Best Practices for Stigma Reduction

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SARDM on Stigma Workshop
Delhi, December 4th, 2008
Format of Presentation

• Definitions/Entry points for intervention
• Stigma-reduction intervention principals
• Program examples
Definitions
What Is Stigma?

“An attribute that is deeply discrediting [and that reduces the bearer] …from a whole and usual person to a tainted, discounted one.”

“Disqualification from full social acceptance”

(Goffman 1963)
Three Types of Stigma

1) Abomination of the body
2) Blemish of individual character
3) Tribal—Race, religion, nation

(Goffman 1963)
Societal phenomenon

- Contextual (social, cultural, political & economic forces)
- Form of social control
- Turns “difference” into inequity (gender, age, sexual orientation, class, race or ethnicity)
- Devaluation to create superiority
- Social exclusion of individuals or groups

(Parker & Aggelton 2002)
Dynamic Process with four steps

• Distinguish & label differences
• Associate negative attributes to perceived differences
• Separation of ‘us’ from ‘them’
• Status loss & discrimination
  \((\text{Link and Phelan 2001})\)

• Response to fear, risk or threat \((\text{Gilmore and Somerville 1994})\)
Discrimination

• Unfair and unjust treatment of an individual based on the basis of the:
  – real or perceived status or attribute (e.g. medical condition)
  – belonging, or being perceived to belong, to a particular group (UNAIDS)
“Stigma Disadvantage”

• ‘unjustified beliefs in immunity against disease’
• internalized stigma often leading to:
  – lowered self esteem, depression
  – changes in behavior (e.g. not taking advantages of services and life opportunities)

(Deacon, 2006)
Stigma & Medical Conditions

- Disease stigma is greatest when:
  - Not well understood
  - Perceived as contagious (physical, social) and a threat
  - Associated with perceived ‘deviant’ behavior
  - Viewed as the responsibility of the individual
  - Condition is severe, degenerative, or disfiguring
  - Undesirable and unaesthetic death

(Alonzo and Reynolds, 1995; Cogan and Herek 1998; De Bruyn 1999)
Cycle of Stigmatization

Marker

Loading

Discrimination

Stigma

Greater susceptibility and vulnerability to HIV & AIDS

Adapted from Sartorius, N., 2006.
Adapted from UNAIDS, 2007.
Intervening to Reduce HIV Stigma and Discrimination:

General Principles & Promising Approaches from the Global Experience
Address Immediately ‘Actionable’ Drivers

- Lack of awareness and knowledge of stigma and discrimination
- Fear of acquiring HIV through everyday contact with infected people
- Values linking People Living with HIV with behaviors considered improper or immoral
Raise Awareness

• Foster understanding and motivation for stigma reduction by:
  – Creating recognition of stigma
  – The benefits of reducing it
  – Safe space to reflect and gain skills for change
Address fears & misconceptions

- Address fears and misconceptions about casual transmission of HIV
  - How it is and is not transmitted
  - In-depth information
  - Interactively
  - Listen, learn & respond to specific fears related to daily living context
“I know up to now it is said that the disease is not too easily transmitted, only transmitted through blood transfer or sexual activities; it is not transmitted through contact. I know roughly, but I am still afraid. Now I would like to have more practical and clearer information to help people understand more deeply. Because some are still worried about the disease, if we want people to stigmatize less, we need the specific information.” (55 year old woman, Vietnam)
This project taught me a lot. Now I am not afraid of him [an acquaintance living with HIV] anymore. I frequently meet him, go to drink coffee and shake his hand normally. It is no problem; he is normal like me;[I have] nothing to fear. Once you understand [about the modes of transmission, then you have] nothing to fear. Before I felt discouraged a little bit, I did not have close contact with him. To be frank, I was afraid. At that time I learnt through newspapers, but in general way, not so specific. People mostly were afraid. Once I understand things, I am not afraid of “AIDS person”. We sit together at the same table, shake hands, share drinks. It is normal - they are like us. (local leader, Vietnam)
Discuss and Challenge the ‘Taboo’

- Provide safe spaces to discuss, reflect, understand and question:
  - The values and beliefs that underlie stigma and discrimination
    - Where they come from
    - What they do
    - Separating the person from the behavior
  - Gender, inequity, sexuality, violence, drug use
Empowerment & capacity building for vulnerable groups

• Involve and strengthen groups experiencing stigma by:
  – Addressing internalized (self) stigma
  – Skills building for advocacy, defence of human rights, education of others
  – Supporting networking between stigmatized populations for joint solidarity
  – Enhancing and Supporting opportunities for full participation in ‘mainstream’ society (e.g. income generation, training, counseling)
  – Treatment Access
Create Safe Space for Interaction

- Central involvement of groups experiencing stigma
- Breaking down the:
  - “us” and “them”
  - Justification for stigma
Start at ‘home’

• Create recognition of stigma
• Space/support to reflect on, evaluate & change
  • Organizational level
    – programs, practices and policies
  • Individual/Personal level
• Build skills
• Provide ongoing support for learning and change
Engage Multiple Change Agents

- Opinion leaders
  - Politicians, faith-based leaders, youth, celebrities
- People living with HIV and other stigmatized groups
- Media

- Private sector
- Police
- Judiciary
- Educators
- Front-line HIV responders
  - Health care workers, CBO and home based care workers
Operate at Multiple Levels

- Individual
- Family
- Community
- Organizational/institutional
- Government/legal
  - National, State, District, Community
Employ a Range and Combination of Approaches

• Participatory & interactive education
• Strengthening organizations of People Living with HIV and other vulnerable groups
• Contact strategies
• Mass Education
• Institutional reform
• Policy dialogue
• Legal & policy reform and enforcement
• Provision of services, including treatment
Address the Multiple Layers of Stigma

- Vulnerable groups experience stigma related to multiple sources:
  - Drug use, sexuality, gender, sex work, HIV, violence
Immediate Actionable Causes

- Lack of awareness
- Fear of casual contact
- Values linking HIV with immoral behavior

Individual
- Address attitudes and behaviors

Environmental
- Meet needs for information, training, and supplies

Structural
- Polices, laws, and systems
Program Example: The Case of Vietnam

1. Reducing stigma in hospitals
2. Community-led stigma reduction
Partners & Donors

- Hospitals and Communities
- Communist Party, Vietnam
- Institute for Social Development Studies (ISDS), Hanoi
- International Center for Research on Women, Washington, DC
- PACT
- US Government (USAID/PEPFAR)
Reducing S&D in hospitals

- Entry through Gatekeepers
- Intervention Design (4 hospitals)
  - Baseline data
  - Hospital steering group
  - Training: 2 to 4 half-day to all staff members
  - Development of Safe and Friendly hospital policy
  - Supplies supporting UP practices
  - Educational materials
  - Monthly monitoring visit
  - Endline data
Results

• Intervention significantly reduced
  – Fear-based stigma
  – Value-based stigma

• Intervention improved practices
  – Marked files & beds indicating HIV status
  – HIV testing without consent & notification of results
  – Universal precautions practice, creating safer working environment for health workers
Lessons Learned:
Address factors at multiple levels

• Individual:
  – Address attitudes and practices of health care workers

• Environmental
  – Meet needs for information, training and supplies to prevent occupational exposure to HIV

• Structural
  – Hospital Policy developed by all hospital employees
Community-led Programs in Vietnam

- Two urban wards (Cai Khe, Can Tho & Cam Dong, Quang Ninh)
- Sensitization workshop for community leaders
- Facilitated Action Planning Workshop
- Action Plan ‘negotiations’
- Small grants
- Community implementation with technical support
Action Plans

• 11-12 stigma-reduction activities
• 4 main ‘comparable’ ones:
  – Training of community educators
  – House to house distribution of fact sheet
  – Sensitization meetings
  – Posters
• School-based activities
Gate Keepers & Multiple Change Agents
Understanding & Ownership
Range and Combination of Approaches

- Participatory learning
- Community educators
- Community meetings
Range and Combination of Approaches

- Billboards
- Factsheets
- Slogans
Design & Methods

• Pre-Post intervention
• Mixed methods to allow for triangulation
  – Quantitative (Surveys)
  – Qualitative (FGDs, IDIs, KI)
• Process Data
  – Routine monitoring
• Mid-term evaluation
  – Qualitative
Analysis: Key Domains

1) Awareness and understanding of stigma
2) Fear driven stigma: Fears of contracting HIV through casual contact
3) Value-driven stigma: Shame, blame and judgment attached to people living with HIV
4) Enacted stigma: stigmatizing and discriminatory behaviors toward people living with HIV
**Evaluation Results: 16 months**

- Significant increase in awareness of stigma
- Significant reductions in fear and value-driven stigma & intention to engage in stigmatizing behavior
- Reported own & observed behavior change
- People living with HIV and families report reductions in stigma & improved community environment
- Dose-response: exposure to more activities = larger decrease in stigma
Key Lessons Learned

- Awareness building & reducing fear driven stigma ‘easier’ than moving value-driven stigma
- Fear of ‘blood’ harder to shift than ‘casual’ contact
- Participatory methods & process work
- Sensitization & training for all implementers
- Community ownership key
- Combination approaches
- Ongoing activities
Lessons Learned—Fear

• Acknowledge fear of a dangerous illness is natural
• Discuss the root causes of fears; specifics of what people fear in their daily lives
• Provide clear, specific and unambiguous information about the ways in which HIV can and cannot be transmitted
• Provide specific information about:
  – what people can do to protect themselves
  – practical steps to take to prevent transmission
• Give community members an opportunity to have their questions answered by informed and trusted individuals
Lessons Learned-Values

• Address the moral dimensions of HIV-related stigma explicitly and openly.
  – address issues of sexuality and drug addiction
• Provide information (e.g. Fact-sheet) on drug addiction and concerns about drug abuse
• Find ways to disassociate disapproved behaviors of drug use and sex work from the person engaging in those behaviors
  – Help community members overcome dilemma of not wanting to stigmatize, while also not wanting to condone unapproved behavior
• Changing value-driven stigma is challenging
  – change likely to be slow
  – is possible and essential to reducing stigma;
“In general it is much different than before. Before, people did not dare to visit a house that had a person living with HIV. Now they visit as normal, they contact as normal, talk as normal and eat as normal. They even share the same eating tray, drink alcohol together, no problem. Before, they did not even dare to visit my house.”

Male, Cam Dong
Questions to ask to determine appropriate measurement

• Where in the process or cycle of stigmatization are you intervening?
  – Changing the marker, loading, stigma, discrimination?

• At what level are you intervening?
  – Individual, environmental, structural
Cycle of Stigmatization

Marker

Greater susceptibility and vulnerability to HIV & AIDS

Discrimination

Stigma

Loading

Adapted from Sartorius, N., 2006.
Adapted from UNAIDS, 2007.
Questions to ask to determine appropriate measurement

• What specifically about stigma are you addressing/trying to change?
  – Awareness;
  – Fear of transmission through casual contact
  – Shame, blame
  – Discriminatory Behavior
Attribution

• Project Coverage: Has the target population been exposed to the project activities?

• What else is going on in your project site?
  – Contributing positively or negatively to stigma reduction?
Detailed Evaluation Results for Vietnam Community-led Stigma reduction program
Design & Methods

• Pre-Post intervention
• Mixed methods to allow for triangulation
  – Quantitative (Surveys)
  – Qualitative (FGDs, IDIs, KI)
• Process Data
  – Routine monitoring
• Mid-term evaluation
  – Qualitative
Survey Data

- **Baseline**: Total n=1392
  - Cam Dong: n=697
  - Cai Khe: n=695

- **Endline**: Total n=1396
  - Cam Dong: n=692
  - Cai Khe: n=704

- **Variables**
  - Sociodemographic
  - Knowledge of HIV and AIDS
  - Fear of infection
  - Attitudes
  - Behavioral intentions
  - Knowing a person living with HIV
  - Media exposure (print, TV, radio)
  - Exposure to project activities (endline only)
Qualitative Data

- In depth interviews: 97
  - 24 persons living with HIV
  - 16 family members of persons living with HIV
  - 57 community members
- Key (community) Informant interviews
  - Regular community members (n=30)
  - Community opinion leaders (n=25)
- Focus group discussions (FGDs)-35
  - Regular community members (25)
  - Heads of residential cluster/units (3)
  - Intervention target groups, including
    - Community educators, teachers, primary school student and secondary school students
Analysis: Key Domains

1) Awareness and understanding of stigma
2) Fear driven stigma: Fears of contracting HIV through casual contact
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Analysis

• Test differences in proportions from baseline to endline:
  – Individual items and indices
  – Chi-square tests of independence (dichotomous measures) and t-tests (continuous measures)
  – Factor analysis, construction of indices, standardization of indices
• Endline: comparison of respondents by activity exposure
  – Logistic and linear regression analysis
• Controlling for other factors that may influence stigma
  • Age, sex, education, marital status, socio-economic status
  • Knowing a person living with HIV
  • Having heard messages about HIV and stigma through media (print, radio, tv)
End-line Analysis - Quantitative

• Restricted to 4 main, comparable activities
  – Fact Sheets
  – Sensitization meetings
  – Household Visits
  – Posters

• By community
  – Cai Khe: 0 vs 1,2,3,4 activities
  – Cam Dong: 0+1 vs 2, 3 4 activities
Project Coverage

Exposure to Total Number of Project Activities

- Exposed to 4 activities: 23.6%
- Exposed to 3 activities: 27.5%
- Exposed to 2 activities: 27.2%
- Exposed to only 1 activity: 27.1%
- Exposed to any activity: 85.2%

Cam Dong (n = 692)
Cai Khe (n = 704)
Project Coverage

Exposure to Specific Program Activities

- Saw Poster: Cam Dong (67.3%), Cai Khe (78.5%)
- Participated in ward meetings: Cam Dong (36.5%), Cai Khe (51.6%)
- Received fact sheet: Cam Dong (54.7%), Cai Khe (73.3%)
- Received household visit: Cam Dong (31.3%), Cai Khe (43.6%)

Percentage of respondents reporting specific program activity exposure
Awareness-Results

Percentage of respondents recognizing the word "ky thi", baseline and endline

<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cam Dong</td>
<td>38.0</td>
<td>82.2***</td>
</tr>
<tr>
<td>Cai Khe</td>
<td>42.4</td>
<td>57.2***</td>
</tr>
</tbody>
</table>

Percentage reporting recognition ($p < .001$, Chi-square)
Awareness: measures

• Survey:
  – Have you heard of the word stigma (‘Ky Thi’)
  – For those who said Yes:
    • provide specific examples of stigma

Qualitative:

• Describing specific forms of stigma, what it does & why it should be reduced
Awareness-Results

Number of correct examples mentioned, by community site

Percentage of respondents reporting correct examples

Baseline | Endline

Cam
1 | 24.2 | 19.2
2 | 4.7 | 0.5
3+ | 15.3 | 15.3

Cai
1 | 24.5 | 20.0
2 | 24.7 | 4.6
3+ | 15.2 | 1.5

***p <.001, **p <.01, Chi-square or Fisher’s exact test
Awareness-
Qualitative
I can see that the propaganda campaign on HIV and AIDS to minimize stigma and discrimination against HIV infected people implemented here has helped to improve people’s awareness. Now people do not keep away from or stigmatize against HIV infected people any more. They have better relationship with people living with HIV. In short, the people here have better awareness and knowledge about HIV now... For example, people often visit and take care of the infected people in my sector.

[FGD_EL,male, Cai Khe]
Fear: Main Outcomes

• Fear reduced significantly after the intervention in both communities
• Project activities lead to decrease in fear at endline, controlling for other factors
• Respondents with exposure to more activities show significantly greater reductions in fear-based stigma
• Fear of casual contact shifted more than fear of situations with potential for blood contact (e.g. manicure)
Fear: Measures

• Capture both the underlying specific fear
  – Body fluids (sweat, spit, urine etc)

• Specific daily living activities around which fear of transmission occurs
  – Sharing a toilet, a hospital room, having a manicure, haircut or going to the dentist

• Factor Analysis led to two indices
  – Casual contact, 7 items
  – Contact with sharp instruments (potential blood contact), 3 items
<table>
<thead>
<tr>
<th>Item name</th>
<th>Cam Dong Baseline</th>
<th>Cam Dong Endline</th>
<th>Cai Khe Baseline</th>
<th>Cai Khe Endline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of infection with HIV through:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exposure to saliva of a PLHIV</td>
<td>18.7</td>
<td>21.8</td>
<td>37.2</td>
<td>39.7</td>
</tr>
<tr>
<td>Exposure to excreta of a PLHIV</td>
<td>35.3</td>
<td>27.2**</td>
<td>44.5</td>
<td>42.0</td>
</tr>
<tr>
<td>Exposure to sweat of a PLHIV</td>
<td>10.2</td>
<td>10.8</td>
<td>25.5</td>
<td>25.2</td>
</tr>
<tr>
<td>Sharing in-patient room with PLHIV</td>
<td>34.1</td>
<td>25.6***</td>
<td>52.3</td>
<td>43.7**</td>
</tr>
<tr>
<td>Sharing a toilet with a PLHIV</td>
<td>16.0</td>
<td>10.0**</td>
<td>47.3</td>
<td>35.8***</td>
</tr>
<tr>
<td>Shaking hands with a PLHIV</td>
<td>6.9</td>
<td>6.2</td>
<td>17.1</td>
<td>16.4</td>
</tr>
<tr>
<td>Going to a dentist</td>
<td>82.1</td>
<td>68.7***</td>
<td>84.7</td>
<td>80.5*</td>
</tr>
<tr>
<td>Having a hair cut</td>
<td>68.4</td>
<td>60.3**</td>
<td>59.5</td>
<td>59.0</td>
</tr>
<tr>
<td>Having a manicure</td>
<td>77.8</td>
<td>61.3***</td>
<td>88.3</td>
<td>76.8***</td>
</tr>
</tbody>
</table>

***p < .001; ** p <.01; *p <.05, Chi-square test of independence
Regression Results: Fear & Project Activities

• Project activities lead to decrease in fear at endline
  – Exposure to more activities=greater reduction in fear index score

• Casual Contact Index
  – Cai Khe: significant decreases start at exposure to 1 activity; increase with each additional activity
  – Cam Dong: significant decreases start at exposure to 3 activities; increase at 4

• Situations with sharp instrument contact
  – Cai Khe: significant decrease only at 4 activities
  – Cam Dong: significant decreases start at exposure to 3 activities
Results-Qualitative

• Before I was sensitized I did not understand, so I was afraid of HIV infection. When people in central level came and sensitized us about anti-stigma towards HIV infected persons I opened my mind. Previously, to be frank, I was afraid to hear about HIV infection… Before when I did not understand, I thought that if I lived with an HIV infected person I would become infected as well. Now I know I cannot be infected when living together with Person Living with HIV.

(FGD, female, Cam Dong)
Results-Qualitative

• Before, since I did not understand deeply, [AIDS] was something that I was afraid to get contact with – [I was afraid] I might get infected. Since a half year ago my understanding improved. And not only myself but also other people. I see the change. There is no more fear.

IDI, female, Cai Khe
Values: Main Outcomes

• Value-based stigma reduced significantly after the intervention in both communities
• Started very high at baseline, still high at endline
• Project activities lead to decrease in value-based stigma at endline, controlling for other factors
• Respondents with exposure to more activities show significantly greater reductions in value-based stigma
Value-Measures

• A series of attitudinal questions capturing
  – Blame toward people living with HIV
  – Shame associated with having HIV
  – HIV as a social evil

• Factor analysis led to 1 Index with 7 items
<table>
<thead>
<tr>
<th>Value-based statement</th>
<th>Cam Dong</th>
<th>Cai Khe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Endline</td>
</tr>
<tr>
<td>Prostitutes are to blame for spreading HIV in our community</td>
<td>87.8</td>
<td>75.0***</td>
</tr>
<tr>
<td>I would be ashamed if someone in my family had HIV or AIDS</td>
<td>48.0</td>
<td>41.8*</td>
</tr>
<tr>
<td>PLHA should bear the consequences of their bad behavior</td>
<td>78.5</td>
<td>64.5***</td>
</tr>
<tr>
<td>HIV and AIDS is a social evil</td>
<td>92.4</td>
<td>76.1***</td>
</tr>
<tr>
<td>IDUs are to blame for spreading HIV in our community</td>
<td>92.7</td>
<td>73.7***</td>
</tr>
<tr>
<td>PLHA are promiscuous</td>
<td>48.1</td>
<td>41.6*</td>
</tr>
<tr>
<td>PLHA are to blame for bringing HIV into our community</td>
<td>71.9</td>
<td>47.7***</td>
</tr>
</tbody>
</table>

*** p < .001; ** p < .01; * p < .05, Chi-square test of independence
Regression Results: Values & Project Activities

• Project activities lead to a significant decrease in value-stigma score at endline
• Exposure to more activities=greater reduction in value-stigma score
• Both communities required exposure to 3 or more activities to see a statistically significant decrease on the value-based stigma index score
• Decreases moderate in size and in significance relative to awareness & fear results
Values-Qualitative

After education and communication people understand that HIV is not social evil but a disease. This has changed the community’s perception - now they think also of circumstances. For instance, this woman returned from Cambodia, or that man may not be HIV infected because of sex work but maybe because of unfortunate love affair, or due to some unexpected circumstance. So not all HIV infections are due to social evils. In reality there are often extenuating circumstances.

FGD, female, Cai Khe
Values-Qualitative

This was brought by social evils - they did not want it themselves. Their families did not want it but the societal reality influenced much on them, they themselves cannot anticipate that problem. Life circumstances pushed them into it. Now that the thing is done and is not reversible we have to help them and should not avoid them. We should help them without question.

IDI_ME, male, 69yrs, Cam Dong
Behaviors: Main Outcomes

• Change evident both in people's descriptions of their own actions and their observations of the actions of others.

• Most commonly reported changes were:
  – Increased willingness to talk and communicate freely with people living with HIV
  – Sit closely, drink and eat in the homes of people living with HIV
  – Attend funerals and pay respects

• Decrease in intention to engage in stigmatizing behavior

• Project activities lead to decrease in reported intention to engage in stigmatizing behaviors

• Respondents with exposure to more activities show significantly greater reductions in intentions to engage in stigmatizing behavior
Intention to discriminate - Measures

• What would you do if:
  – sitting next to someone who know or suspect is HIV-positive in a tea/food shop;
    • do nothing = non-discriminatory behavior
    • move their seat, ask the person to change places, or leave the shop = discriminatory behavior
  – sharing an in-patient hospital room with someone they know or suspect is HIV-positive;
    • do nothing = non-discriminatory behavior
    • ask to change rooms, ask to remove the person with HIV, or ask to be discharged = discriminatory behavior.
  – buying food from a vendor who they know or suspect is HIV-positive, but is not showing any physical symptoms of being ill
    • Buy food = non-discriminatory behavior
    • Not buy food = discriminatory behavior
<table>
<thead>
<tr>
<th>% reporting intention</th>
<th>Cam Dong</th>
<th>Cai Khe</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Endline</td>
</tr>
<tr>
<td>In a tea or food shop has HIV</td>
<td>18.0</td>
<td>5.6***</td>
</tr>
<tr>
<td>In an in-patient hospital</td>
<td>26.4</td>
<td>9.7***</td>
</tr>
<tr>
<td>In a market by not buying food</td>
<td>20.9</td>
<td>14.3**</td>
</tr>
</tbody>
</table>

*** p < .001; **p < .01; *p<.05, Chi-square test of independence
Behavior-Changes in Community

In general it is much different than before. Before, people did not dare to visit a house that had a person living with HIV. Now they visit as normal, they contact as normal, talk as normal and eat as normal. They even share the same eating tray, drink alcohol together, no problem. Before they even did not dare to visit my house (IDI, male, Cam Dong)
Behavior-Changes in Community

Before the project when I met a HIV infected person who was bleeding I was so afraid. Now after involving in the project I myself have given a first aid to my neighbor who was either in shock due to cold or on a drug high. It occurred when I came back from morning exercise - he was lying on his bed, foaming in his mouth with blood. I asked his wife to wipe out the blood and I massaged him and gave first aid. I helped him twice. He always said that he would die without my help.

FGD_EL, male, educator, Cam Dong
Behavior-Changes in Community

- I do not know about other people, but in my case many people care for me. This project came to the ward and educated people in residential clusters, so people understand more now compared to previous years - 2003 -2004. People have a step forward that people have fewer stigmas on persons living with HIV. Residents in residential clusters, and head of clusters and units attended the education meetings, and they become educators to other people. For example, in my club women attended meetings then in their turn they educate other persons. So from person to person, then residents now do not stigmatize as strong as before. It is not that stigma ended totally, stigma still exists but it depends on persons. Not all people stigmatizing HIV. Female living with HIV, Cam Dong
Behavior-Changes in Community

In this sector, there is a family trading in banh trang [griddle cakes]. This family has a member who has HIV. Being worried about the risk of infection, fewer and fewer people bought their cakes and then that family had to close their shop. Before the [project’s intervention], people were very frightened; they dared not use the food sold by that family with an HIV infected person. Now, that family can open their shop again...

Cai Khe, FGD, female
Conclusions

• Project had significant effect
• Exposure to more activities = larger impact
• Awareness & fear of casual contact easier to shift than ‘blood’ fear and value-driven stigma
• More efforts needed to maintain and continue stigma reduction