Addressing stigma is identified as the most ambitious outcome of the Scottish Government's Sexual Health and Blood Borne Virus Framework.[31] Significant progress towards this outcome has been slow due to factors impacting individuals' experience of stigma, lack of understanding of causes and fragmented approaches that only target one social level. Four main and interrelated elements should be addressed in order to achieve large-scale success.

1 LACK OF FOCUS ON INTERSECTING INEQUALITY

People affected by HIV-related stigma are not homogenous. They do not experience the same stigma, social exclusion, or are not equally disempowered and able to identify and challenge stigma. Social categories such as gender, sexuality, race, and socioeconomic status influence people's perceptions, fear, values and experiences of HIV-related stigma. HIV-related stigma can reinforce inequality and deepens social divide based on these categories. National policies can further perpetuate stigma and exacerbate inequalities for sex workers and people who inject drugs.

Social inequalities are not static attributes of individuals but rather social processes and performances of power.[32,33] Understanding the relationship between these social inequalities and HIV-related stigma is essential to better understand the intersectionality entrenched in experiences of stigma.

GENDER

Gender inequality significantly impacts on people's experiences of HIV and related stigma.

Misogyny and transphobia are key types of gender based stigma and discrimination that create significant barriers and inequalities for women, girls, trans men and trans women. This is due to the power inequality in societies and by devaluing non normative gender identities, experiences and expressions. Gender-based inequalities are compounded and exacerbated by HIV.[34]

SEXUAL PREJUDICE

People who experience HIV-related stigma are likely to experience sexual stigma as well. Sexual stigma refers to stigma associated with same sex desires, sexual behaviours, and hypersexuality.[35] Sexual stigma can be experienced by sex workers. Homophobia is sexual stigma and prejudice that involves fear, aversion and hatred towards gay, lesbian and bisexual people. People who experience sexual prejudice are likely to experience perceived HIV-related stigma based on societal devaluing of their sexual practices.

RACISM, CULTURE AND RELIGION

People living with HIV from within the black, Asian and minority ethnic (BAME) communities are disproportionately affected by HIV, especially those from black ethnic groups. The findings indicate that the lived experiences of HIV positive BAME individuals are different from the wider population of HIV positive people.[36] Studies have demonstrated that specifically Africans living in Scotland face higher levels of perceived stigma and discrimination based on their race rather than their status.[37] Racism can directly affect people's health in multiple ways, such as racial bias in medical care, the stress of experiences of discrimination or acceptance of societal stigma of inferiority.[38]

CLASS AND POVERTY

Negative views and attitudes towards people from lower socioeconomic statuses can lead to perceived stigma and increase vulnerability to health inequalities. Socioeconomic inequalities lead to food and residential insecurity.[39] There are psychological impacts of living in poverty, such as shame and embarrassment.[40] Poverty is more pronounced in the BAME community overall[41] and further research on the links between poverty and at-risk populations, as well as the effect of poverty on adherence and health outcomes among BAME people living with HIV, is recommended.[42]

CRIMINALISATION

Criminalisation of HIV, drug use, and sex work promotes stigmatisation and the burden of which is largely carried by already marginalised or vulnerable populations.[43] Punitive laws that criminalise disclosure of status, potential exposure, non-intentional transmission of HIV,[44] drug use, and sex work exacerbate experiences of stigma and discrimination and create further barriers for accessing treatment, care or support. Research has demonstrated that criminalisation of drug use has fuelled the HIV epidemic and has resulted in overwhelming negative health and social consequences.[45]

2 LACK OF A UNIFIED APPROACH

An effective national strategy for addressing HIV-related stigma requires collaboration across various sectors and engagement with a diverse set of actors. There are a number of programmes across Scotland that are successfully addressing HIV-related stigma, such as NHS Greater Glasgow and Clyde's HIV +ve, and Waverley Care's Caring Conversations. However, more must be done to address the other social environments where HIV-related stigma is experienced. Scotland requires a unified approach to addressing HIV-related stigma that builds on the work that is being done and creates greater shared responsibility at a national level.

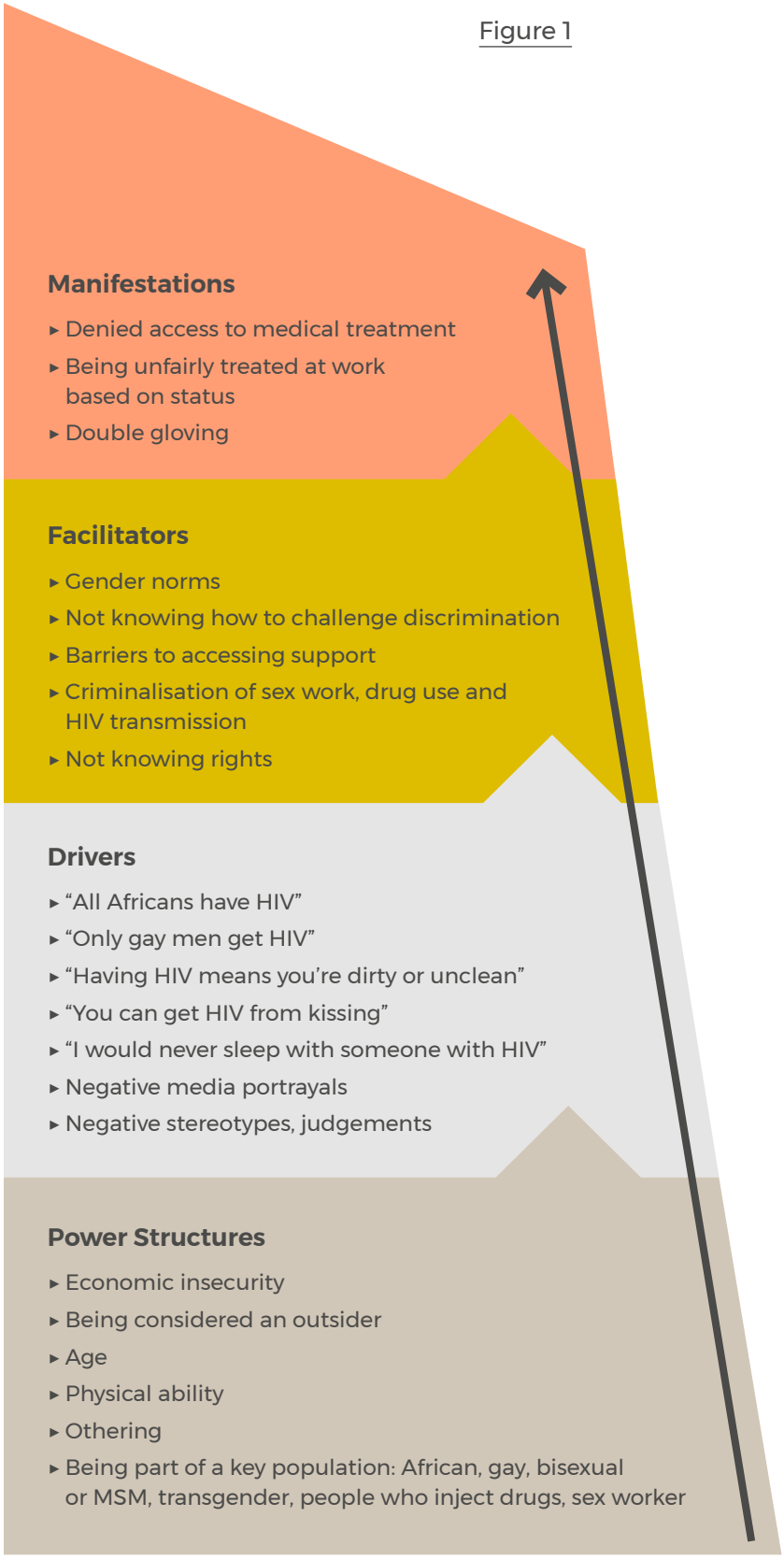
3 INABILITY TO ADDRESS CAUSES OF STIGMA

HIV-related stigma is complex and the underlying causes are often not addressed or taken into account when developing stigma interventions. It is essential that the causes of stigma are understood in order to design programmes that fully address the social structures and power inequalities that are held in place by stigma.

Stigma is caused by drivers, facilitators, power structures and manifestations.[46 47] These four components interact to perpetuate stigma.

Figure 1 illustrates the interplay between the causes of stigma. Each tier is not isolated. The attitudes and actions on the bottom tier reinforce those higher up. This is systematic and if it is to change, each layer must be addressed.

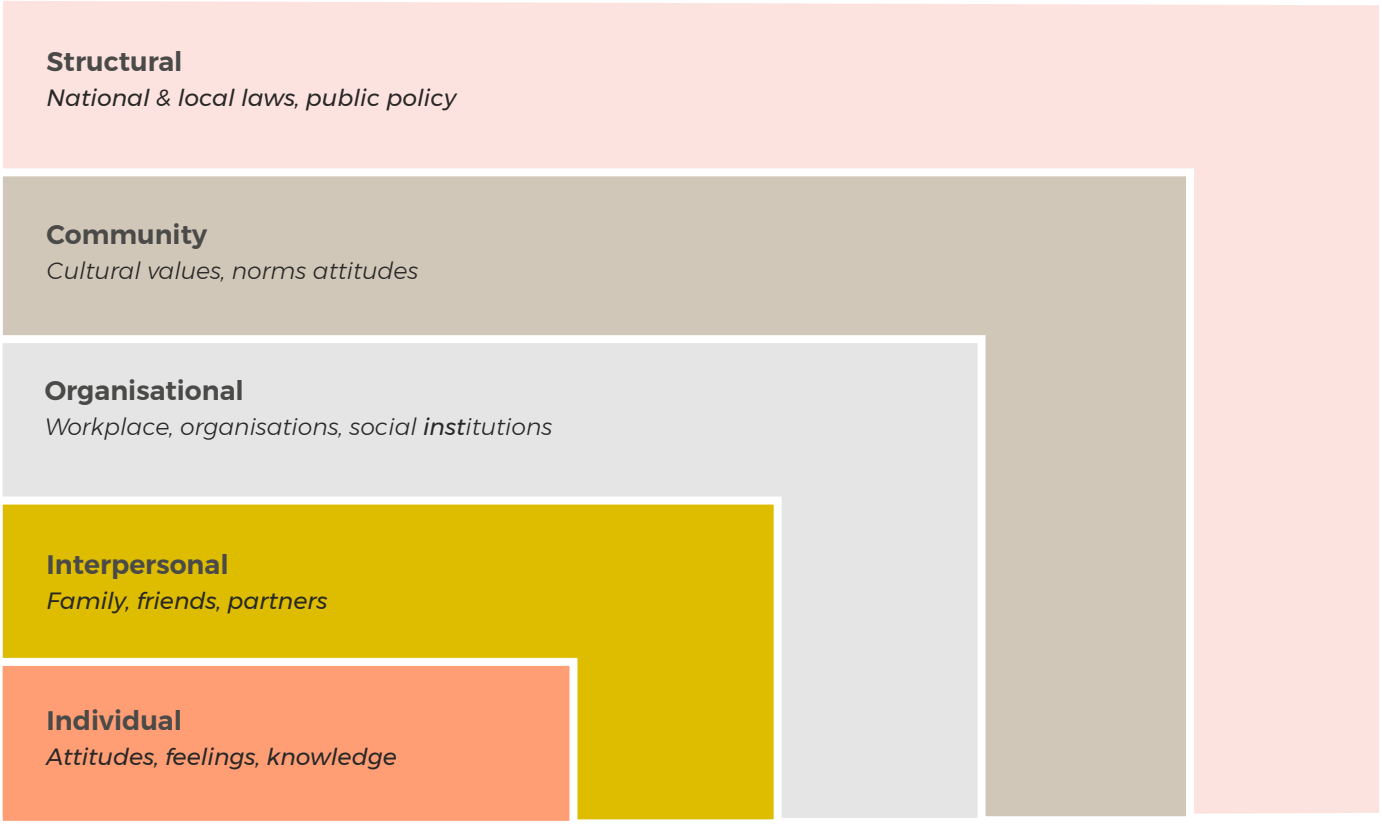
Figure 1



4 INTERVENTIONS TARGETTING ONE EXPERIENCE

The experiences of stigma for people living with and affected by HIV have been profound and lasting. Even though Scotland is experiencing a rapidly changing landscape of HIV prevention with a strong focus on the implementation of effective and efficient strategies and programmes, we need to understand how and where people are experiencing stigma in order to fast-track and promote effective intervention strategies. Past interventions have only addressed one level of stigma. Based on the socioecological model (Figure 2), stigma interventions should focus on five social environments: Individual, Interpersonal, Organisational, Community and Structural.[48] It is crucial that interventions focus on the social and structural drivers of HIV acquisition and transmission, and to do so, we need to address stigma at each of the socioecological levels.[49]

Figure 2



INDIVIDUAL

Individual level stigma refers to the stigma felt by individuals in response to HIV and can include self-stigma or internalised stigma. In the case of self-stigma, this can result from one's own perceptions of HIV or as a result of experiences of HIV-related discrimination. It can include feelings of being unclean, a bad person, being punished, and expressing feelings of fear, shame and guilt for being HIV positive.[50] Faith and culture can also play a role in self-perception. These ideations of negative self–worth and self–image can be the greatest obstacle to leading a healthy and enjoyable life.

The People Living with HIV UK stigma survey[51] showed that people living with HIV in Scotland felt high levels of guilt, blame and shame because of their status. In 2015, 41% of respondents had a negative self-image in relation to their status and 22% reported suicidal thoughts. The study delves further and separates research findings by populations; these include black, Asian and minority ethnic (BAME), gay and MSM, women, transgender people and people who inject drugs. When comparing experiences between populations, it is clear that the levels of self-stigma are similar. However, more research needs to be done to see whether the reported levels of self-stigma were in any way influenced by existing stigmas these populations are already experiencing.

"When I was first diagnosed, I was suicidal, I thought that was it."

Man living with HIV, Edinburgh

"If I had someone to talk to or chat to about what I'm going through, it would really help."

Woman living with HIV, Glasgow

INTERPERSONAL

Interpersonal level refers to social and sexual networks which are comprised of interpersonal relationships including family, friends, neighbours and others that directly influence health and health behaviours for an individual. Experiencing stigma and discrimination at the interpersonal level leads to significant stress, psychological side effects and can lead to disintegrating social supports, networks and structures.

Exposure to HIV and other health outcomes are associated with "social influence, social engagement, disease prevalence, access to information, intimate contact and social networks"[52] and it is important to understand that different networks (i.e. sexual or drug use network vs family networks) have varying degrees of exposure probabilities.

Fear of being identified as 'tainted' or 'less desirable' is a major social risk for people living with HIV seeking interventions and help.

This can increase isolation and create barriers in accessing and adhering to treatment, and undermine prevention efforts. Family and social networks have shown to provide social support, reduce poor mental health, and reinforce positive health behaviours that reduce HIV transmission risks.[53] In addition, perceived social support from family and friends can mitigate the negative effects of stigma. In the People Living with HIV UK stigma survey, participants felt well supported upon telling someone in their social or professional circle and almost half of respondents felt empowered by telling someone. In addition, participants reported that at least one friend was aware of their status and two thirds of respondents felt well supported. It should also be noted that not all people will want to disclose their HIV status, trans identity, sexual orientation, drug use or sex work and that individuals should feel supported to choose to either keep this private or to share with others.

"When I was at the hospital I heard my nurse say to the x-ray technician "can you please wear gloves, she's HIV positive."

Woman living with HIV, Glasgow

ORGANISATIONAL

Experiencing stigma at the organisational level refers to the stigma that occurs in workplaces, schools, and healthcare settings. This includes attitudes associated with fear of transmission and disapproval of lifestyles. This level is impacted by discriminatory policies, uncertainty of rights and the systems by which organisations are arranged and operate including, for example, appointment systems. Organisational stigma can sometimes be a result of individuals within organisational contexts as well.

In health and social care, experiences of stigma can directly affect people's ability and willingness to access necessary care. In Waverley Care's survey[54] they found that 40% of respondents reported that they had been treated differently or badly by a healthcare worker because of their HIV status.[55]

It also found that of healthcare experiences of people living with HIV in Scotland, 58% of respondent's feared stigma and 39% of respondents did not disclose their status to healthcare professionals out of fear of stigma. The fear of being stigmatised is usually a result of previous poor experiences from within that organisation or similar organisations, or from commonly held societal attitudes that they see as being reflected within the organisation.

The findings from British HIV Association's (BHIVA) primary care project showed that practitioner knowledge was key to the quality of care experienced by people living with HIV in primary care.[56] HIV Scotland's National Survey of GPs[57] indicates that GPs in high prevalence health boards feel their training has not been adequate on HIV. In addition, GPs express low confidence and a lack of knowledge around HIV. Inadequate training and lack of knowledge of HIV can lead to stigmatising behaviour.

COMMUNITY

Community level pertains to cultural values, norms, behaviours and attitudes. Changing cultural norms requires changing how people think and feel about HIV. Interventions targeting changing cultural values, norms and attitudes include increasing knowledge and awareness raising.

A key driver of stigma is lack of knowledge and understanding about transmission and the current realities of living with HIV. NAT's 2014 survey[58]monitoring public knowledge and attitudes towards HIV in the UK suggests that there are still people who report negative attitudes towards people living with or affected by HIV. Support for people living with HIV is higher among people with greater knowledge of HIV although this does not mean that improving knowledge alone will reduce stigma.[59]

"People think all Africans have HIV."

Woman living with HIV, Glasgow

Negative media can perpetuate negative stereotypes, judgement and labelling. A 2015 analysis of UK media coverage shows that there is still an issue with negative portrayals of HIV, and much of this is related to criminal prosecutions around HIV transmission.[60] In addition, media portrayals of intersecting stigmas related to drug use, sex work, immigration status, race or sexuality can also perpetuate negative attitudes. Media coverage of PrEP in the UK has contributed to new stigmatising attitudes towards people who support or are taking it. The coverage contributed to a polarising debate between those who support it and those who think it would lead to more risky sexual behaviour. Individual responses may also have been influenced by their own community-based values and norms. Changing media portrayals is a priority for the Scottish Government who have stated that efforts to promote a positive approach to HIV in the media should continue nationally and locally through linking with media groups.[61]

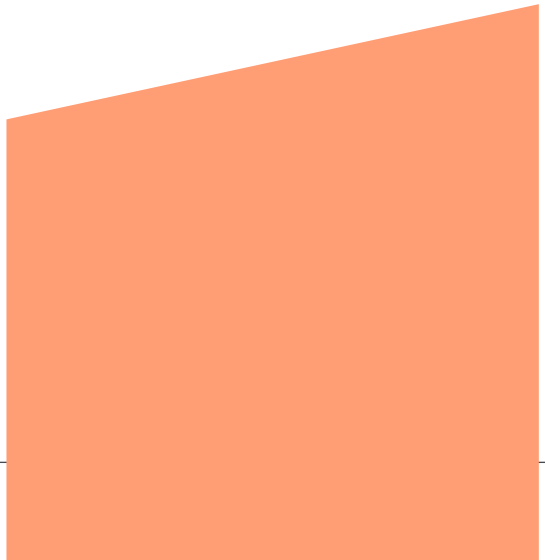
STRUCTURAL

Structural level refers to national and local laws, and public policy that contribute to stigma or discrimination. The Oslo Declaration on HIV Criminalisation, states that singling out HIV with specific laws or prosecutions further stigmatise people living with and affected by HIV.[62] For example, laws criminalising sex work and HIV non-disclosure, exposure and transmission create barriers for sex workers living with HIV to realising their human rights and accessing justice.[63] The relationship between stigma and criminalisation is a process that often leads to discrimination and this discrimination at the structural levels initiates this process.[64] While Scotland's Sexual Health and Blood Borne Virus Framework has made great progress towards addressing the HIV epidemic, the absence of effective public policy interventions that address socioeconomic inequalities for HIV-vulnerable populations undermines the endeavour to reduce structural discrimination and stigma.

In Scotland, there has been longstanding concern that the quality and content of relationship, sexual health and parenthood (RSHP) lessons are not fully equipping young people with the knowledge they need about HIV and wider sexual health issues. There is no statutory requirement for all schools to teach young people about HIV, harm reduction and routes of transmission and studies have shown that HIV is not consistently taught through RSHP lessons.[65]

The Sexual Health and Blood Borne Virus Framework[66] notes that RSHP education should be provided to all young people, with delivery in line with equality and diversity legal obligations. The Framework further states that RSHP is an important tool to address stigmatising attitudes towards sexual health and blood borne viruses.

In the UK, HIV is a protected characteristic under the Equality Act 2010 and people living with HIV are protected from discrimination from the point of diagnosis. However, many individuals are unaware that they can use this when they have been discriminated against. The People Living with HIV UK stigma survey in Scotland found that of the participants that had reported instances of discrimination, they did not seek redress because of lack of confidence that the outcome would be successful, fear of media attention or insufficient financial resources. In addition, while 71% of participants were aware the Equality Act 2010 protects people living with HIV against discrimination, only 18% felt able to influence legal or rights matters affecting them. As part of the Scotland's National Action Plan for Human Rights 2013-2017, one of the priorities is to increase people's understanding of human rights and their participation in decisions. The Scottish Government's Sexual Health and Blood Borne Virus Framework[67] recognises that more work is needed in the criminal justice field to challenge stigma by ensuring that confidentiality, rights and access to treatment while in custody and in prisons are upheld. Interventions at the structural level would include development of a national strategy and updating or amending policies to include new evidence about HIV transmission.



HOW

WE GET TO ZERO STIGMA

To achieve the ultimate goal of zero HIV-related stigma will require identifying evidence for what actions and activities work to address HIV-related stigma coupled with previously identified barriers to success.

NAT has outlined, from global evidence, successful interventions in addressing HIV-related stigma. This research is collated in *Tackling HIV Stigma: What works? Using the global evidence base to reduce the impact of HIV Stigma.*[68] The report outlines best practice from both national and international organisations working in HIV.

From their research, NAT identified that to have a meaningful impact HIV-related stigma must be addressed through a multi-level approach that addresses experiences of stigma in each social environment. A strategy to address HIV-related stigma must address the multiple elements that make up and perpetuate stigma. Their research found that there is a definite lack of evidence for effective stigma interventions, highlighting the importance of ongoing monitoring and evaluation of programmes designed to reduce stigma in specific populations or places.

The report sets out a summary table (figure 3) of what works for reducing HIV-related stigma in different contexts. This table outlines the structure that developing actions and activities should follow to successfully address stigma.

Figure 3

WHERE?	Stigma at a public policy/structural level
HOW?	▸ End the criminalisation of reckless transmission of HIV and other laws criminalising people at increased risk of HIV ▸ Remove policies that reinforce negative attitudes towards people living with HIV or people at increased risk ▸ Provide information on rights to people living with HIV ▸ Increase access to justice for people living with HIV ▸ Implement policy to ensure that high quality information on HIV is provided through the school curriculum
WHERE?	**Reducing stigma between individuals in communities**
HOW?	▸ Increase access to accurate information on HIV and HIV transmission using a range of media tools ▸ Expose people to a range of messages addressing different aspects of stigma ▸ Challenge negative media messaging around HIV and use relationships with the media to maintain more accurate reporting ▸ Link to opportunities for people to further engage with campaigns at a local or community level ▸ Involve people living with HIV in the delivery/facilitation of interventions ▸ Provide information on HIV stigma and its effects within interventions ▸ Provide opportunities to discuss stigma and the factors contributing to it with peers ▸ Use mixed media to deliver a relatable narrative to encourage empathy with people living with or groups affected by HIV
WHERE?	**Reducing stigma in organisational settings**
HOW?	▸ Develop and deliver group-based workshops/programmes where information is combined with skills-building activities. ▸ Involve people living with HIV in the delivery of these programmes, e.g. train people living with HIV as facilitator. ▸ Involve staff across the organisation in the programme design and implementation, not only senior staff ▸ Identify individuals who hold influence to provide leadership and championing of the anti-stigma message ▸ Develop strong organisational policies that promote safe working and zero tolerance to discrimination ▸ Talk about HIV not only in the context of prevention but in the context of the wellbeing of individuals living with HIV
WHERE?	**Self-stigma**
HOW?	▸ Programmes for people living with HIV which combine skills-building activities, peer support and opportunities to discuss stigma and its effects ▸ Promote opportunities for people living with HIV to speak as a community in challenging stigma and discrimination

MOVING FORWARD

Achieving zero stigma requires an intensified effort that brings together community, third sector and the public sector. Current barriers to success are inability to address inequality, gaps in policy and a lack of cohesion among projects.

There is no singular experience of HIV-related stigma and work must be done to address the inequalities that further deepen social divides based on gender, race, ethnicity, class, sexuality and culture. This Road Map outlines the need for a cross sector and multi-level approach that is informed by people living with and affected by HIV.

We know what causes HIV-related stigma, how it is experienced, and what works to address it. We must now come together to take this work to the next step and create a shared ownership of addressing HIV-related stigma. Decision makers must come together to work collaboratively to identify and develop an action plan for Scotland.

The HIV Anti-Stigma Consortium will work to actively involve service providers, decision makers and public bodies in the development of this action plan. We want to achieve greater public awareness, a more empowering and supportive legal environment, policies and services shaped by people living with and affected by HIV, and health and care services that are fully compliant with their public-sector equality duty. We will do this by meeting and consulting over the next three months with partners to determine practical and measureable activities and shared responsibility for ending HIV-related stigma.

THE CONSORTIUM HAS IDENTIFIED THE FOLLOWING KEY PARTNERS:

- People living with and affected by HIV
- Third sector partners
- Local authorities
- The Scottish Government
- NHS Boards
- Police Scotland
- Crown Office and Procurator Fiscal Service
- Prisons
- Social care providers
- Members of Scottish Parliament
- National Union of Journalists

In addition to this, we see the need to change public opinions and this can be done in a variety of ways. The Consortium aims to empower people living with and affected by HIV, peers, allies and organisations to work towards eliminating stigma, and we are open to other partners joining us to work together.

CALL TO ACTION

COMMITMENTS TOWARDS ZERO STIGMA

The HIV Anti-Stigma Consortium will be working with key partners to strengthen and sustain political, public and community commitment for reaching our goal of zero stigma by setting a common agenda among key policy and programme makers.

The role of the Consortium is to focus on generating commitment and accountability towards the development and implementation of the Action Plan.

Achieving zero stigma requires shared responsibility and ownership. The Consortium has identified five key commitments for partners to make as part of their support for Scotland's HIV Anti-Stigma strategy.

PARTNERS COMMIT TO:

1. **Ending HIV-related stigma in Scotland.**
2. **Participating fully in designing, implementing and monitoring programmes for reducing stigma.**
3. **Working collaboratively with other partners to introduce necessary policy changes.**
4. **Strengthening meaningful involvement of people living with and affected by HIV.**
5. **Holding each other accountable for progress towards zero stigma goals.**

THE HIV ANTI-STIGMA CONSORTIUM

This document was developed through a collaborative multi sector approach. The HIV-Anti Stigma Consortium was formed to create a shared ownership over eliminating stigma. The Consortium held five meetings to discuss HIV-related stigma and what needed to be done in Scotland to address it. HIV Scotland administered the group and worked to capture the collective voice of the Consortium.

The report has gone through many draft stages and was continually circulated among the Consortium for critical feedback. Through the collaborative process, there was greater accountability and a wide array of expertise incorporated into the report. Each member of the Consortium signed off in support of the Road Map to Zero. As a result we have created a partnership of shared responsibility for tackling one of the biggest barriers in HIV.

Members of the Consortium include:

Alastair Hudson – The People Living with HIV UK Stigma Index

Cathy Crawford – Lothian Patient Forum

Evarist Chahali – Hwupenyu Health and Wellbeing

Fiona Gilbertson – SCOT-PEP

George Valiotis – HIV Scotland

Jo Zinger – NHS Greater Glasgow and Clyde

Kat Smithson – NAT (National AIDS Trust)

Katai Kasengele – Brownlee Patient Forum

Kelsey Smith – HIV Scotland

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NOTES

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