Introduction

Stigma is magnified for adolescents growing up with HIV infection. Discrimination affects access to and uptake of services while constraining the overall well-being of adolescents living with HIV. Effects of stigma and discrimination include social isolation, propagation of myths, acts of violence and blaming which affects an individual’s self-worth, hinder correct information and quality of care and other services. Building psychosocial resilience of adolescents living with HIV who may experience stigma and discrimination due to HIV is critical especially if coupled with interventions that address broader stigma ranging from family to various institutions, structures and policies. This policy brief provides rationale for proposing programming and policy alternatives to address stigma and discrimination among adolescents living with HIV.

AIDS related deaths tripled for adolescents since 2000\(^1\) and AIDS is currently the leading cause of death among adolescents in Africa aged 10-19 years old\(^2\). Evidence suggests that stigma and discrimination affects the psychosocial well-being of ALHIV. The majority of them risk depression while in one study 23% of ALHIV reported suicidal ideation in the seven days preceding the survey\(^3\). Stigma and discrimination further results in social isolation and to some extent limits potential to fully develop. Stigma and discrimination pose key challenges especially as evidence already shows that the over 2 million adolescents aged 10–19 who are living with HIV have low levels of knowledge of status, linkage to care and prevention, and poor retention in care and adherence to antiretroviral treatment (ART).\(^4\)

The Challenge

Key challenges related to stigma and discrimination include inadequate involvement of ALHIV in their care, inadequate resourcing for Adolescents in National Strategic Plans (NSPs), inadequate research in adolescent health along with policy and legal barriers to adolescents access and utilization of HIV information and services.

Adolescents are particularly sensitive to the stigma associated with HIV and this affects disclosure. Provider and community stigma, as well as inadequate or misinformation about HIV have proven to be major barriers to utilization of available services.

Stigma and discrimination affects adherence to ART especially as high adherence to ART by ALHIV is linked to adequate psychological adjustment, effective coping mechanisms, and discussion about and adoption of explicit medication routines.

4. See more at: http://www.data.unicef.org/hiv-aids/adolescents-young-people.html#sthash.RSXwCEj.dpuf

RIATT-ESA is the regional voice for children and families affected by HIV.
Stigma and discrimination affects retention in care as ALHIV’s level of self-esteem and feeling of empowerment to make decisions has been linked to improved retention in care. Stigma and discrimination also affects successful transition to adult services which should be determined by rights, readiness, and willingness of the adolescent to assume responsibility for various activities including taking medication, making appointments, asking questions to health-care providers, and helping to choose their own treatment plans.

**Effects of Stigma and Discrimination**

HIV related stigma and discrimination have been consistently cited as barriers to universal access to HIV and broader Sexual and Reproductive Health (SRH) services among adolescents and young people living with HIV. The key barriers include social norms (which do not approve of early sex) and provider attitudes and assumptions that ALHIV are not sexually active after learning their status. Stigma contributes greatly to non-adherence to treatment which in turn leads to treatment failure and deterioration of health. Thirty years into the epidemic, UNAIDS acknowledges that stigma remains high in most countries where it affects the uptake of testing services, prevents uptake of HIV prevention and treatment services while restricting spaces for disclosure as well as meaningful participation in national HIV and AIDS responses.

*“I was made to remain behind when others were going to parties because my caregivers thought I would infect others with my sores or my cough.” (Isaac, Male, 17 years, Zambia.)*

**Gaps in current interventions**

There are current interventions targeting ALHIV but these lack resources; are limited in scale and scope and not rigorously evaluated. Existing HIV and AIDS programs and policies have not completely integrated stigma reduction strategies.

There has also been inadequate prioritization of promising multi-sectoral approaches that integrate health, education, and social protection. Interventions have also not sufficiently ensured provision of safe spaces for young people in communities, at home and in schools to encourage open communication about treatment, adherence, disclosure and issues to do with HIV related stigma. Family--centered approaches have not received adequate investment although there is acknowledgment that a child’s quality of life is interwoven with the life and experience of the family in which they live.

**Adopting a Human Rights Based Approach**

International human rights law guarantees the right to equal protection before the law and freedom from discrimination on many grounds. The Office of the Commissioner for Human Rights has confirmed that “other status” in non-discrimination provisions in international human rights treaties is to be interpreted to include health status, including HIV and AIDS. As the most widely ratified human rights treaty in the world, the Convention on the Rights of the Child establishes the basic parameters for the development and care of children.

*“At school, others discriminate against you and call you names especially if you have symptoms of HIV such as weight loss, or a skin condition.” (Faith, Female, 13 years, Zimbabwe.)*

*“Sometimes you meet a medical staff who is supportive and on another day you meet some nasty medical personnel who passes judgmental comments as if you went out looking for the virus.” (Thulie, Female, 18 years old, Swaziland.)*

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6. See more at: [http://www.data.unicef.org/hiv‐aids/adolescents‐young‐people.html](http://www.data.unicef.org/hiv‐aids/adolescents‐young‐people.html)

7. UNAIDS, (2012). Guidance Note on Key programmes to reduce stigma and discrimination and increase access to justice in national HIV responses.


Recommendations for advocacy on stigma and discrimination

- Guidelines and standards on HIV protection must include a focus on understanding and addressing HIV stigma and discrimination as experienced by adolescents.
- Adolescents living with HIV must be included in all aspects of HIV programming to help reduce HIV stigma and discrimination and improve protection, mental health and psychosocial well-being outcomes.
- Family centered strategies that build on intrinsic community strengths and social networks to mitigate HIV stigma and discrimination should be adopted.
- Allocate resources for programs that integrate care and support with sexual reproductive health for adolescents.
- Support research and build evidence on the value of ending HIV stigma and discrimination for adolescents.