ADDRESSING HEALTHCARE RELATED STIGMA TO INCREASE HIV PREVENTIVE CARE ACCESS AMONG MSM

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This brief is directed to policy makers, Ministry of Health, legislators, healthcare administrators, healthcare providers and education boards. It serves as a guide to; understand how stigma in healthcare setting against men who have sex with men (MSM) can impede HIV preventive care access and, implement strategies for its elimination.

The marginalised MSM population in Malaysia records very low uptake of HIV preventive care services due to numerous structural and social barriers – with healthcare related stigma being one of the most significant barriers. Due to this, high prevalence of HIV transmission has been observed among them. Addressing healthcare related stigma is therefore fundamental in delivering quality health services and reducing HIV transmission in MSM population.

KEY POINTS

HIV prevalence among MSM in Malaysia had increased about 2.5 folds, from 8.8% in 2014 to 21.6% in 2017.

Healthcare related stigma towards MSM can undermine HIV prevention efforts when it discourages individuals to seek for preventive care services.

In 2019, MOH reported that MSM had the poorest access to HIV preventive care service compared to other high-risk groups.

Healthcare Stigma and HIV Preventive Care Access by MSM

HIV prevalence among MSM had increased in alarming rate from 8.8% in 2014 to 21.6% in 2017, making Malaysia one of the countries with highest prevalence in the world (1,2). Increased prevalence of MSM is associated with high-risk behaviour and low HIV testing uptake. Compelling evidences indicate imminent need to focus HIV preventive care on this key population as social, cultural and other structures often make this group highly susceptible to HIV infection.
Nevertheless, one of the major barriers for MSM to access HIV preventive care intervention is due to being stigmatized by healthcare workers (HCW) or within healthcare settings. Many feared being devaluated or received negative reaction from HCW when seeking care. As a result, MSM populations are less likely to access HIV services than heterosexuals, be it preventive or treatment (3). The Ministry of Health Malaysia (MOH) stipulated that stigma and discrimination (S&D) towards MSM, makes them one of the most hard-to-reach and hard-to-identify population. This contributes to poor access to HIV prevention services by MSM with below 50% coverage in 2019, lowest, compared to other high-risk groups (4). With pervasive stigma documented within Malaysian healthcare setting, it is unfortunate that stigma reduction efforts are severely lacking (5). To step up this effort, it is crucial to be able to recognise stigma and work against it in order to deliver equitable healthcare, ultimately reducing HIV transmission.

Understanding Stigma in Healthcare Setting

Stigma in healthcare setting can lead to outright denial of care or provision of sub-standard care causing unequal treatment, driving health disparities. In healthcare setting, S&D can be intentional or unintentional, manifested in many forms such as (6,7);

- Disclosing personal details without client consent (e.g. sexual orientation)
- Failing to disseminate HIV-related information
- Obstructing access to medical services
- Performing forced HIV testing
- Failing to provide treatment to those eligible, or delaying treatment
- Using unnecessary additional precautions to prevent infection
- Verbal abuse including mockery or subtly through gossiping or labelling
- Physical abuse or subtly through negative body language
- Refusing to examine, provide testing and counselling or passing responsibility to another colleagues

Mounting evidence have supported the fact that S&D by healthcare provider significantly discourages MSM from accessing HIV related services (8). Stigmatization towards MSM can undermine HIV prevention effort when anticipated healthcare stigma amplifies individuals' reluctance to disclose their same-sex behaviour or sexual identity to attending HCW, rendering delay or potential delivery of preventive measures.

Healthcare stigma can occur at any point of client's contact with healthcare facility. Figure 1 depicts presence of stigma in healthcare setting at different levels of occurrence which are interconnected to each other, that potentially impair delivery and access to healthcare by MSM (9,10). Stigma at individual level stems from the individual HCW who is interacting with the client. Environmental level refers to the setting where healthcare services are delivered such as the hospital, clinic or pharmacy. While at structural level, stigma can be propagated through implemented procedures, policies or related legislations that influences how healthcare services are being delivered.

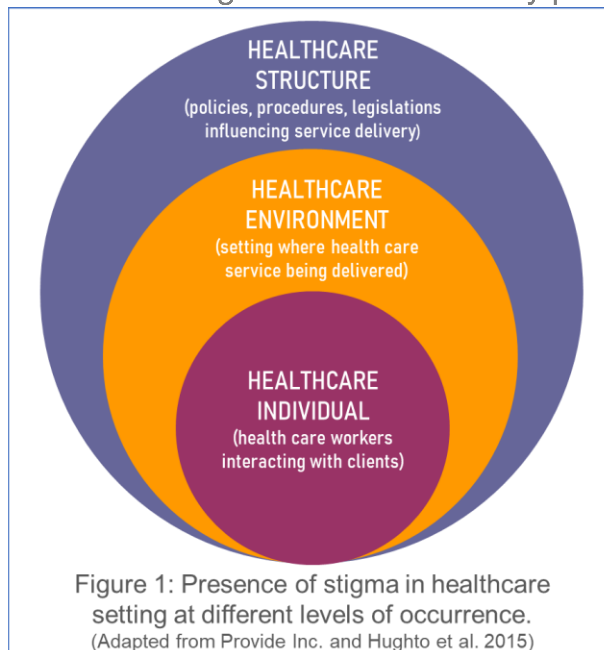

Figure 1: Presence of stigma in healthcare setting at different levels of occurrence.
(Adapted from Provide Inc. and Hughto et al. 2015)

UNAIDS 2019 reported that where programmes were introduced to counter S&D, access to HIV prevention care, testing and treatment improved significantly.

The Actionable Drivers of Stigma

Cultural competence is widely viewed as the basis for reducing inequality through culturally sensitive, unbiased and quality care. Butler et al. expanded cultural competence concept to a boarder term - diversity competence, encompassing "other marginalized population groups who are ethnically and racially similar to a provider but who are at risk for stigmatization or discrimination, are different in other identities, or have differences in healthcare needs that result in health disparities"(11). Individuals of the stigmatized community require culturally competent providers that are sensitive to their special needs and circumstances. Developing cultural competency among HCW which possess cultural awareness, knowledge and skills is crucial in eliminating stigma while dealing with MSM (12). Targeted approach modifying actionable stigma drivers as shown in Figure 2 can be designed for elimination of healthcare related stigmas such as (13,14,15,16);

i. Individual level - focusing on attitudes, S&D knowledge, HIV knowledge, soft skills among HCW to produce "culturally competent" HCWs – through behavioural change strategy such as sensitisation training (17,18).
ii. Structural level - targeting legislations, healthcare policies, work environment.

IDENTIFIED DRIVERS OF STIGMA AND DISCRIMINATION IN HEALTH FACILITIES

INDIVIDUAL HEALTH FACILITY STAFF LEVEL

- **Lack of awareness and understanding of stigma & discrimination (S&D)**
  - Ways of S&D manifestation
  - S&D impact
- **Social Judgement**
  - Prejudice & negative stereotyping
  - Lack of understanding on stigmatized community special needs and situation
- **Fear of HIV Infection**
  - Lack of HIV transmission knowledge

INSTITUTIONAL LEVEL

- **Lack Policies and Guideline**
  - Dealing with key populations
- **Inadequate Trainings & Monitoring**
  - S&D reduction
- **Physical Environment**
  - Lack stigma-free setting (e.g. signage indicating HIV clinic)
- **Legal Environment**
  - Criminalisation of same sex-behaviour, drug use
  - Lack emphasis of human rights law for key populations

Figure 2: Identified drivers of stigma and discrimination in health care setting.
(Adapted from Jain A. et al. 2012 & Stangl AL.et al. 2019)

Sensitisation Training – Individual Level

Sensitisation training among HCW helps to develop cultural competency which supports them to overcome personal and institutional discriminatory attitudes and actions towards MSM (19). Evidence shown that sensitisation training for HCW can promote inclusion and increase access to HIV preventive care services (18). A nationwide sensitisation training outcome in South Africa revealed that HCW are more confident in delivering appropriate and sensitive services to vulnerable key populations through skill acquired, accompanied by improved knowledge, consciousness about specific HIV-related health needs and vulnerabilities key populations encounter – aiding in reducing prejudice and discrimination (20). According to WHO, MSM are also more likely to seek and benefit from the preventive services or any interventions they required, "when providers respect

confidentiality and demonstrate good communication skills, and when they are knowledgeable, sensitive, non-judgmental, empathetic and supportive" (21).

People-centred service delivery models – Institutional Level

MSM that had experienced healthcare stigma from medical providers are more likely to develop medical mistrust impairing their access to healthcare services (22). Establishing healthcare system which is stigma-free and non-discriminatory based on people-centred service delivery models, have been shown to foster trust between HCW and beneficiaries, enhancing service experience and outcome, besides improving access to healthcare. With respect to HIV services, the model of people-centred care refers to preventive care or any intervention delivery that is "acceptable, accessible, quality, and meeting the needs of clients" (18).
At such, the regulative pillars as drivers of stigma at structural levels i.e. policies and legislations need to be readdressed in order to create an enabling environment within the healthcare system – for the delivery of equitable and quality healthcare.

Recommendations

Based on scaling up sensitisation initiatives and facilitating people-centred service models delivery, the recommended actions at micro and macro levels include:

Policymakers, ministry and legislators

- Review current laws which perpetuate S&D impeding HIV prevention strategies, contravene public health interventions and "right-to-health" (23, 24).

Action MOH, religious authorities and legislators must reconcile and find a middle ground for key populations to access preventive care equally without fear (25).

- Develop and implement national- and facility-level policies to support the delivery of people-centred service models.

Action Introduce stigma-free policies e.g. Key-population friendly policy empowers HCW to provide service with lesser conflict of conscience, and creates 'safe space' for MSM to access healthcare without being judged.

- Create an actionable evaluation and feedback mechanism for stigma reduction by setting targets and measuring progress as a part of national healthcare quality performance standard.

Action Implement a linked harmonised tool to systematically measure S&D within entire healthcare sector. Harvested data used to aid in (i) system-wide monitoring, (ii) designing nationwide awareness programmes and enhancing policies, (iii) provision of evidence-informed responses such as budgeting. Malaysia can adopt the intervention package implemented by Thailand's Ministry of Public Health (26).

- Highlight the importance of S&D reduction throughout healthcare sectors.

Action Utilize evidence-based sensitisation training package developed by the United Nations Development Programme and WHO, specifically tailored for HCW to address S&D towards gay, MSM and transgender people in healthcare settings in Asia - e.g. "The Time Has Come" (27). MOH can adopt this data driven training package for integration into national HIV training programme for HCW, as done by neighbouring countries - Indonesia and Philippines (28).

- Allocate funding.

Action: Mobilise funds for policy implementation, training and research (29).

Healthcare facilities and healthcare workers

- Employ policies and practice at operational stage facilitating HCW to deliver people-centred healthcare, based on the actionable stigma drivers at both individual and facility level.

Action: Encourage stigma-free culture by introducing MSM-friendly policies within healthcare institutions – enhancing HCW awareness and sensitivity (30).
Create a feedback mechanism through customer satisfaction survey to identify gaps to be addressed.
Incorporate compulsory sensitisation training into pre- and in-service training for all cadres of HCW (31).

- Accredit facilities with S&D reduction intervention incorporated into service delivery system as one of the quality healthcare indicators.

Action: Malaysia Society for Quality in Health (MSQH) healthcare facilities accreditation to include HIV key populations friendly service into standard service list.

- Integrate stigma reduction into hospital/facility quality management (18).

Action: Erect a Key Performance Index (KPI) to ensure maximum training coverage on all HCW and certify those who accomplished training. MOH should make sensitisation training compulsory in all government health facilities.

Healthcare professional boards and Higher education boards

- Accredit healthcare related courses with sensitisation module as compulsory part of syllabus.

Action: Malaysian Qualifications Agency and healthcare professional boards (i.e. Medical or Pharmacy Board) to review course requirements.

Medical and Allied health training institutions

- Integrate sensitisation modules into all medical and allied health undergraduate curricula in education institutions to nurture HCW free of S&D.

Action: Design programmes involving prosocial contact with MSM and implement MSM-friendly policies campus-wide to boost student's cultural competency (32)

In order to achieve Malaysia target of 95-95-95 in "Ending AIDS" by 2030, drastic actions must be taken immediately to reach all marginalised key populations for HIV prevention and treatment. This is certainly true for MSM populations, which may carry the heaviest HIV burden in Malaysia in time to come.

REFERENCES

1. Malaysia Integrated Biological and Behavioral Surveillance Survey 2017. Putrajaya: Ministry of Health Malaysia, Division DC; 2017.
2. UNAIDS. AIDSinfo. 2019 Updated July 2019.
3. UNAIDS. BLIND SPOT: Addressing a blind spot in the response to HIV - Reaching out to men and boys. Geneva: UNAIDS Joint United Nations Programme on HIV/Aids; 2017 n.d.
4. Suleiman A, Ramly M. Global AIDS Monitoring 2020 : Malaysia HIV/AIDS Progress Report. Ministry of Health Malaysia, Malaysia HSHCSoMoH; 2020.
5. Codeblue. Adeeba: Malaysia's HIV Stigma Stronger Against LGBT Than Drug Users. 2019 26 July 2019.
6. Nyblade L, Stockton MA, Giger K, Bond V, Ekstrand ML, Lean RM, et al. Stigma in health facilities: why it matters and how we can change it. BMC Medicine. 2019;17(1):25.
7. ASHM/OSSHHM Technical Brief: HIV stigma and discrimination: a guide for health care workers in the Pacific ASHM International Oceania Society for Sexual Health and HIV Medicine. 2018.
8. Ayala G, Makofane K, Santos GM, et al. Access to Basic HIV-Related Services and PrEP Acceptability among Men Who Have sex with Men Worldwide: Barriers, Facilitators, and Implications for Combination Prevention. J Sex Transm Dis. 2013;2013:953123. doi:10.1155/2013/953123
9. Provide I. How Does Stigma Show Up In Health Care And Social Service Delivery? : Provide, Inc.; 2019 [Available from: https://providecare.org/how-does-stigma-show-up-health-care-social-service-delivery/.
10. White Hughto JM, Reisner SL, Pachankis JE. Transgender stigma and health: A critical review of stigma determinants, mechanisms, and interventions. Soc Sci Med. 2015 Dec;147:222-31. doi: 10.1016/j.socscimed.2015.11.010. Epub 2015 Nov 11. PMID: 26599625; PMCID: PMC4689648.
11. Butler M, McCreedy E, Schwer N, Burgess D, Call K, Przedworski J, et al. Improving cultural competence to reduce health disparities. 2016.
12. Nadal KL, Rivera DP. Stigma and its role in HIV prevention and care of gay and bisexual men Washington, DC: American Psychological Assoc.; 2012
13. Jain A, Nyblade L. Scaling up policies, interventions, and measurement for stigma-free HIV prevention, care and treatment services. Washington: Health Policy Project. 2012.
14. Stangl AL, Earnshaw VA, Logie CH, van Brakel W, C. Simbayi L, Barré I, et al. The Health Stigma and Discrimination Framework: a global, crosscutting framework to inform research, intervention development, and policy on health-related stigmas. BMC Medicine. 2019;17(1):31.
15. Barmania S, Aljunid SM. Navigating HIV prevention policy and Islam in Malaysia: contention, compatibility or reconciliation? Findings from in-depth interviews among key stakeholders. BMC Public Health. 2016;16(1):524
16. Lim SH, Mburu G, Bourne A, Pang J, Wickersham JA, Wei CKT, et al. Willingness to use pre-exposure prophylaxis for HIV prevention among men who have sex with men in Malaysia: Findings from an online survey. PLoS One. 2017;12(9):e0182838-e.
17. Nyblade L, Srinivasan K, Mazur A, Raj T, Patil DS, Devadass D, et al. HIV Stigma Reduction for Health Facility Staff: Development of a Blended- Learning Intervention. Front Public Health. 2018;6:165.
18. UNAIDS. Confronting discrimination: Overcoming HIV-related stigma and discrimination in healthcare settings and beyond. Geneva: UNAIDS Joint United Nations Programme on HIV/AIDS; 2017.
19. UNAIDS. Evidence for eliminating HIV-related stigma and discrimination. Geneva: Joint United Nations Programme on HIV/AIDS (UNAIDS); 2020.Duby Z, Fong-Jaen F, Nkosi B, Brown B, Scheibe A. 'We must treat them like all the other people': Evaluating the Integrated Key Populations Sensitivity Training Programme for Healthcare Workers in South Africa. South Afr J HIV Med. 2019;20(1):909
20. Duby Z, Fong-Jaen F, Nkosi B, Brown B, Scheibe A. 'We must treat them like all the other people': Evaluating the Integrated Key Populations Sensitivity Training Programme for Healthcare Workers in South Africa. South Afr J HIV Med. 2019;20(1):909-.
21. Organization WH. Serving the needs of key populations: Case examples of innovation and good practice on HIV prevention, diagnosis, treatment and care: World Health Organization; 2017.
22. Eaton LA, Driffin DD, Kegler C, Smith H, Conway-Washington C, White D, et al. The Role of Stigma and Medical Mistrust in the Routine Health Care Engagement of Black Men Who Have Sex With Men. American Journal of Public Health. 2015;105(2):e75-e82.
23. UNAIDS. Hiv And Stigma And Discrimination - Human Rights Fact Sheet Series 2021. UNAIDS; 2021
24. Madrigal-Borloz V, Püras D. Call for the effective implementation of SDG Goal 3: Removing barriers and closing the gap of health disparities for lesbian, gay, bisexual, trans and gender-diverse people: UN OHCHR; 2019
25. UN M. Review and Consultation on the Policy and Legal Environments Related to HIV Services in Malaysia. Kuala Lumpur: UN; 2014.
26. Siraprapasiri T. Measurement and interventions for HIV related stigma reduction in health-care settings THAILAND (Power point presentation). UNAIDS; 2017.
27. WHO, UNDP. "The Time Has Come" Enhancing HIV, STI and other sexual health services for MSM and transgender people in Asia and the Pacific - Training package for health providers to reduce stigma in health care settings. Bangkok, Thailand: United Nations Development Programme. UNDP Asia-Pacific Regional Centre; 2013.
28. PTF M. ISEAN HIVOS Programme Kuala Lumpur: PT Foundation (M); n.d. [Available from: http://ptfmalaysia.org/v2/isean-hivos-programme/.]
29. amFAR. Trans Populations and HIV: Time to End the Neglect. Washington: The Foundation for AIDS Research Public Policy Office; 2014.
30. Organization WH. Values and preferences of MSM: the use of antiretroviral therapy as prevention. World Health Organization; 2014.
31. UNAIDS. 41st PCB meeting Background Note -"Zero discrimination in health-care settings". UNAIDS/PCB (41)/17.27 ed. Geneva: UNAIDS Programme Coordinating Board; 2017
32. Earnshaw VA, Jin H, Wickersham JA, Kamarulzaman A, John J, Lim SH, et al. Stigma Toward Men Who Have Sex with Men Among Future Healthcare Providers in Malaysia: Would More Interpersonal Contact Reduce Prejudice? AIDS Behav. 2016;20(1):98-106.