



**STIGMA RELATED TO SEXUAL ORIENTATION
AND GENDER IDENTITY OR EXPRESSION
WITHIN STRATEGIES TO CONFRONT HIV**

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FIRST RESULTS OF AN INTERNATIONAL FIELD SCAN
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Objectives and background

Recent publications, debates and presentations on strategies to combat HIV among key populations largely acknowledge the absolute need for an effective strategy to address the structural elements which drive concentrated epidemics amongst Men who have Sex with Men (MSM) and Transgender populations.

This concern expresses itself under various terminologies, from 'adopting a human rights based framework' to 'addressing system changes', but the objective is always to strategically take into account the factors that limit people's access to prevention, treatment and care.

Stigma related to Sexual Orientation and Gender Identity/Expression (SOGI) has been identified as one of the key structural drivers in numerous studies and reports, such as the Global Forum MSM report on social discrimination¹.

SOGI-related stigma acts not only as a direct driver (through discrimination from health workers for example, or through self-stigma keeping people away from health-care facilities), it also lies at the foundation of policies which increase the vulnerability of key populations (for example through criminalization of same sex relationships or gender expressions which differ from majority norms).

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Fighting stigma and discrimination has actually become an essential part of the strategic plans of many grassroots organizations. But while many plans explicitly detail their approach towards discrimination, strategies to confront social stigma are much less documented, commented on and analyzed. Only very few publicly available studies focus specifically on stigma related to sexual orientation and gender identity or expression, and even fewer provide detailed documentation of the tools and frameworks being implemented, and of their effectiveness.

In order to contribute to highlighting the gaps and needs in this area, the IDAHO Committee, with the support of a large consultative group of donors, research institutions, HIV-focused networks and organizations² conducted an international survey on how grassroots organizations viewed their approach to stigma related to sexual orientation and gender identity or expression.

¹ http://www.msmgf.org/files/msmgf//Advocacy/Policy_Briefs/Stigma_EN_hi.pdf

² The consulted entities include: AIDES, AMFAR, AMSHER, APCOM, ASICAL, GATE, GFMSM, HIVOS, John Hopkins Institute, Latrobe University, Sexuality Policy Watch, Sidaction, Stigma Action Network, UNDP and UNAIDS. The elements of this publication are of the sole responsibility of the IDAHO Committee and do not necessarily reflect the views of the consulted entities.

Results indicate strong awareness and ownership



The survey was distributed via HIV-focused networks and listservs and allowed for the collection of responses from 173 organizations in English (43% of responses), Spanish (37%) and French (20%) mainly from Africa, Latin America and Asia. Only very few organizations from Eastern Europe and the Caribbean contributed. Around half of these organizations specifically work with MSM and/or trans communities, with the other half working with these groups but within a broader mandate, including other vulnerable groups.



About 94% of respondents confirmed that confronting stigma related to sexual orientation and gender identity or expression was part of their strategic objectives. 80% indicated that this objective had high, to very high priority. This demonstrates a very large ownership of the issue, and a broad acknowledgement of its importance.



Stigma enacted by society at large came as a priority focus issue, with over 87% of respondents stating that this was part of their scope.

Self-stigma (i.e. stigma enacted by people upon themselves) seemed to receive somewhat less attention, with 66% of organizations including it in their focus. Only 46% of organizations mentioned stigma enacted upon sexual and gender minorities by other members of sexual and gender minorities (for example stigmatization and rejection of trans people by MSM).



Stigma enacted by health workers was also high on the list, with 77% of organizations listing this as their objective.

Limitations in implementation also shown to be significant



While the intentions are clear, the implementation seems to be less obvious. Amongst the 173 respondents, only 129 detailed their activities. Most respondents focused on specific target groups; either the community groups they service (82%) or the target group they seek to influence, such as health sector workers or educators (81%). Whilst 87% of respondents said that fighting stigma in society at large was a priority need, only 51% reported taking action in this area.



An average of 59% of respondents reported drawing on academic research. Reasons for not drawing on academic research mainly included a lack of available material but, almost equally, a lack of time and resources to use available material or to conduct primary research. Worryingly, almost a third of respondents considered formal research as not useful to understanding stigma and estimated that their empirical knowledge was sufficient.



In line with this, only 46% of respondents indicated undertaking any activity to measure levels of stigma. Yet even among the respondents who reported that they do, some limit their measurement to HIV-related stigma through the global PLWHA stigma index, while many others focus their measurement on the effects of stigma (e.g. monitoring of hate crimes) rather than of its nature (like analyzing the content of hate speech, media coverage, or the social expressions of stereotypes, etc).

Interestingly, organizations seem to be highly aware of the limitations which they are facing, with 78% self-assessing their strategies as unsatisfactory.



Structural barriers (like laws limiting the capacity to conduct research or to carry out public campaigns) and social constraints (like refusals by clinics to allow organizations to conduct training sessions, even when local regulations would allow them) scored high on the list of factors limiting the development of strategies to confront stigma related to sexual orientation and gender identity or expression (cited by respectively 72% and 79% of respondents). Still, the lack of technical and financial support to develop strategies was identified as even more problematic, with 85% of respondents citing them as limiting factors.

