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Stigma: Breaking the Silences - Dealing with Stigma and Exclusion for PLHIV and HIV/AIDS Affected Populations
Kaiser Family Foundation
July 25, 2012

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MARIA EKSTRAND: Good afternoon and welcome to this session, titled Stigma: Breaking the Silences - Dealing with Stigma and Exclusion for People Living with HIV and HIV/AIDS Affected Populations. My name is Maria Ekstrand, and I'm from the University of California, San Francisco. It's my pleasure to introduce my co-chair, Dr. Shalini Bharat from the Tata Institute for Social Sciences in Mumbai, India.

SHALINI BHARAT: Hello, everybody. We are here to listen to five speakers on the topic of stigma. Without wasting much time let me introduce to you the first speaker, Mr. Tsegazeab Bezabih, he obtained his MSD degree in demography from [inaudible] University in 2003.

He worked in various organizations, including the World Food Program, as research and [inaudible] officer. He worked with UNAIDS and [inaudible] advisor, and recently worked as a principal investigator for a national level study on stigma. Mr. Tsegazeab Bezabih [applause].

Miss Jain is a PhD candidate at Johns Hopkins University and is currently an independent consultant. Previously Miss Jain worked at the International Center for Research on Women and Gender Health, on a variety of sexual and reproductive health research projects, including HIV and Stigma. Over to you Miss Jain.

APAMA JAIN: Thank you, Shalini. It's a great pleasure and honor to be here today, and to share the results of this study. I would like to take a moment to first explain the organizations roles on the project. The population community and development association implemented the Positive Partnership Project Phase 2. They did this with support from PACT Thailand, and with funding from PEPFAR. The International Center for Research of Women provided technical assistance in the analysis of the community baseline and inline data sets. I was hired as an analysis expert to consult with ICRW.

This is the outline of my presentation today. I'm gonna go ahead and jump right into the project interventions. The main goal of the Positive Partnership Project was to provide low interest loans to a buddy pair, that's an HIV positive and an HIV negative individual. This was done to economically empower people living with HIV and improve their quality of lives. There was also a focus to reduce HIV stigma and discrimination within the communities where the loan recipients lived.

For the overall evaluation study data were collected among multiple groups, including people living with HIV who received loans, their buddies, and community members. From the overall evaluation we know that receiving loans has improved the self efficacy and the self esteem of people living with

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HIV, but the focus of this presentation today is only on the community dataset, and the specific HIV interventions at the community level.

Two project models were implemented and developed. The first was the PPP clubs, and these were formed organically by support groups of people living with HIV. The second model was village development banks, that were formed mostly by community members and community leaders. Both of these entities were responsible for dispersing loans and conducting HIV awareness activities within their communities.

Four HIV stigma reduction activities were implemented within the community. The first activity was monthly meetings on banking days. These days included both financial and HIV education activities. For example, one village development bank reported inviting a person living with HIV who is open about their status to speak about their experiences with HIV stigma.

The second activity was HIV campaigns and these were held continuously throughout the project intervention period. An example of this was house to house visits to provide residents with HIV knowledge and raise their awareness about HIV stigma.

The third intervention was three IEC materials and those are posters, banking slips, and radio dramas. Fun fairs was a final intervention and these are basically education and entertainment events that focus on disseminating HIV information.

Eleven PPP clubs and 12 village development banks were formed, the project was implemented from April 2008 to September 2010. As I mentioned earlier the community dataset was just one piece of the overall evaluation study. The community study consisted of a panel of 11 communities, two cross sectional surveys were implemented, one at baseline and one at end line. A sampling frame of households was developed in each community, and households were selected using systematic random sampling. All individuals 15 years and older were interviewed within each of the household.

Previously validated measures and new items to the Thai context were used in the surveys. The measures captured two drivers of stigma. The first driver is fear of acquiring HIV through everyday contact with a person living with HIV, and the second driver is related to values that link people living with HIV to behaviors that are considered improper and immoral.

For the multi variant analysis we developed scales using principal component factor analysis to identify uni-dimensional contrasts at baseline. We then confirmed these factors and end line. We tested the reliability and the validity of each scale and then predicted regression scores.

We then standardized the scales to have a mean of 50, a standard deviation of 10, and the scales range from zero to 100, where higher scores indicated more stigma.

Responding characteristics were similar at both baseline and end line. For example, as you can see there, there's no significant difference in age. Correct knowledge of HIV transmission, prevention, care and treatment, increased from baseline to end line. Across these eight questions, correct knowledge increased significantly on the first five that are presented here on the graph. While correct HIV knowledge improved at end line it remained relatively low.

Fear of HIV transmission through everyday contact with HIV positive individuals reduced, four of six items reduced significantly. Agreement with statements about shame reduced from baseline to end line.

In this graph we can see exposure to the interventions, and exposure to three of interventions was relatively low, and that's the banking day meetings, the campaign, and the fun fair. In this exposure variable we combined four interventions, the banking day meetings, the fun fair, and the HIV campaigns, and an exposure to at least one IEC material.

Exposure to at least one IEC was formed by combining posters, radio dramas, and banking slips. We found that 87-percent of respondents reported exposure to at least one IEC

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material. This graph shows that the majority of respondents were exposed to only one intervention.

We first conducted bi-variant analysis and then ran our multi-variant models. This model shows the beta coefficients, 95-percent confidence intervals, and the P values of three main predictors on fear driven stigma. This model is adjusted for respondent characteristics, media exposure to HIV messaging, and baseline community average of fear.

Respondents who reported that they personally knew someone living with HIV scored 2.6 points lower on the fear scale. Higher HIV knowledge at end line also predicted lower levels of fear, where respondents who answered four to nine questions correctly scored 4.8 points lower.

And in terms of the intervention exposure, the effect of participating in three interventions, specifically the campaign, fun fair, and IEC, reduced fear on a scale by 3.8 points when compared to no intervention exposure or exposure to exactly one.

This model presented the adjusted linear regression of the same three key predictors on the shame scale. As with fear, respondents with high levels of correct HIV knowledge scored 3.8 points lower on the shame scale. Also respondents who reported exposure to the campaign, fun fair, and IEC materials scored 4.3 points lower on the shame scale.

Personally knowing someone living with HIV was borderline significant with a P value of .05.

In summary we found that with relatively minimal community level HIV interventions we began to see shifts in correct HIV knowledge, fear of HIV transmission, and shame associated with having HIV. However here we are 30 years into the epidemic and low levels of HIV knowledge continue to persist in these communities.

From our multi variant linear regression analysis we found that respondents with a greater correct HIV knowledge scored lower on both the fear and the shame scales. We also found that personally knowing someone living with HIV was associated with lower levels of fear, but now with shame.

Finally our results suggest that a combination of interventions helped in beginning the shift in community level or fear, and shame, and specifically those are the HIV campaigns, fun fairs, and IEC materials. Even though the focus of this project was to provide loans to people living with HIV, there are some important conclusions that we can draw about HIV stigma.

The first conclusion, which is also a lesson learned, is that the project involved affected populations in every step of the design, from developing the intervention models, to implementing the HIV community level activities. In spite of

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some of our study limitations our findings are in line with previous research. Our study reconfirms the importance of tackling HIV stigma in ultimate ways. The project used IEC materials and also developed platforms for interactions between community members and people living with HIV. Our results suggest increasing correct HIV knowledge is an important first step in reducing HIV stigma.

This research is especially important given Thailand's new HIV/AIDS strategy in which one of its goals is to reduce HIV stigma by half by 2016. These findings provide a good starting point for policy makers to consider in achieving this goal.

I would like to acknowledge the following individuals for their contributions in the study and presentation, and the Department of Population Family Reproductive Health, and the Bill and Melinda Gates Institute, both at Johns Hopkins for supporting my participation at this conference. Thank you [applause].

SHALINI BHARAT: Thank you, Apama. We would like to now open the floor for some questions for just five minutes, so please stay on here. Any questions specific to this presentation? Okay, mic four.

MALE SPEAKER: Were there any faith groups that were involved in this study?

APAMA JAIN: Were there any faith-based groups involved in the study? One of my co-authors is in the audience who's very involved in the project. Prim, I believe that there weren't any faith-based organizations, but I'd like her to please answer it. Mic three?

PRIM: There were not any faith-based groups, but the fun fairs sometimes were organizing a temple or a Christian church.

SHALINI BHARAT: Any other questions? Okay, thank you very much. We now have the second presenter, Carmen Logie. Carmen Logie is a Canadian Institutes of Health Research Postdoctoral Fellow at the University of Toronto. Her research focuses on health, equity, and human rights, with particular attention to associations between stigma and health outcomes among the LGBDQ population. Carmen, your presentation?

CARMEN LOGIE: Hello, everybody. Thank you for coming today. I'm going to be talking about racism, sexism, HIV related stigma, and associations with the quality of life among HIV positive African, Caribbean, and black women in Toronto, Canada. I'd like to acknowledge my co-authors, Llana James, Magarie Throw [misspelled?], and Mona Loutfy.

In Canada, African, Caribbean, and black women are seven-fold over represented in HIV new infections in comparisons with their white counterparts, and qualitative

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research suggests that stigma and discrimination based on race and ethnicity, gender, and HIV status contribute to both increased vulnerability to HIV infection and reduced access to care once people are HIV positive.

I'm sure more people already understand what HIV related stigma is, but I just want to provide you the definition I'm working from, which is processes, a devaluing, labeling, and stereotyping that result in loss of status, unjust and unfair treatment, and social isolation of people living with and associated with HIV.

There's multiple forms of HIV related stigma that I'll be talking about today, so enacted includes acts of decimation, internalized as negative beliefs, views, and feelings about HIV/AIDS and oneself, and perceived which is awareness of negative social attitudes, and the negative social identity associated with people living with HIV.

We also looked at racism and racial discrimination, which refer to inequitable and oppressive systems, founded on ethical racial differences, including beliefs, attitudes, exclusion and these are also manifested across institutional domains, such as unequal access to material conditions and opportunities, so personally mediated, so acts of prejudice and discrimination and internalized racism.

Sex as a gender discrimination are oppressive and inequitable systems based on gender bias, and attitudes, treatment values, and also manifest in violence, discrimination, and across institutional policies.

We address two gaps in the literature, the harmful impacts of HIV related stigma, sexism and racism, have been widely documented across diverse samples. However we found no studies that looked at these three forms of stigma and discrimination concurrently, so that was something that we looked at in order to fill that gap. Also, the roles of social support and resilient coping, and moderating or mediating the impact of these forms of discrimination on well being are not well understood.

We use an intersectional theoretical approach that looks at the interdependent relationship between social identities, such as ethnicity and social inequity, such as racism.

Objectives were two fold, we examined the associations between racial discrimination, gender discrimination, HIV related stigma and quality of life, among African, Caribbean, and black women living with HIV in Ontario, Canada, and we looked at social support and resilient coping in the role as moderators and mediators of the association between these forms of stigma, discrimination, and quality of life.

This as a multi method approach, the qualitative phase, which is phase one involved 15 focus groups, diverse women living with HIV across Ontario. 104 women participated. We published this study which was presented in Vienna actually, and [inaudible] in November, and we came up with conceptual model, which we tested in this phase two that I'm talking about today, that looked at racism, HIV related stigma, and sexism, across micro, mezo, and macro levels, and also we looked at resilience and social support as coping strategies that women living with HIV enact to deal with these forms of stigma and discrimination.

What I'm talking about today is phase two, we conducted a cross sectional survey with HIV positive African, Caribbean, and black women, and 166 women participated. We used a community based approach.

We used measures with established reliability and validity, the HIV related stigma scale revised based on Berger's scale, which looked at personalized, which is so much an active stigma, disclosure, negative self image which is similar to internalized stigma, and public attitudes which corresponds to perceived stigma.

We used the everyday discrimination scale to look at racial discrimination, and we modified that to look at gender discrimination. The WHO quality of life, HIV brief scale that had six dimensions of quality of life, physical health, psychological health, independence, social relationships, environment, and spirituality. We used the MOS social support scale and the brief resilient coping scale.

We conducted bi-variant correlations in the hierarchical block regression analysis to look at the associations between the independent variables, so HIV related stigma subtypes, racial discrimination, gender discrimination, the moderator and mediators social support, and resilient coping and the dependent variable, which is the quality of life.

Moderation analysis tests if the social support and the resilient coping changes the strength of the direction of the relationship between stigma discrimination and quality of life, whereas the mediation analysis assessed if the independent variables were associated with significant changes in the mediators, so social support and resilient coping, which would then in turn impact quality of life.

Brief look at our sample characteristics. The mean age was 40.7 years, the mean length of time in Canada was 8.9 years, about 90-percent of participants were born outside of Canada across about 50 different countries. Education was a very diverse group of educated people, so some people 28-percent less in high school, 26-percent at high school, 28-

percent had college diploma, and 16-percent had an University degree.

I just want to give you a glimpse of our frequencies, so almost 30-percent of participants reported they experienced racism on a frequent or everyday basis, 22-percent, over one-fifth of participants experienced sexism on an everyday or very frequent basis, and participants reported experiencing most types of the HIV related stigma we measured, so 84.4-percent disclosure related stigma, over half personalized stigma, 40-percent public attitudes, and over one-quarter negative self image.

I'm not going to talk about all of the bi-variant correlations, but what's important to note is that HIV related stigma, gender discrimination, and racial discrimination were correlated with one another, and with lower levels of quality of life, social support, and resilient coping.

In the first regression analysis we looked at what were the correlates of overall quality of life. In the block one we put the different forms of stigma and discrimination and we see that, that, those variables accounted for 20-perecent of the variance and quality of life scores, but actually the only significant correlates in this block were HIV related personalized stigma, and HIV related negative self image.

In the second block we added resilient coping, the different forms of social support, and we found informational support was the only significant correlate, and that model accounted for 30-percent of the variants and quality of life.

In our moderation analysis we did not find that social supporters in coping moderate of the impacts of the independent variables on quality of life, either the overall quality of life, or the quality of life domains. We did find however that social support partially mediated the relationship between HIV related stigma and quality of life, but wait a second it's not so simple.

We get a very different picture when we look at the different quality of life domains, and you can see that every single domain of quality of life has different correlates associated with it. HIV related personalized stigma is associated with a psychological quality of life, environmental aspects of quality of life.

The HIV related negative self image is associated with psychological, independence, social relationship, spirituality. Racial discrimination is associated with social relationships and environments, and the resilient coping is associated with psychological, independence, and social relationships, so it's very complex picture here. I color coded it just to try to show how every single domain has different correlates.

Then a similar situation happened when I looked at the mediators, so social supportive and coping mediated the impact of HIV related stigma on psychological quality of life, independence, and social relationships, and social support was a partial mediator of the association between HIV related stigma and environmental quality of life.

To summarize that there's a really complex relationship between the different forms and types of stigma, and the different quality of life domains. HIV related stigma was associated with most quality of life domains, four out of six.

Resilient coping associated with half, and personalize HIV related stigma and racial discrimination with a third of the domains of quality of life, and resilient coping and social support were also associated three out of six and two out of six domains.

What does this all mean? The associations I talked about the bivariant correlations between racial discrimination, gender discrimination, and HIV related stigma, highlights the importance of using an intersectional approach. We looked at the different forms of stigma and discrimination based on different aspects of someone's identify.

HIV related stigma was associated with lower quality of life, and social support and resilient coping did mediate the relationship between stigma and quality of life across several

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domains. Racial discrimination was also associated with lower quality of life and the domains of social relationship and the environment.

You might ask why are racial and gender discrimination correlated with overall quality of life in bi-variant analysis, but not in the regression analysis. You might remember, I mentioned, we didn't find any studies that ever looked at, at least three variables at the same time, and their associations, and in particularly not with quality of life, so our results do suggest that HIV related stigma might play a larger role in predicting overall quality of life among African, Caribbean, and black women living with HIV in Ontario.

Why, we don't really know. I have some hypotheses. There might be less within group variability regarding racial and gender discrimination among ACB women, then experiences living with HIV.

With regards to living with HIV, there could be different context, and length of diagnosis, different beliefs in attitudes regarding HIV, from growing up to current situations, different levels of support and disclosure. Racial discrimination was associated with certain quality of life domains, but not the overall quality of life score.

This really highlights for us that we need to look at the different domains of quality of life. We only measure discrimination, so an act of stigma, rather than the other aspects of stigma associated with gender and race, such as internalized stigma, so this is a limitation of the study and perhaps if we had used more complex racial and gender discrimination tools we would have found that there was other aspect of racism and gender discrimination that would have been correlated with quality of life.

Sexist and racial stereotypes have permeated HIV discourse since the epidemics beginning, so it may be hard to disentangle the separate effects of racial discrimination, gender discrimination, and HIV related stigma.

The implications, multi-level interventions, we could have counseling that challenges the negative self image associated with HIV and associated with lower quality of life. Strategies to build this resilient coping skills, which can mediate the relationship between stigma and quality of life.

Meza level interventions, social support groups, and initiatives, campaigns for example, what was discussed by the previous presented, community based campaigns, mass media campaigns to challenge stigmatizing social norms and values, not just associated with HIV, but also racism and sexism within society, and within HIV discourse, and HIV stigma, and structural interventions to train healthcare providers and AIDS service organizations to address racial and gender discrimination, and HIV related stigma. Also to really try to promote programs that will promote quality of life.

Researchers, we should integrate intersectional approaches and research, so not just look at HIV related stigma, but look at stigma discrimination based on other aspects of peoples identities, and also to look at the complexity of quality of life, and the complexity of the different forms of stigma.

I just want to acknowledge Canadian Institutes of Health Research for funding the operating grants. The PIs were my co-authors on the study, Dr. Mona Loutfy and Lungarie Thero [misspelled?], and post fellowship that supported me during the analysis of this research, and the participants, peer research assistants, community advisory board, and participating agencies. Thank you [applause].

SHALINI BHARAT: Thank you, Carmen, for your presentation. We will now take questions on this presentation. Mic number three?

MALE SPEAKER: Yes, I just wondering to what extent do you think it's appropriate and relevant for healthcare providers and counselors to use as an intervention their self disclosure of their HIV status in trying to reduce stigma with those they're working with who are dealing with HIV?

CARMEN LOGIE: That's an interesting question. I think it depends on the context of the relationship between either the ASO or the healthcare provider. A lot of cities have shown that disclosure of a similar marginalized status does promote rapport between either a provider and a patient, or a provider and a client.

I mean I think that there's a potential way to build rapport between. I think as a social worker I also know that there's issues sometimes with boundaries as well, and sometimes assumptions if you both share the same experience that is similar rather than different, so I think that's a very complex area that we haven't really looked at enough when it comes to sharing HIV status between say, doctors and patients.

I haven't seen a lot of literature on that, but I think it's really important to look at that. I've seen more of it with regards to say, peer workers, so all of the research assistants either identified as an African career woman, or a Caribbean woman living with HIV, which I definitely think helped to build rapport for these women to even fill out the survey, which was a very, very personal questions. I don't think we would have had the same level of honesty in this project without engaging people who shared some sort of similar experiences.

MALE SPEAKER: Thank you.

SHALINI BHARAT: Yeah. Again the mic three, and then we'll go over to mic four, please.

MALE SPEAKER: Hi, that was a really great study. It was really nice to see the way you tried to disentangle some of these multiply-stigmatized identities. I was wondering if you could tell me a little bit grief coping or the resilient coping and what that measure was like.

CARMEN LOGIE: Well, the scale is very useful because it has only four items, and most times when I've seen research on coping and people living with HIV, it's more maladaptive coping strategies rather than on resilience and resilient coping. So the questions included things like I believe I can learn from difficult things that happened to me. I believe that, you know, if difficult things happen, I can make it through them. So it was sort of optimism as well as resilience, and I've validated it and established a liability among different populations around the world as well.

So I'd be willing, if you're interested, I can send you the scale.

MALE SPEAKER: Great, thank you.

CARMEN LOGIE: Okay.

SHALINI BHARAT: Microphone four?

MALE SPEAKER: Hi, I'd also like to thank you for your presentation. I'm wondering two things. First the

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intersectionality theory that you have, doesn't that also imply interaction terms within your model, and did you test that? Were you able to test that? The second thing was enacted stigma and discrimination may be different than the stressfulness of that stigma, and I don't know if I missed that. Did you measure also how stressful the situations were?

CARMEN LOGIE: No, we didn't measure the stress of a situation, but what we're doing right now is a national study that's looking at racism, and we're looking at, I think, the frequency of experiencing racist events and the stress. So this was pretty small sample size. So with all of the variables I included I didn't test interaction terms, but I tested moderation and mediation. So there is a possibility that we didn't have sufficient power to detect if we did have a moderation effect, but, yeah, I think what this really highlighted is the need to go more in depth into our analysis of racism and sexism and make more, use more complex scales that there are many, many racism measures out. So to really look and see what makes sense for this population, which was actually a challenge because most racism scales have been developed in the United States, not in Canada, there is differences.

We spent about six months trying to choose the scale that would be the most appropriate, and we pilot tested it to

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see if it had some validity for the population we're working with.

MALE SPEAKER: Thank you.

SHALINI BHARAT: Thanks. Now, please, go ahead.

FEMALE SPEAKER: I'm a nurse practitioner at San Francisco General Hospital in the AIDS clinic, and I'm wondering if you have suggestions for medical providers about how we can work with our patients in a medical appointment who are dealing with these kinds of discrimination?

CARMEN LOGIE: Well, I think there's something about open dialogue about another result that came out of this that I don't present today but is two-thirds of the participants in this study met the criteria for moderate to severe depression, and so I think that's very clear. Our healthcare providers, when they're working with people living with HIV and women living with HIV, particularly marginalized women like African and black women, to maybe screen for depression, to talk to people about this stigma that they're experiencing to make sure that they are aware of the community groups that can work with women living with HIV so they can refer them to support groups, possibly to counseling if that's what people want, to other community based agencies.

So I think having an open dialogue about stigma and discrimination, which I'm not sure how often that happens between healthcare providers and patients, and also the doctor being aware or the healthcare provider being aware of what services are out there. So that could take maybe connecting with different agencies and doing a little bit of research, and then, third, to look at depression.

FEMALE SPEAKER: So I think I shy away from asking a direct question like are you dealing with stigma, but it sounds like you're suggesting to go ahead and do that?

CARMEN LOGIE: Sorry, I can't hear you very well.

FEMALE SPEAKER: I think that I shy away from asking a direct question like are you dealing with stigma, but it sounds like you're suggesting to go ahead and do that?

CARMEN LOGIE: Well, I think it also depends on the comfort level and the knowledge of the healthcare provider around what is stigma and what is discrimination, but I think doing even a brief mental health assessment, talking with people, building a rapport about their life, I think that that might be a step towards women even talking about these experiences.

FEMALE SPEAKER: Thank you.

SHALINI BHARAT: Okay, the last question at mic four?

MALE SPEAKER: I understand it was a relatively small study, but I wonder if you could either conclude or maybe just suggest that negative self image is the most important factor in stigma?

CARMEN LOGIE: Well, in this analysis it was associated with the most quality of life domains. So I would say for this analysis negative self image. I'm hesitant to say that because then that leaves the impetus on the person to change their self image rather on us to create a more equitable and non-stigmatizing society. So I'm like yes. [Applause]. There is a lot of associations between negative self image and quality of life, but I think that's really indicative of social norms that are stigmatizing.

MALE SPEAKER: To me it's also a challenge to the faith community because a lot of negative self image is associated with judgmental faith attitudes. So to me I take your study as a challenge to faith communities to really work on this negative self image thing.

SHALINI BHARAT: Okay, Carmen, and I would now invite Maria to introduce the remaining speakers. [Applause].

MARIA EKSTRAND: Thank you, Shalini. It is my pleasure to introduce Gabriela Gomez, who is a post-doctoral fellow at the Amsterdam Institute for Global Health and Development. She obtained her Ph.D. in infection disease epidemiology and is currently working on operational research projects including the assessment of cost effectiveness of service expansions for

HIV treatment and prevention for key populations in Southern Africa. Welcome.

GABRIELA GOMEZ: Thank you. Thank you very much, and good afternoon, and it is a pleasure for me and an honor to be here to have this opportunity to share with you some of the results of this analysis.

We look at the statements or status disclosure within partnerships in four African countries using a mixed method approach. As you know disclosure of one serostatus to partners is a difficult step, and disclosure is also reported to be low in general and in sub-Saharan Africa also in particular. However, the knowledge of each other's serostatus is a prerequisite and to fully access prevention and care for serodiscordant couples.

The rates of disclosure vary both between and within countries, and within particular it varies by ethnicity, gender and age, with a significant proportion of HIV positive patients waiting over a year to disclose to their partners. Fear of an enacted stigma, which includes experiences of violence, abandonment and divorce, also prevent disclosure to partners.

In general partner disclosure requires trust, trust that the intimate other will provide care and understanding while refraining to contribute to the enacted stigma. So for this study our aim was to explore the determinants of disclosure to partners in four countries in sub-Saharan Africa, integrating data from the qualitative and the quantitative arms of the match study to better understand this process.

So the match study was a survey among clients from healthcare facilities in the capital region and one rural province or district in each country. The countries were Uganda, Kenya, Burkina Faso, and Malawi. It included health facilities including integrated facilities such as hospitals and primary care facilities where the city was provided and also [inaudible] and other facilities offering care to pregnant women and stand along facilities for VCT but also for other HIV prevention services.

A total of 3,659 participants completed the questionnaires. We also undertook 102 in depth interviews with key informants and 20 focus group discussions with support group members. For the quantitative analysis we selected from the 3,659 participants those that had an HIV test that was performed after 2007 that knew their HIV serostatus to be positive for more than a week and that reported to be married or cohabitant, and at the end at total of 280 participants were included in the analysis.

Our analysis was a hypothesis driven analysis. We looked at the narrative of the HIV positive participants from the open ended questions in the questionnaires and also in their answers to the in depth interviews and the focus group discussions to define the determinants that we were then going to include in the quantitative analysis. Those determinants were at an individual level where gender, age, education, the presence of [inaudible] require an HIV test, or treatment of the most recent test. We also looked at membership to support groups and stigma.

Stigma was in particular defined as two variables, self stigma, which included inner feelings of worthlessness and/or guilt, and enacted stigma, which reflected experiences of verbal abuse and ridicule, physical assault, or stresses from social life, abandonment by spouses, partners, or the families, disinheritance, job loss, and denial of healthcare due to being HIV positive. We built by variable and multivariable logistic regression models to look at the interaction between these, and their main outcome was disclosure to partners.

As you can see all participants that were included actually reported disclosing their serostatus to someone of which 60-percent reported doing so to partners. The prevalence of disclosure varied across countries. While it was very high in Kenya, it was quite low in Malawi. Participants were more likely to report self stigma in Burkina Faso. While they were less likely to report self stigma in Malawi, it was in this country that they were most likely to report enacted stigma.

In fact, it was mainly individual enacted stigma. Community level stigma was actually quite low, and it was reported in approximately the same levels across the four countries.

Here we present the results of our logistic regression models. In the first column of the table are the determinants of the results--sorry. They're an adjusted [inaudible] ratios where you can see that most of the determinants were actually found to be associated with disclosure except for self stigma.

So basically men were likely to disclose as were those with higher education level or older age, and members of support groups, those participants report an enacted stigma, and those presented with symptoms were less likely to report disclosure to partners.

In the second column we present the [inaudible] ratios as adjusted for country of recruitment. In this model were the effect of the country of [inaudible] accounted for we observed that only membership to support groups and individual characteristics such as age and gender remain associated with disclosure.

The third and final column presents the results of the models, including the four determinants that are age, gender, membership to support groups, and country of recruitment, and in this model we observe that the main drivers of disclosure to

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partners were country of recruitment and membership to support groups independently of age and gender.

An analysis of the narrative of our in depth interviews showed that the reasons for disclosing to partners vary. In some cases HIV positive partners feel the need to disclose to protect their partner. In other cases healthcare needs drive the disclosure process while others emphasis the good quality of their relationship. Showing that trust and motivation to adopt prevention, behaviors are related to disclosure. Confidentiality was also considered crucial and fear of enacted stigma remains an important reason for non-disclosure in the qualitative analysis.

For those participants that had disclosed they reported a variety of consequences. In particular we found that the acceptance of a partner's HIV status is a process of gradually coming to terms with the results. The initial reaction was often one of shock and disbelief, but most partners actually grew more supportive over time.

In conclusion people living with HIV disclosed their status to people within their support network. However, the disclosure within partnership is less common. We found that there is a relationship between a stigma and disclosure to partners, but this association is dependent on the setting. It

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was reported in the interviews that the fear of enacted stigma remains an important part of disclosure to partners.

Finally, we also found that membership to a support group was associated with non-disclosure to partners. However, this was a cross-sectional survey, and we cannot really state the directionality of this association. It might be that people reluctant to disclose to their partners tend to join support groups, or it can be also that the members of the support groups are satisfied with the space for discussion and do not feel the need to disclosure to partners, but in any case it appears that support groups play a key role and should be fully engaged and integrated in HIV prevention programs. They provide a safe space for discussion of, among other things, the benefits of early disclosure but also the benefits of immunization of the HIV treatment in these serodiscordant couples.

This project was funded by an NIH grant, and I want to acknowledge all my coauthors and in particular the participants and the clinic staff of the match study. Thank you. [Applause].

MARIA EKSTRAND: Thank you, Gabriela, for a very interesting and thoughtful presentation. So at this point we can take a few questions. It looks like it was crystal clear. Thank you so much.

GABRIELA GOMEZ: Thank you. [Applause].

MARIA EKSTRAND: So we're moving on to our next presenter, Dr. Tsegazeab Bezabih from Ethiopia who has already been introduced, but for those of you who joined us later I would like to mention that he is working in--he's at Addis Ababa University where he received his master of science degree in demography from Addis Ababa University in 2003 and has worked in various organizations including WFP as a research and [inaudible] officer, UNAIDS and UNAIDS, and he most recently has worked as principal investigator for a national level study on stigma. Please go ahead.

TSEGAZEAB BEZABIH: Thank you. The issue that I'm going to present is a specific respect of stigma, which is internal stigma among the HIV positive adult population in Ethiopia. This study is part of the Ethiopia stigma and discrimination index study, which was conducted in 2010 and 11.

Internal stigma, which is [inaudible] stigma or self stigma [inaudible] used to describe the way a person living with HIV feels about himself or herself, and specifically if he or she feels a sense of shame about being HIV positive. This study is part of the PLHIV stigma index research in [inaudible] to feel the gap in the global and the national understanding of stigma and discrimination in connection to HIV and AIDS.

The index was developed by the partnership of GNP+ and ICW, UNS, and IPPF, and the study was implemented by NEP+, which is the Network of Networks of HIV Positives in Ethiopia. The methodology that we used in the designing of this study or in the Ethiopia stigma index survey is [inaudible] multistage [inaudible]. The survey team prepared the list of PLHIV in the selected districts in consultation with AIDS facilities [inaudible] clinics, PLHIV [inaudible] working on HIV, home based care providers, case managers, case workers, PLHIV support groups, health extension workers, and at the end of the day, when we're able to successfully interview 3,360 PLHIV all over the country using the standard [inaudible].

All the data collected were PLHIV or HIV positive. In addition to the quantitative survey there was also qualitative data collection, which include 30 focus group discussions were carried out with [inaudible] subgroups including [inaudible] male and female PLHIV from different parts of the country.

The ethical consideration that we observed during the study or during the survey included all participants involved in the study had signed an agreement to keep the confidentiality of personal information they came across in the course of the data collection. Before [inaudible] the data collectors contacted the [inaudible] PLHIV service providers who are well aware of the HIV status of the person to be

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interviewed, approached the selected [inaudible] HIV and reviewed the consent form.

Then upon the agreement of the PLHIV the data collector will process to interview the PLHIV. The interviewers used an information sheet and informed consent form with each interviewee, and right there then putting the name of the PLHIV to be interviewed on the questionnaire, we used unifying code, and we also have secured clearance from the Ethiopian Health and Nutrition Research Institute.

Regarding the level of internal stigma, as you can see from the figure here, this figure prevents the proportion of PLHIV who disclosed that the nature of various feelings of consequential self stigma they had before being HIV positive. This feeling include societal ill fitting, feeling of being punished, feeling of having low stigma, blaming others, blaming oneself, and blaming guilty, and feeling ashamed. As you can see from the graphs, everyone in five of PLHIV in Ethiopia have societal feeling because of the internal stigma they harbor.

Nearly half of the PLHIV in the country also have low self esteem and blaming themselves, and nearly half of them also feel guilty and nearly half of them also feel ashamed of being HIV positive. When we see the gender dimension, societal feeling, feeling of one should be punished and having low esteem, and blaming others is higher among the females while in terms of blaming oneself and feeling guilty, the males are slightly higher than the females.

From the qualitative data, just let me show you and present you some quotes. I got tested for a third time in the hospital, and finally I admitted that the virus is in my blood. Hence, I decided to commit suicide in the absence of my wife, but I saw my child crying, and I started to cool down. Another woman living with HIV also disclosed that I know a husband and wife living in our locality. The husband is HIV positive, and the wife is HIV negative. They have four children. She said to him that they can live together and raise their children, but he didn't accept the offer. He was caught by the shackles of self stigma vision, and I had to counsel him several times so that he can correct his behavior.

Another woman living with HIV also told us from now on this I do not have the hope of getting married and giving birth. These are some of the causes that displayed their situation of internal stigma among the PLHIV.

The other aspect of internal stigma is withdrawing from, abandoning as punishment of or life goals is also an important and measurable manifestation of internal stigma. During the survey a respondent is asked if they have forgone various family and social activities or [inaudible] and

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discussion of the services in the last 12 months before the survey in connection with their HIV positive status.

As you can see from the figure more than half of the PLHIV have decided not to have children or more children. Some 40-percent of the PLHIV decided not to have sex, and significant proportion of PLHIV decided not to get married, and nearly a quarter of them isolated themselves from family and friends, and one in five of the PLHIV also have chosen not to attend social gatherings.

What this shows is significant proportion of the PLHIV are withdrawing from the social and communal activities, and they also withdraw themselves from taking services like health and education because of their feeling about their being HIV positive.

The last aspect that we're going to see regarding internal stigma is some fear or incidents that the respondent has had, fear for [inaudible] in the last 12 months. Nearly three-fourths of the PLHIV had a fearing of being gossiped about.

Nearly half of them also being fear of being verbally insulted, harassed, and/or treated, being physically assaulted. When you compare the level of their fear compared to the actual or the enacted stigma, their fear or their internal stigma

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because of their self-stigmatization is far higher than an active stigma or the actual stigma.

To conclude, the magnitude of internal is far higher than an active stigma and was noted to be a pressing problem among people HIV in Ethiopia, significantly higher proportion of PLHIV compared to their male counterparts are noted to taken such measures enough to have children, not to have sex, not to get married, to keep themselves from their family and all friends as result of their HIV positive status.

The prevailing the level of internal stigma has deterred significant proportion of PLHIV from active, but especially in social economic activities of the community out of fear of having their status revealed or being discriminated against because of their HIV positive status.

The prevailing level of internal level of stigma has affected significant proportion of PLHIV in Ethiopia to low self-esteem, a sense of worthlessness and depression, self-deprivation of access to services and opportunities. They generally [inaudible] in order to address the problem and peer-to-peer support groups, skill building, natal building, counseling training should be given attention. Thank you. [Applause].

APAMA JAIN: Thank you for the very interesting and informative presentation and we're now ready to take some questions, I see we have some on mic 4.

MALE SPEAKER: Do you have any data of the mode of transmission might change the feelings of internal stigma?

TSEGAZEAB BEZABIH: We didn't collected that type of data.

MALE SPEAKER: Yeah, it's very interesting presentation and I'm finding the answer interesting. How this data is useful for deprivation and the prevention part of the aspect of the HIV/AIDS and how is it useful for the health workers and the caregivers?

Particularly the caregivers? I struggled around that study of the caregivers if we see almost half of the caregivers in this population at the family level, they are the spouses and declaration in a global study shows that deprivation is the problem for the spouses and the partners. How does this information is going to be really useful for the prevention and the public health workers also?

TSEGAZEAB BEZABIH: Okay. The study covered only the PLHIV HIV, the study subject were only PLHIV. We were not able to interview the other groups like health workers or volunteers or this type of categories, but in the study, there were the

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PLHIV were asked their feelings toward this volunteers and health workers.

The perception that we found out in the study is that they have accepting attitudes towards the health workers than any other group, like religious leaders or teachers or other government officials. So the PLHIV much, much more positive attitude towards these health workers and other social workers.

TRAVIS LIM: Thanks so much for your presentation. Travis Lim from Johns Hopkins. You mentioned that because of internalized stigma, there were several people who reported, PLHIV, who reported, they stated they made the decision not to get pregnant or not to get married and so on, and often we think of those choices as joint choices, so I was wondering how you distinguish between internalized stigma, versus for example, stigma from their partner or elsewhere, how that affected that decision.

TSEGAZEAB BEZABIH: During the study, we interviewed PLHIV what significant decision have they made during their life or after they realized they are HIV positive and significant number of male and female PLHIV have this thought that they do not, they have decided not to have more children and not to get married since because of their feeling about themselves because of their HIV status.

These attitudes are developed not because of other factors, but only because of the fact that they are HIV positive.

APAMA JAIN: We will take two more questions. First, mic number 1 and then mic number 3. Please go.

MALE SPEAKER: Thank you for your presentation. You have presented differences between gender, male and female regarding some important decisions, especially about women. Do you have these persons, or women, have access to treatment or medications? Specifically those pregnant women? Thank you.

TSEGAZEAB BEZABIH: Some 86-percent, they interviewed people were on ART while the study was being undertaken and among them were women who were interviewed or who had been pregnant before some 12 months before the study, almost three fourths of them had been on PM City Service [misspelled?]; so even though they are accessing this type of treatment services, it didn't prevent them from internalizing or stigmatizing themselves.

GARY BROUGH: Thanks very much. Gary Brough, Terrence Higgins Trust. I was just wondering given the fact within those choices that were being made, it was within the last 12 months, what was the average length of the diagnosis for people in the study since often people tend to have those feelings of not being able to have sex, not being able to engage with life

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issues very early on in diagnosis, but that often subsides over time, especially with getting to sort of grips with diagnosis. So what was the length of diagnosis on average for the population?

APAMA JAIN: The length of diagnosis on average, how long had time passed since people first found out that they were HIV positive?

TSEGAZEAB BEZABIH: I don't remember the data, but we have collected the data on this, but for the time being, I don't have the data ready on my hand.

APAMA JAIN: Thank you. [Applause]. It now gives me pleasure, I would like to introduce our last speaker of today, Dr. Deepa Rao, from University of Washington, Seattle. She's a clinical psychologist and research assistant professor and her professional interests are in designing effective interventions to improve mental health and reduce stigma for vulnerable populations worldwide. She conducts work in the United States and in South India, particularly with women. She also co-directs the program on global mental health at the University of Washington.

DEEPA RAO: Thank you. Hello, thank you for having me here and I also wanted to say I'm honored to be here, honored to be speaking in the same room as the AIDS quilt. It's quite moving to see it.

I thought I would start by grounding my work a bit in a conceptual model and I know we've heard a lot about definitions of stigma and what not, but I wanted to highlight, we know that stigma originates from culture, particularly power structure, social norms, shared beliefs about the body, mental health and illness, and those take the form of public and institutional stigmas that ultimately impact the individual.

From my survey of the literature, many stigma reduction programs tend to stay in this public level and many studies are grounded in stigma reduction among healthcare workers. There's very little that we have as evidence as to what coping skills worked to help a person living with HIV combat or cope with the stigma that they face.

So this work and this line of work that I'll describe to you is grounded at this individual level and what we have tried to do is take a look a bit at intersectionality and try to look at ways of reducing stigma na and the context of other marginalized statuses that can impact the person living with HIV.

We do know that internalized stigma has an impact on medication adherence. Many research studies these days make that connection. We suspect also that internalized stigma impacts treatment utilization and poor health outcomes.

How can we reduce stigma? We've heard a bit in the presentations here and we know from the literature that at the societal level, there are studies that institutional stigmas, if they're removed, we can reduce stigma in the community, we can use microfinance programs to promote economic empowerment and empower individuals living with HIV. We can use community organizing to empower and reduce stigma.

What we know less about are the effectiveness of individual level techniques. We know that there are techniques out there, but what we don't know is whether not they work, so there are educational tools that we can use, there are coping skills out there that we can teach and we know that fundamentally that contact between and among people living with HIV can help to reduce stigma. So social support is a nice tool that we can use to reduce stigma.

Many years ago now, it was AIDS 2006 in Toronto, Laura Nyblade was presenting for the first time I believe the HIV Stigma Toolkit and this is a toolkit that actually contains some of those elements that I mentioned before: education had the potential to promote contact between individuals and helped to reduce internalized stigma. This is a toolkit that was originally developed in Zambia and since then, facilitators have been trained globally and it's used worldwide.

What we did was we took the 40 plus exercises from the toolkit and held some focus groups with African American women living with HIV both in Chicago and Seattle and we asked them for their feedback and ask them to help us to repackage the materials into an intervention that was relevant for them.

We also developed trigger videos from the toolkit and the trigger videos were meant mainly to model proactive behaviors and trigger discussion around how to handle stigmatizing situations.

We called the repackaged intervention the Unity Workshop and I’ll mention why we called it the Unity Workshop. Why do I keep wanting to call it the University Workshop? I don’t know, but Unity Workshop [laughter] and this is basically a workshop that we piloted to be held across two afternoons. It was peer facilitated. Basically we have a wonderful African American woman living with HIV, she’s an activist and role model and she was trained to basically facilitate this group workshop.

We also we recruited participants and ultimately 24 African American women living with HIV from the Seattle area participated. These women were living with HIV from anywhere from three months to 25 years. At the start of these workshops, I’ll give you a few examples of the content of these workshops. We started out by discussing group expectations, so this was a very participatory workshop. We didn't set out ground rules, we asked them what their expectations were for the workshops.

We asked them to talk about their experiences around stigma, what did stigma mean to them, to help promoting social support within the group. We also have some exercises where we ask them to share their methods of coping with stigma, like prayer or speaking with family. They're able to share reasons and discuss with their peers in their group about what worked and why it worked for them.

We also gave them time to role play ways to navigate stigmatizing situations. We had one exercise that was in the original HIV stigma toolkit where the women formed a web of string and the women named this web. They said it represented peace, unity, and togetherness, which is why we called the workshop the unity workshop because of their name for this web and also what the workshop symbolized for them.

I'm going to show you a trigger video now so you can get a sample of one of the four videos we used in the intervention. [Video played]

So you can see from the video that basically this particular video had three separate endings and it was able to promote discussion on different ways of handling a potentially stigmatizing situation: a passive way, an aggressive way and an

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assertive way. The women were able to bounce around the pros and cons each type of manner of handling the situation. The other thing I wanted to mention was we had four trigger videos and after each one during our pilot study, the women really couldn't contain themselves after seeing these videos. They promoted so much discussion that everybody wanted to speak at once, so it was an exciting aspect for the intervention for the women.

We did do also a classic pilot study and look at not only feasibility, but preliminary effectiveness. We used a pre-test, post-test design and a para te test [misspelled?] to analyze the data.

Our primary outcome was the stigma scale for chronic illness which is a 14 item scale that we adapted for African Americans living with HIV and we validated it with this population.

If you're interested in more about this scale, I have the paper that's under review with me and we can take a look at some of the items, but basically the results said that after pre-seating to one day after the intervention, there was a five-point decrease in stigma scores and then one week later, there was a four point decrease in stigma scores.

So basically stigma was reduced after participation in this intervention. The results were not significant but we did

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see a trend, so and the other thing to notice here is that there's a slight creeping up of levels of stigma after about a week.

Limitations of the study were primarily there was no control group and there was not significance, although we did find a trend. Our hope and thought is that we only had 24 participants and that if we increase the sample size, we might see some statistical significance.

We also potentially foresaw the need for a booster session and the stigma levels started to increase a bit and so we foresaw the need for that and our next step is basically a full scale randomized clinical trial and we hope to conduct this trial in two different cities in Chicago and Birmingham in the future.

I'd like to thank our supporters and funders and first and foremost, our participants and Tom Etlinger [misspelled?] who produced the videos, James and Margaret Mownley [misspelled?] who did camera and sound for these videos and Yamlang Molina [misspelled?] who helped script some of the videos, some of the content came from focus group discussions and some from the ICRW HIV Stigma Toolkit and I'd also like to thank the NIH who funds my career development in order to promote this work, so thank you.

APAMA JAIN: Thank you, Deepa, for this interesting presentation and now we will open the floor for questions.

FEMALE SPEAKER: I'm wondering if there have been any studies that have done research in regards to people outside of urban areas?

DEEPA RAO: I would. There is. There is some work going on stigma reduction in Vermont, in rural areas. It's just coming out now I believe. There was a paper out very recently, so yeah, I haven't mentioned it here, but there is work in rural areas on stigma and stigma reduction.

MALE SPEAKER: I apologize if you had already mentioned this, but are those videos available for use by other organizations and if so, where would we find them?

DEEPA RAO: Good question. Yeah, I guess due to my own, I had promised to give them to the Stigma Action Network to put on their website, and I think I failed to do so, have I not, Anne? So they are on YouTube, but it's hard to search for them, which is why I'd like to do that.

I have three copies of the video on DVD right now, though I'm anticipating the demand might be more than three copies, so I would say look on the Stigma Action Network and what? A few months they might be there? It might take longer? I think it depends on me. My email was up there, it's just my

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name at uw.edu and you can email me and I can send you the links to the videos.

We’re also hoping to put, by the way, the workshop materials on the website as well, not just the videos, because the videos are embedded within the workshop material’s manual.

FEMALE SPEAKER: My question has to do with the group participants. Were any of the women lesbian, bisexual or transgender that participated and the second part is, did any of those trigger videos address that diversity? Or did they assume that most women were not —?

DEEPA RAO: I’m trying to think if we collected that data and I don’t think we did, however the eight hours of the workshop were open to discussion on any topic, so women did talk about race, they did talk about being women within African American communities and that marginalized status that they had.

They had been open to talk about other things, some women did talk about drug use, but I’m really unsure whether sexual orientation, I don’t think it came up it the workshops. I sat through both versions of the workshop, but the discussions had a lot of open time for the people to bring up any experiences that they had that they wanted to discuss or any status or condition, anything they wanted to bring up that they felt stigmatized by.

FEMALE SPEAKER: The reason I asked the question was because in Toronto, we work with a lot, I work with Carmen as well as African Caribbean Black Indian women and in the study that we did, we did ask about Black queer women living with HIV and it was resounding in that both the focus group and follow up felt completely silenced and they had a challenge with any of the supports that were offered because that didn’t feel supported or have the courage to bring that up and when they did, they were shut down. That’s one of the reasons I asked, so if there was a trigger video or material, I would be more than happy to share it.

DEEPA RAO: The other thing I wanted to mention was that our peer facilitator did openly disclose that she has a female partner, so that was one of the part of the group expectations, respecting others in your group and that sort of thing and feeling open to talking about anything, but it’s really nice to hear that you have some materials on this as well.

FEMALE SPEAKER: So, we’ll talk, thank you.

LIZZIE SCHMIDT: Lizzie Schmidt from Philadelphia. Can you tell us if the peer facilitator had training and if so, can you describe it?

DEEPA RAO: So there were three people in the room. I was there just to observe we had a social worker and then our

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peer friend who was there to help with data collection, but the peer facilitator was trained. We had manualized the intervention and we trained her in how to, we ran through the exercises and she also brought in her thoughts and group expectations was actually her idea rather than laying down ground rules so she was experienced in peer group facilitation.

She runs a weekly support group and she knew that procedures to follow in case of highly distressing situations, that sort of thing. I'm a clinical psychologist by training, so I was there in case any issues came up.

APAMA JAIN: Okay, now the last question for the evening.

LAURA NYBLADE: Hi, this is Laura Nyblade. This is less than a question than a comment just to say thank you for your work and for using the stigma toolkit. I just wanted to make a slight correction and that is it was developed in Ethiopia, Tanzania and Zambia as well as eventually in Vietnam just to give those countries credit of that and just to say that the Stigma Reduction Toolkit is available on the Stigma Action Network.

I don't know if you already talked about that availability. We also have similar tools that work on stigma towards sex workers and stigma towards men who have sex with men and stigma towards drug users as we've been talking about the intersections here, I just want to say those tools are available.

I want to make one last plug, since you are all here late for a stigma reduction section, is that this evening we have the Robert Carr Memorial Lecture. Robert Carr was an activist in the Caribbean who worked tirelessly to reduce stigma and discrimination and we're having the first memorial lecture tonight. It's in the Global Village and Stephen Lewis will be speaking on stigma, so I think you all will want to go. I have flyers if you want one on the way out. It's at:30. Thanks.

APAMA JAIN: Thank you. This will be the last question.

MALE SPEAKER: Good evening and thank you for your presentations. This is not a question directly to the presenter, but just earlier before a gentleman was mentioning about AIDS based communities and I was just wondering how as physicians, as social workers, you can deal with MSMs, lesbians, etcetera where you have the community, the Christian community for example. They are totally against these types of behaviors in order to reduce the stigma reduction, because we're trying to help everyone, so it can be a little difficult so I'm just asking if you can shed some light on that.

DEEPA RAO: I don't think this is a question just for me, but the one comment I could make is I'm a trainee of

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Patrick Horeogen [misspelled?] in Chicago and he has recently said in a paper of his that contact is fundamental, so promoting contact and dialogue and having discussions fundamental in reducing stigma of any type.

APAMA JAIN: Thank you, people, for this very interesting presentation. With that we come to the end of this session and would like to give warm applause to all of them.

We thank all the five presenters and we thank the audience and we thank those who ask questions and lead this very lively discussion sessions and I'd like to also like to think, Maria, my co-chair and we understand that in the fourth decade of the epidemic, stigma continues to be a challenge and continues to make us think that we needed to invest more energy, more research and perhaps more funds into understanding stigma as a phenomenon and to see how we can address stigma as a real barrier to accessing services and to utilizing services. Thank you all very much. [Applause].

[END RECORDING]
