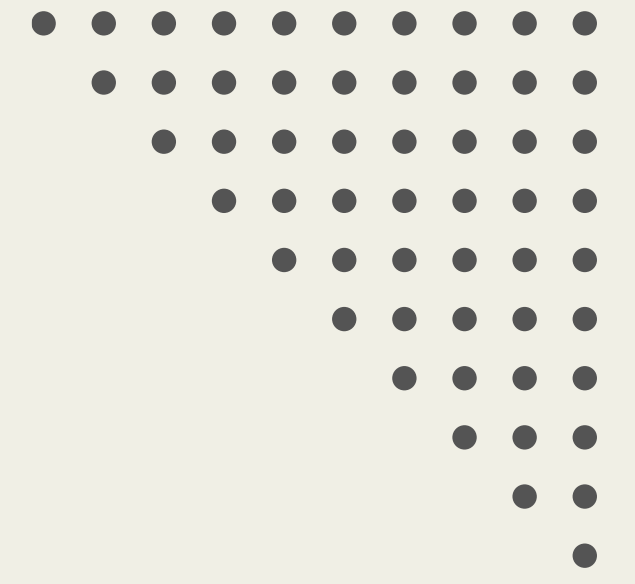
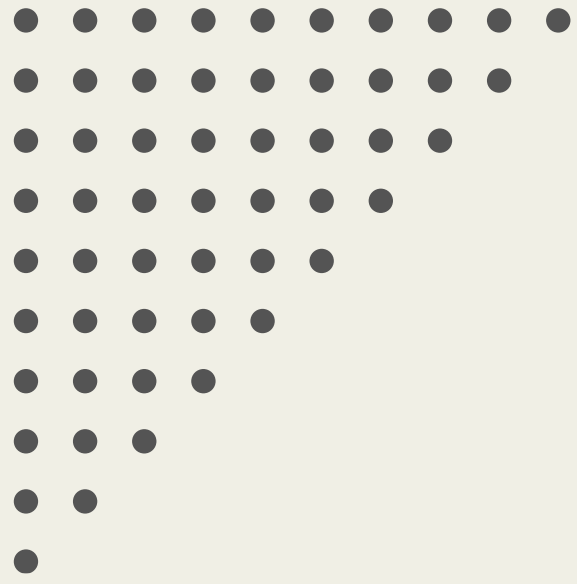


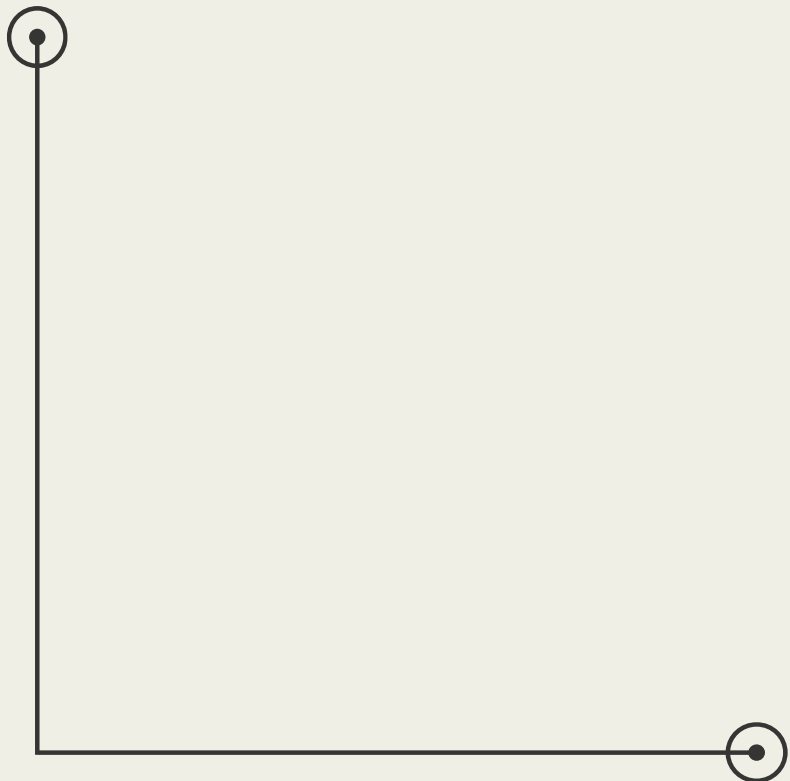


# “Internalised Stigma as a Barrier to HIV Care”

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***"What if the biggest barrier to HIV care isn't a clinic  
but rather a feeling?"***



# What Is Internalised Stigma?



## External Stigma

- Discrimination by healthcare workers, employers, or family
- Being denied services or treated with less respect
- Community ostracism or social rejection
- Visible — can be witnessed, documented, reported
- Can be considered the same as enacted Stigma



## Internalised Stigma

- Shame and self-blame absorbed from society's moral judgments
- Negative self-belief: 'I deserve this' or 'I am dirty'
- Present even without any direct discrimination
- Hidden — self-silencing, avoidance, withdrawal from care

**KEY INSIGHT:** *A person can experience severe internalised stigma even if they have never faced direct discrimination and has simply absorbed society's judgment as their own.*

# How Internalised Stigma Blocks the Path to Care



## Anticipated Stigma

People do not wait to be discriminated against — they predict it. They imagine the nurse's reaction, who might see them in the waiting room. This prediction drives avoidance just as powerfully as real discrimination — it is rational behaviour in response to an irrational burden.

Source: Earnshaw & Chaudoir HIV Stigma Framework (2009)

## The Clinical Cost: Depression & Viral Suppression

WHO (2025) confirms the pathway ends in measurable clinical failure: individuals without depression are 30% more likely to achieve viral suppression than those with depression (OR 1.3; 95% CI: 1.2–1.5). Stigma causes depression. Depression blocks suppression.

Source: WHO Guideline on HIV Service Delivery, Section 3 (2025)

# What Research is telling us

## Testing

### Internalised stigma independently predicts delayed HIV testing

People who anticipate stigma are 2.4× more likely to delay care until critically ill. ((UNAIDS / AIDS 2024))

## Adherence

### Higher stigma = lower ART adherence and higher loss to follow-up

Patients don't abandon treatment because they don't care about their health. They abandon it because every clinic visit re-activates the shame. Stigma accounts for significant variance in adherence outcomes independent of other factors. (Turan et al., JAIDS 2023)

## Mental Health

### 31% depression · 29% anxiety · 20% suicidal ideation among PLHIV

WHO (2025) systematic review: pooled prevalence of 31% depression, 29% anxiety, 20% suicidal ideation, 20% PTSD and 44% psychological distress. Rates are higher in resource-limited settings. Among adolescents in sub-Saharan Africa, depression burden is significantly higher vs HIV-negative peers. (WHO Guideline, Section 3, 2025)

## The Gap

### 84.8% of PLHIV globally report internalised stigma

The gap between people who know their HIV status and those engaged in care cannot be explained by access alone. Internalised stigma is among the strongest explanatory variables for that gap. (PLHIV Stigma Index, December 2023)

**KEY INSIGHT: The barrier is not logical but emotional. Clinics can be free, a few minutes away, fully stocked, however, person with high internalized stigma will find reasons not to access**

# Who Carries the Heaviest Burden?

## Women

HIV shame is fused with judgments about sexual behaviour, fidelity, and reproductive choices. In maternal care, HIV disclosure carries risk of rejection, violence, and loss of custody.

## People Who Use Drugs

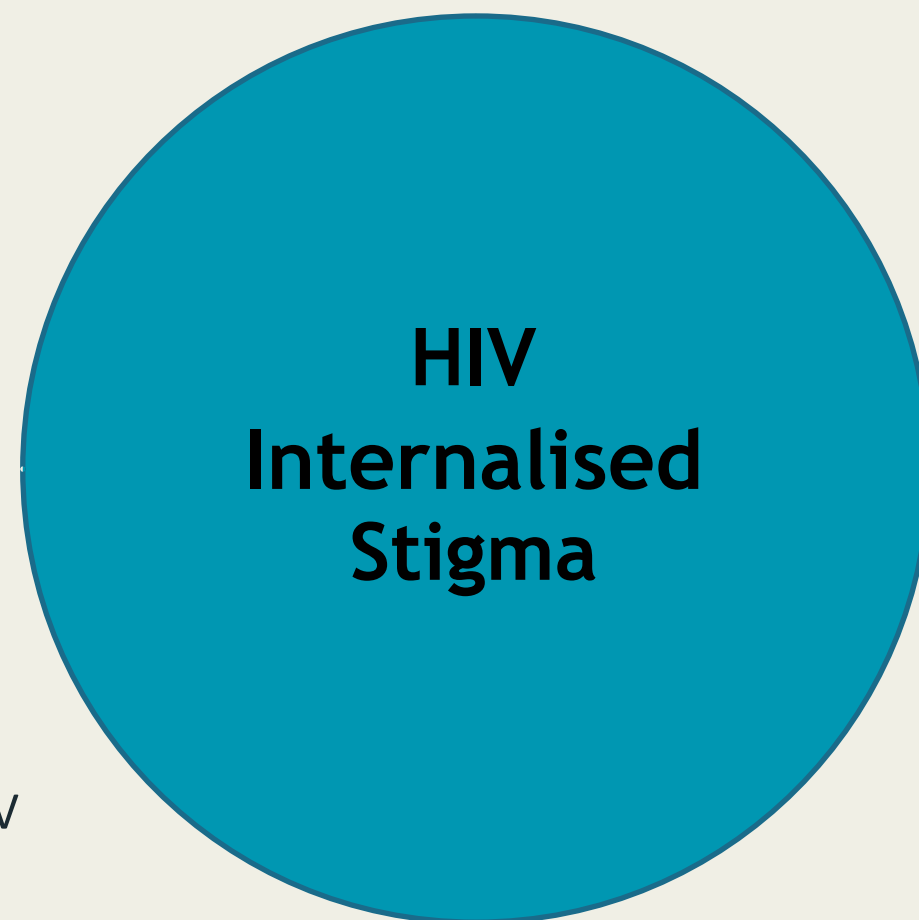
Moral frameworks linking HIV to 'deviant behaviour', particularly for people who use drugs. Internalised shame compounds barriers at every step — testing, disclosure, adherence. The stigma of drug use and HIV stigma reinforce each other, making disengagement from care more likely.

## Gay, Bisexual Men & Trans People

HIV stigma sits on top of existing discrimination related to sexual orientation and gender identity — creating 'double stigma'. Trans women in Latin America report the highest levels of internalised stigma globally. Trans women face 49× higher HIV risk than the general population (UNAIDS 2024).

## People in Poverty

Structural vulnerability amplifies shame: if you cannot afford transport, housing, or food, addressing internal shame feels impossibly remote. Poverty is both a cause and a consequence of stigma-driven disengagement.



# What Works: At the Individual Level



## Cognitive Behavioural Therapy (CBT)

Strongest evidence base · WHO 2025 endorsed

CBT adapted for HIV-related shame shows consistent positive outcomes across RCTs.

- Helps people identify and challenge the cognitive distortions driving avoidance.

WHO (2025) confirms task-shared CBT for PLHIV with depression improves life expectancy and is cost-effective in South Africa. Combining CBT with ART is more effective than ART alone.



## Peer Support & Peer Navigation

Community-led · US\$13 per DALY (WHO 2025)

Peer-led approaches reduce shame in a way specialist services cannot.

- When someone with lived experience says 'I was where you are , I am still here' . . it dismantles isolation.

WHO (2025) confirms group psychotherapy by trained lay workers costs just US\$13 per DALY averted — among the most cost-effective health interventions on record.



## Self-Affirmation & Values-Based Approaches

Promising — community demand confirmed

Emerging evidence supporting identity-rebuilding beyond the diagnosis.

- Values-based interventions reconnect people to their core sense of worth outside their HIV status.

In a 2025 WHO survey of PLHIV communities, 58% agreed mental health care should be offered in the same clinic as ART — showing demand exists.

# What Works: Changing Systems & Communities



## Health System Level

### Stigma-Free, Trauma-Informed Communication

Train clinicians to avoid language that reinforces shame — 'non-compliant', 'high-risk behaviour'. WHO (2025) confirms acceptability is high among healthcare workers when integration is properly structured. Language choices are associated with patient trust and return rates.

### Integrated Mental Health Screening — WHO Strong Recommendation

WHO (2025) STRONG RECOMMENDATION: mental health care for depression, anxiety & alcohol use disorders should be integrated with HIV services. Integration improves retention in care (OR 2.0) and viral suppression (OR 1.6). Use validated tools: PHQ-9, PLHIV Stigma Index.

### Redesigned Clinical Environments

Separate waiting areas, clear confidentiality policies, removal of stigmatising signage. Physical signals of safety matter — if a patient fears being seen entering an HIV clinic, they will not return. 58% of PLHIV surveyed by WHO (2025) want MH care in the same clinic as ART.



## Community & Structural Level

### Contact-Based Stigma Reduction Campaigns

The most robust evidence for attitude change at community level: real people sharing real stories of living well with HIV. Statistics inform — stories shift beliefs. Community-led, designed by PLHIV, not delivered to them.

### Religious & Traditional Leaders as Change Agents

In many contexts, religious and traditional leaders define the moral narrative around HIV. Where they have been engaged as partners, stigma reduction has been faster and more durable. They are the most powerful voices for change.

### Task-Shifting to CHWs — WHO 2025 Confirmed Cost-Effective

WHO (2025) confirms task-sharing is feasible and cost-effective across LMICs. Group psychotherapy by lay workers costs US\$13 per DALY averted (Uganda). Upfront training investment is offset by long-term cost savings and improved outcomes.

# A Direct Message for Everyone in This Room



For PLHIV & Advocates



For Clinicians & Health Workers



For Policy Makers & Funders

*The shame you carry is not a personal failing or a moral verdict. It was constructed by the world around you — and the world can change it.*

*“You are not the problem”*

*In a WHO (2025) survey, 44% of PLHIV said integration could reduce stigma and discrimination. 58% said mental health care should be in the same clinic as their ART. Your voice is already in the evidence.*

*WHO (2025) has issued a Strong Recommendation:*

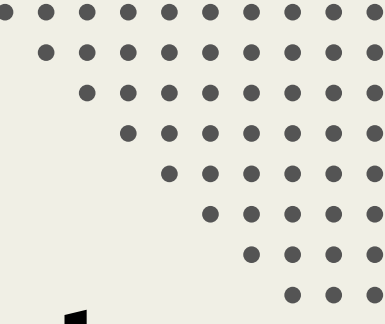
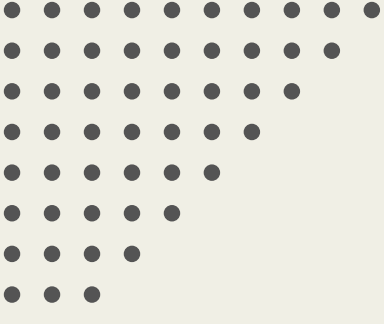
*“Integrate mental health care into HIV services. The evidence shows integration doubles retention and improves viral suppression”*

*The next time a patient disengages from care, ask — not what is wrong with them, but what are they carrying? That question is your intervention.*

*84.8% of PLHIV globally report internalised stigma — it appears in no programme report.*

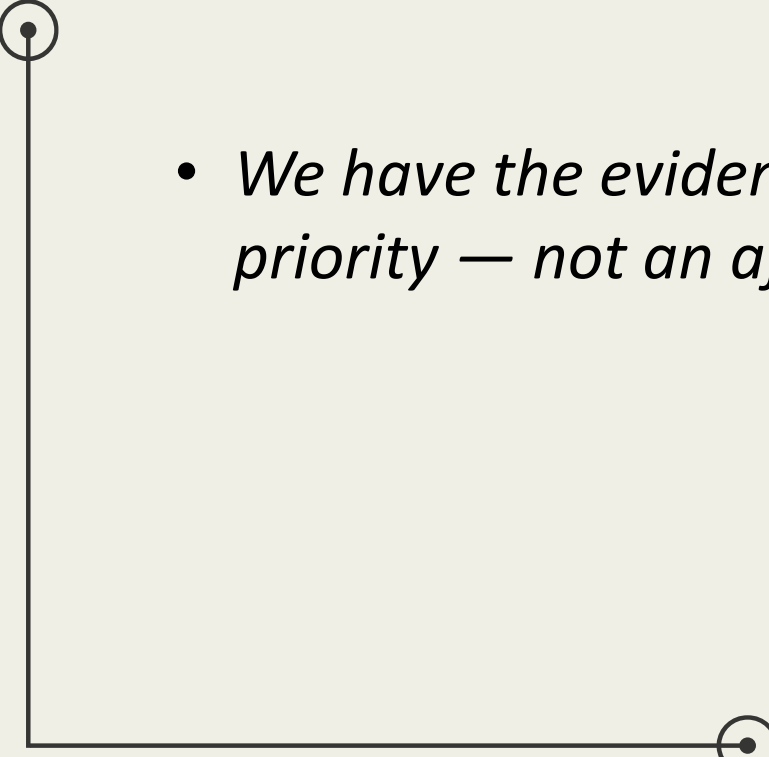
*Group psychotherapy by lay workers costs US\$13 per DALY averted (WHO 2025).*

*A global ROI analysis confirms substantial returns in healthy life years and economic productivity. Integration is not a cost. It is an investment with a measurable return.*



# Internalised stigma is not a personal failing

- *It is a public health problem: One that was created by social forces, reinforced by health systems, and one that require a systemic response at every level: individual, clinical, community, and policy.*

- 
- *We have the evidence. We have the interventions. What we need now is the will to make psychological safety a clinical priority — not an afterthought.*

# 5 Recommendations for Action

1

## Integrate Mental Health Screening at Every HIV Care Contact

WHO (2025) issued a STRONG recommendation: mental health care for depression, anxiety and alcohol use disorders must be integrated with HIV services. Use validated tools — PHQ-9, PLHIV Stigma Index — at ART initiation and every routine review. Evidence: integration improves retention (OR 2.0) and viral suppression (OR 1.6).

2

## Train the HIV Workforce in Psychosocial and Stigma-Competent Care

Every nurse, counsellor, and community health worker should be trained to recognise internalised stigma, use non-shaming language, and respond to psychological distress. WHO (2025) confirms acceptability is high among healthcare workers. Structured training and institutional accountability — not optional workshops.

3

## Scale Peer-Led, Community-Rooted Stigma Reduction Programmes

Contact-based, peer-led interventions are among the most cost-effective tools available. WHO (2025) confirms group psychotherapy by lay workers costs US\$13 per DALY averted. Lived experience is the most credible voice. Programmes must be designed by communities of PLHIV — not delivered to them.

4

## Redefine Success: Include Psychological Safety in Programme Targets

Individuals without depression are 30% more likely to achieve viral suppression (WHO 2025). 84.5% internalised stigma alongside 95% viral suppression is not complete success. A WHO global ROI analysis confirms substantial returns from investing in mental health. What gets measured gets funded.

5

## Design Intersectional Interventions for the Most Marginalised

Women, trans people, people who use drugs, and those in poverty carry compounded stigma burdens. WHO (2025) confirms the double stigma of HIV and mental health conditions is an important clinical consideration. Universal approaches will fail the most marginalised. Investment must target co-designed, intersectional responses.

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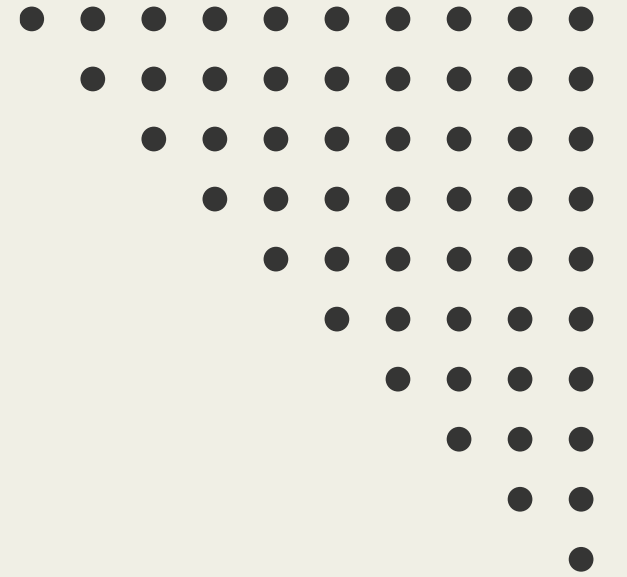
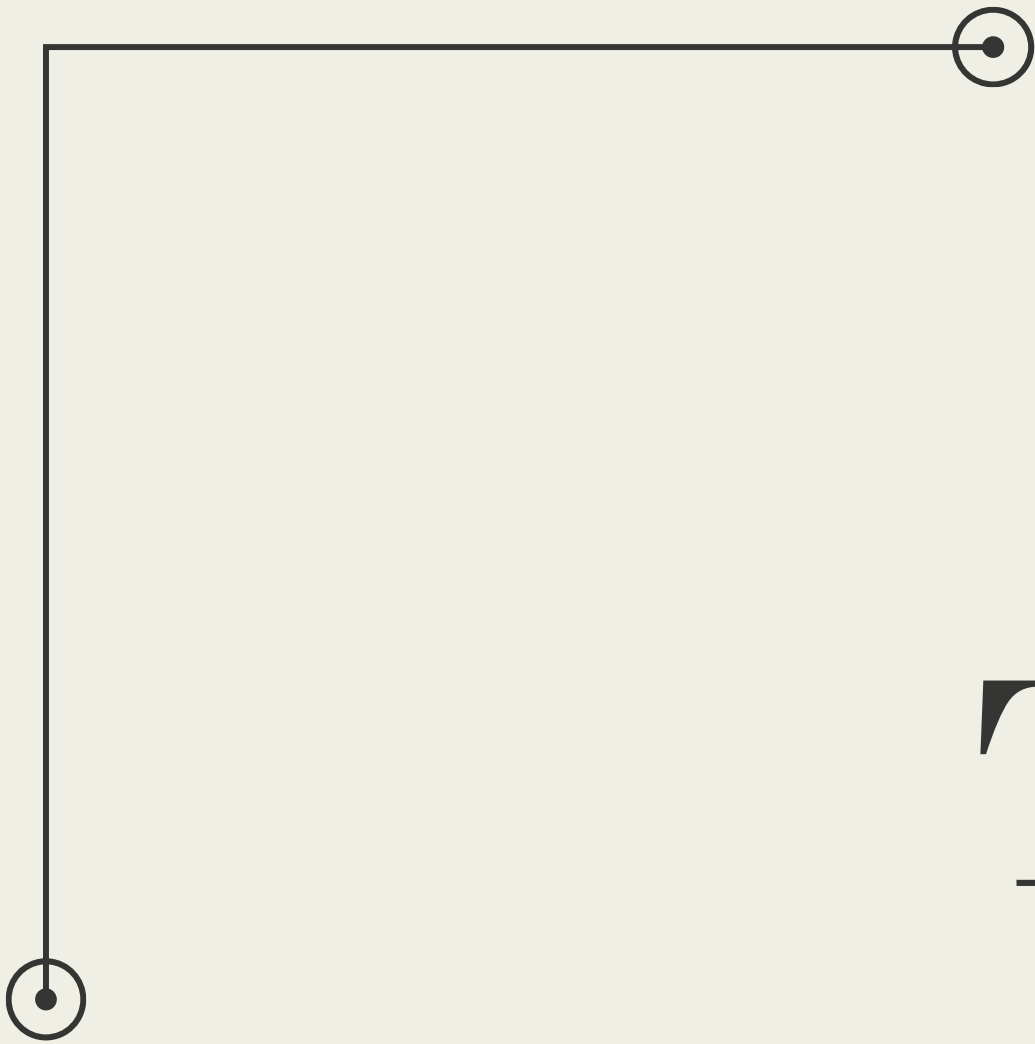
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**THANK YOU**

