An Overview of Health-Related Stigma Reduction Interventions

This document provides an overview of what is known about health-related stigma reduction interventions. It is based on a synthesis of the articles included in the 2019 issue of *BMC Medicine* and a 2013 review of stigma reduction interventions conducted by Stangl et al. The 2019 *BMC Medicine* issue provides the most current thinking and evidence on health-related stigma, derived from its nine articles that include four systematic reviews of stigma reduction interventions taking place in a variety of countries and addressing a range of disease-related stigmas; several stigma frameworks; and reviews and assessments of measurement tools. See sidebar for overview of the features of the stigma interventions reviewed in *BMC Medicine* issue and the 2013 review article.

What We know:

- While several reviews of stigma reduction interventions have been completed, the state of knowledge is **not yet** at the place where **we know what works for whom in what contexts, and how**.
- Many stigma reduction interventions exist and have been evaluated (close to 150). Despite the prevalence of interventions, **stigma reduction is not routine in health care or part of pre-service or in-service training** for most health care workers (Nyblade et al., 2019).
- **Most interventions show decreases in stigma**. For example, in the review conducted by Nyblade et al. (2019), 32 out of the 42 intervention (76%) showed reductions in stigma. In the review conducted by Rao et al. (2019), 17 out of the 24 studies reported reductions in stigma. In the review conducted by Stangl et al. (2013), 79% of the 48 interventions reported statistically significant reductions in all stigma measures.

The landscape of stigma reduction interventions.

Health conditions addressed:
HIV/AIDS, tuberculosis, mental illness, substance use, diabetes, leprosy, cancer, STI, epilepsy.

Number of interventions or articles reviewed:
Nyblade et al. (2019) – 42 interventions.
Kemp et al. (2019) – 29 interventions.
Roa et al. (2019) – 24 studies.
Stangl et al. (2013) – 48 articles.

Countries: where interventions were implemented
Angola, Australia, Bangladesh, Botswana, Canada, Cameroon, Chad, Czech Republic, Chile, China, Cote D'Ivoire, Egypt, El Salvador, England, Equatorial Guinea, Ethiopia, Ghana, Greece, Haiti, Hong Kong, India, Indonesia, Ireland, Israel, Kenya, Lesotho, Malawi, Malaysia, Mozambique, New Zealand, Nigeria, Peru, Puerto Rico, Russia, sub-Saharan Africa, Saudi Arabia, Senegal, South Africa, Swaziland, Tanzania, Thailand, Uganda, UK, USA, Vietnam, Yemen, Zambia, Zimbabwe.

Developed by Marla Steinberg for the Pacific AIDS Network
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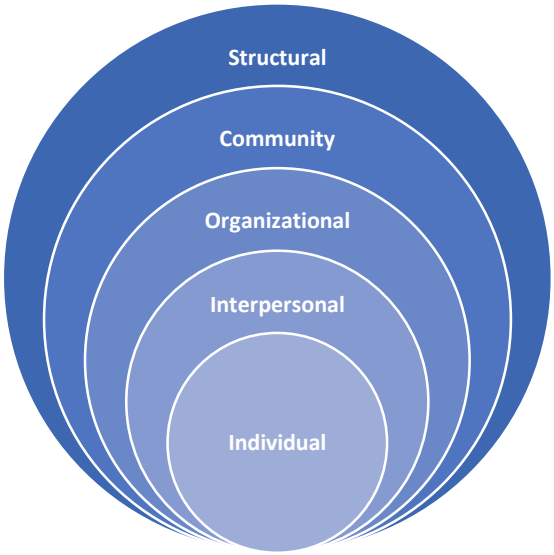
What We Know - Continued

- The main limitations of our knowledge of intervention effectiveness is that most studies **do not provide information on the long-term impact of the interventions**. The education interventions, which are most common, tend to collect data at the conclusion of the intervention.
- **Effects have tended to be small-to-moderate** and limited to changes in attitudes and knowledge, with less evidence concerning long-term impacts on behaviour change and health (Kemp, et al. 2019).
- The few studies that compared differences in delivery methods (e.g., in-person vs video based, etc.) did not find significant differences in stigma reduction suggesting **that any number of delivery methods can be effective** (Nyblade, et al. 2019).
- Interventions using **more stigma measures** were more likely to obtain **mixed results** than those using just a few measures (Nyblade, et al. 2019).
- **Intervention descriptions are sparse** and often lack key details necessary for the replication and adoption (Kemp, et al. 2019). As noted by Kemp et al. (2019), few manuscripts included in their review of 29 interventions taking place in low- to middle-income countries offered links to formal manuals or protocols detailing intervention content and procedures.

Overall conclusion

"Available evidence suggests that stigma should be tackled at multiple levels, by using multiple strategies and the interventions must be context specific and continued or repeated to achieve a lasting impact." (Brakel et al., 2019, p. 18).



Individual level	Here interventions can focus on: (1) people living with stigmatized conditions or identities. Interventions involve self-help, counselling and treatment. (2) Service providers where the focus is on awareness raising and stigma reducing practices.
Interpersonal level	Here the focus of interventions is on support in the stigmatized persons' local environment of family, friends, and networks.
Organizational level	Here interventions focus on reducing stigma within organizations or institutions.
Community level	Community-level interventions target the general public. Here the focus is on increasing awareness of the harmful effects of stigma and reducing stigmatizing attitudes and behaviours in non-stigmatized groups.
Structural or policy level	Here interventions focus on establishing and enforcing legal, policy and rights-based solutions.

Types of Interventions

The literature on health-related stigma interventions shows that different types of interventions can be effective. The main types of interventions are described below.

Education/Provision of information – providing information about stigma producing health conditions or about stigma itself and its manifestations and impacts on health. Information-based strategies are used to reduce negative attitudes and perceived stigma in the community. Negative attitudes are assumed to be based on lack of knowledge, incorrect knowledge, myths, beliefs or stereotypes about a given condition or group of people. Information can be provided in a variety of ways including print, media campaigns, posters, radio or television, internet, and arts-based methods. Education can take place in classroom settings, professional education workshops or community settings.

Social marketing – social marketing interventions target community norms, values, and attitudes toward stigmatized populations. These can be considered a delivery method for education/provision of information.

Skills building (also can include problem solving and counselling) – supporting people to develop the appropriate skills for working directly with the stigmatized group or to support stigmatized people in developing resilience and other coping strategies.

Empowerment – supporting clients to develop coping mechanisms to manage anticipated or actual stigma experiences.

Peer counselling or counselling/support– In these interventions, people with the same conditions are trained as counsellors and support others through listening, problem solving, and provision of information, including information on human rights. The counsellor can also serve as a role model. Other terms used for this type of intervention include peer educator or community-linkage facilitator. These interventions have been used in the fields of mental health and HIV.

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Social Media

Sickboy podcast (www.sickboypodcast.com) is a weekly podcast about the stigma associated with illness and disease. It has been turned into a live show and the podcasters also offer speaking engagements.

Education & Empowerment

The Karnataka Health Promotion Trust organization (India) educated female sex workers on their legal rights and implemented sensitization and awareness training with government officials, policy, and journalists (Kemp, et al. 2019).

Skills Building

An anti-stigma HIV intervention in Nigeria involved providing life skills education. (Kemp, et al. 2019).

An anti-stigma HIV intervention in Tanzania and other African countries involved community mobilization, community HIV voluntary counselling and testing and post-test support services.

Economic Empowerment

Brakel et al. (2019) describe an economic empowerment intervention where stigmatized groups or people are given job skills or linked to saving schemes or micro-finance interventions.

Types of Interventions Cont.

Contact with stigmatized group – relies on involving members of the stigmatized group in the delivery of the intervention to develop empathy, humanize the stigmatized individual, and break down stereotypes. Contact can take different forms including direct or live contact or contact via media (videos). According to Brakel et al. (2019), opportunities for discussion are an important element.

Change agents/Popular opinion leaders (POLs) – POLs display positive attitudes and spread a non-stigmatizing message. They can even fight enacted stigma in a social group. POLs interventions have been implemented with different populations in many countries.

Structural or policy change – includes policies, providing clinical materials, complaint systems, and facility restructuring. Examples include anti-discrimination policies, infection control supplies, standardized precaution infection control practices, client complaint and compliment mechanisms, and changes to physical spaces.

Biomedical – biomedical interventions for HIV, for example, include testing and anti-retro viral therapies. While these interventions do not directly target stigma, they can affect stigma and are considered by some part of the multi-component, multi-level programming needed to combat stigma.

Many interventions combine several different approaches to support individuals and bring about organizational and structural changes.

- Stangl et al. (2013) reported on an intervention that combined information and skills building for healthcare works with the provision of universal precaution supplied at intervention hospitals in China.
- Stangl et al. (2013) also reported on an intervention that combined community-wide availability of home-based HIV counselling and testing with counselling and support for people living with HIV.

Contact

In intervention reported by Nyblade et al. (2019) involves primary health providers and clients with mental illness or substance abuse working together to produce art that is presented to others.

Popular Opinion Leaders

An HIV-related intervention offered in China involved participatory training of champions from several hospitals and the provision of universal precaution materials (Nyblade, et al. 2019).

Another HIV intervention also offered in China involved training market vendors and community popular opinion leaders. (Kemp et al. 2019)

Multi-Component Interventions

An intervention to reduce stigma for people using heroin involved education sessions and training on motivational interviewing for health care workers in China.

An HIV intervention in Ghana involved mass media, promotional materials, and training for local religious leaders.

Beyond Single or Multi-Level Interventions

Collective impact interventions bring stakeholders with common interests together to support them in addressing and evaluating interventions (see Kania & Kramer, 2011). There are many existing collective impact initiatives and online forums for people engaged in these initiatives. In Canada, for example, the Ontario HIV Treatment Network (OHTN) runs a collective impact initiative in HIV/AIDS (www.ohtn.on.ca).

Implementation support interventions help practitioners deliver evidence-based interventions (Kreuter and Bernhardt, 2009). Systems for implementation support typically include tools, training, technical assistance, and quality assurance/quality improvement (Wandersman, Chien & Katz, 2012). The Canadian Public Health Association is currently implementing a 5-year project (2017-2022) to provide a suite of professional development and knowledge translation resources focused on the reduction of stigma associated with sexuality, substance use and STBBIs. The website for this project offers several supports that are typically included in implementation support systems (see https://www.cpha.ca/sexually-transmitted-and-blood-borne-infections-and-related-stigma).

Because of the ubiquitous nature of stigma and the need for multi-level, multi-component interventions (Nyblade, et al. 2019), stigma reduction could also be supported through collective impact and/or implementation support systems, in addition to the single or multi-level stigma reduction interventions.

Four Keys to Intervention Planning

1. Involve people with lived experience
2. Form a working group or coalition
3. Use a variety of evidence and information
4. Evaluate.

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Provincial Health Services Authority
Province-wide solutions. Better health.

CAI Community Action Initiative
Collaboration to address mental health and substance use

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