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STUDY OF HIV RELATED STIGMA IN PEOPLE LIVING WITH HIV/AIDS (PLHA): ROLE OF GENDER DIFFERENCES

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ABSTRACT

HIV/AIDS is increasingly being accepted as not merely a medical problem, but a social problem as well. HIV-related stigma remains one of the greatest barriers to the health and well-being of people living with HIV (Herek, 1999; UNAIDS, 2007) and it is a major barrier in path of HIV testing and counselling. In present research, the main aim is to study the stigma related to HIV in people living with HIV/AIDS (PLHA) and to study the role of gender differences in PLHA. The cross-sectional descriptive study was conducted among 100 HIV patients (50 Males and 50 Females) who were registered in ART centre, Patiala for HIV treatment. The information was collected by using HIV stigma scale (Berger, 1996) and results were analysed by using t-test values. The results of present research showed that HIV females scored higher on stigma scale as compared to HIV males. Similarly, two subscales of HIV stigma i.e. personalized stigma and public attitude were also high in HIV females as compared with HIV males. Thus, findings suggest different approaches may be required to address HIV-related stigma based on gender.

KEYWORDS : HIV/AIDS Stigma, Personalized Stigma, Disclosure, Negative Self-image, Public Attitude, Gender Differences

People living with HIV/AIDS (PLHA) face not only the physical and psychological consequences of their infections; but also face stigmatising reactions from others. For example, PLHA may experience problems in their relationships, have trouble attaining insurance or may even lose employment as a result of their HIV status (Herek, 1992).

Stigma remains the single most significant barrier to public health in case of HIV. It is the main reason why too many people are afraid to see a doctor to determine whether they have the disease or to seek treatment if so. It makes AIDS the silent killer, because people fear the social disgrace of speaking about it or taking the easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate the societies around the world.

HIV-related stigma refers to the devaluing of HIV-positive people and may result in discrimination based on actual or perceived HIV-positive serostatus (UNAIDS, 2007). HIV-related stigma can negatively impact social relationships, access to resources, social support and the psychological well-being of PLHA (Bos, Schaalma & Pryor, 2008). In addition, HIV-related stigma hampers effective HIV prevention activities (UNAIDS, 2008) and is a barrier to voluntary HIV counselling and testing (Meiberg, et al., 2008).

In the recent AIDS epidemic update regional summary in Asia (UNAIDS, 2007), it has been estimated that 2.5 million people in India have HIV and that adult national HIV prevalence is 0.36%. In some states, HIV prevalence is as high as 1.13%. Even though prevalence in India is much lower when compared to some sub-Saharan African countries, the absolute number of infections can be much higher. The fact that India has a population of 1.13 billion people makes HIV/AIDS in this country a point of much concern.

In India, the first case of HIV/AIDS was reported in Tamil Nadu in 1986. Since then the virus has spread from the high-risk groups to the general population very fast. Disclosure of one's HIV positive serostatus to friends, family, social support networks and health care providers has been associated with marginalization, isolation and social exclusion (Abell, et al., 2007). Fear of disclosure associated with purchasing and taking antiretroviral drugs may negatively impact treatment adherence (Konkle-Parker, Erlen, & Dubbert, 2008). Thus HIV-related stigma may lead to sub-standard treatment and can also present a barrier for PLHA accessing and retaining health care services and

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social supports (Bradford, Coleman, & Cunningham, 2007). Reducing HIV-related stigma is therefore key to promoting the health of PLHA.

Further, gender norms suggested that women are considered as caregivers, mothers and nurturers. This can worsen stigma directed toward HIV-positive women who may be viewed as ill/diseased and therefore a failure in personal and social roles. The intersections of gender differences are essential to understanding contexts of women's HIV risk and experiences of stigma (Logie, 2011). Therefore, gender difference needs to be taken into consideration while engaging in stigma research. The present study was a small step in this direction. It attempted to examine the role of gender differences on HIV/AIDS stigma.

MATERIALS AND METHODS

Ethics Statement

The Govt. Medical College, Rajindra hospital had granted institutional ethical approval for the study.

Participants

A cross-sectional descriptive study was conducted among 100 HIV positive patients (50 males and 50 females), who were registered in ART centre, Patiala for HIV treatment. Purposive sampling was done. The age range of the patients was 18 years and above and subjects from both urban and rural areas were included. Both married and divorced/separated patients were included in the study. Majority of the participants belonged to lower to middle socio-economic status families. Unmarried subjects and children having HIV were excluded.

Tool

The HIV Stigma Scale (Berger, 1996) is a forty items self-report scale used to measure the experiences, feelings, and opinions as to how people with HIV feel and how they are treated. This scale consists of four subscales: the personalized stigma, the disclosure, the negative self-image and the public attitudes. HIV stigma scale items are scored on four-point likert scale ranging from 1 ("strongly disagree") to 4 ("strongly agree"). Items 8 and 21 are reverse scored. The range of possible scores depends on the number of items in the scale. For the total HIV Stigma Scale, scores can range from 40 to 160 [1 x 40 items to 4 x 40 items]. For the personalized stigma subscale, scores can range from 18 to 72. For the disclosure subscale, scores can range from 10 to 40. For the negative self-image subscale, scores can range from 13 to 52. For the public attitudes subscale, scores can range from 20 to 80. Higher scores indicate greater HIV stigma. As per Berger, Ferrans and Lashley, 2001 construct validity was supported by relationships with related constructs: self-esteem, depression, social support, and social conflict. Coefficient alphas between .90 and .93 for subscales and .96 for the 40-item instrument provided evidence of internal consistency reliability. The HIV Stigma Scale was reliable and valid with a large diverse sample of people living with HIV (Berger, Ferrans, & Lashley, 2001).

Procedure

For assessing stigma related to HIV in HIV positive adults, informed consent was taken. They were assured that their personal information as well as their responses would be kept strictly confidential. Then a set of one questionnaire and demographic information were given to the participants. The instruction for questionnaire was given at the top of scale. Scale measuring HIV Stigma and demographic information were administered and scoring of stigma scale was done as mentioned in its respective manual.

Statistical Analyses

In order to analyse the role of HIV/AIDS related stigma in PLHA and gender differences in them, t-tests were applied to compare the HIV/AIDS stigma in males and females and column diagram was made to explain the role of gender differences in HIV/AIDS related stigma. The data was analysed by using the software Statistica 7.0.

RESULTS AND DISCUSSION

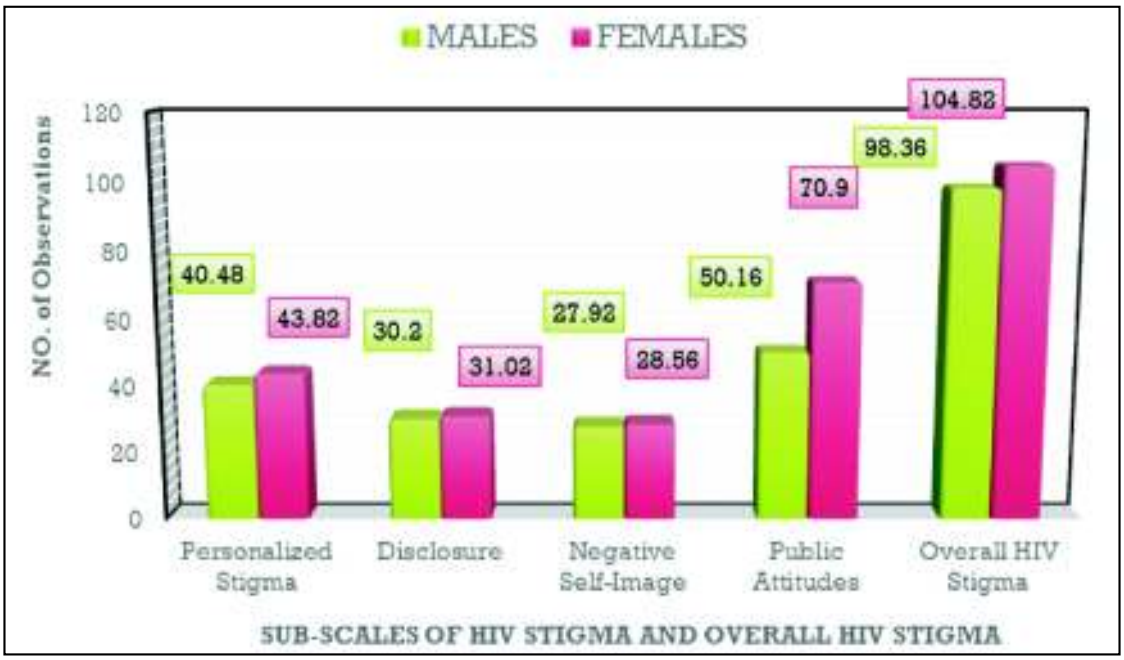
t-tests: In order to examine the role of gender differences in HIV/AIDS, table 1 reveals that females having HIV/AIDS showed more scores on personalized stigma ($t= 3.88$; $p<0.01$) and public attitude ($t= 15.14$; $p<0.01$) as compared with males having HIV/AIDS. Similarly, in overall HIV stigma scale, HIV females scored high on HIV stigma ($t= 6.53$; $p<0.01$) as compared to HIV males. Whereas, disclosure and negative self-image

Table 1: Showing Means. S.D.'s and T-tests Values for Females (n=50) Versus Males (n=50) Having HIV/AIDS on HIV Stigma Scale and on Sub-Scales of HIV Stigma Scale

VARIABLE	Males (N=50)		Females (N=50)			
	MEANS	S.D.	MEANS	S.D.	SE	t-VALUES
Personalized stigma subscale	40.48	3.14	43.82	5.26	0.86	**3.88****
Disclosure subscale	30.20	3.40	31.02	3.94	0.73	1.12
Negative self-image subscale	27.92	2.45	28.56	2.34	0.48	1.33
Public Attitude subscale	50.16	3.25	70.90	9.16	1.37	**15.14****
Overall HIV Stigma	98.36	4.52	104.82	5.37	0.99	**6.53****

p<0.01**

Column Diagram: Showing the Gender Differences on Subscales of HIV Stigma and Overall HIV Stigma



(another two sub-scales of HIV stigma scale) did not show any significant gender differences.

Stigma refers to as an "undesirable" or "discrediting" attribute that an individual possess, thus reducing that individual's status in the eye of society (Goffman, 1963). In terms of HIV, stigma plays an important role. It is associated with prejudice, discounting, discrediting and discrimination directed towards people with HIV/AIDS. The aim of the current study was to study the role of HIV/AIDS related stigma in PLHA and gender differences.

Results indicate that females having HIV had greater stigma as compared with HIV males. Further in females, personalized stigma and public attitude scores were high (subscales of HIV/AIDS stigma scale) as compared with males having HIV/AIDS. This showed that females having HIV have more personalized stigma and they perceive more stigmatized public attitude as compared to males. This exhibited that females having HIV have to face more problems as compared to males.

Van Hollen (2010) also found that society tends to blame women for the spread of HIV/AIDS, and as a result, HIV-positive women face greater stigma and discrimination than HIV-positive men.

Additional, results also revealed that disclosure and negative self-image (another two sub-scales of HIV stigma scale) did not show any significant gender differences. This showed that both males and females

having HIV didn't want to disclose their HIV status due to stigmatization and rejection by others. They worry that people who will know that they have HIV will tell others and they will be dishonoured and ignored by relatives and peer groups. Even they perceive that other people will look for flaws in their character. They might lose their friend circle and their children might also be rejected by the society.

Gao, et al. (2004) found that in rural areas, the primary manifestation of stigma is exclusion and isolation and a majority of people are reluctant to talk or eat with an HIV-infected people. In India, HIV status in females is always linked with their immoral character. The situation worsens for females when their spouse doesn't have HIV; the female is rejected by their family members and in-laws. In the society, their HIV status leads to rejection of other family members also, such as, their children are also rejected by their peer group and they have to face many other problems also. Social stigma researchers also have noted that HIV/AIDS stigma is frequently embedded in other sources of stigma including race, social class and gender (Aggleton, 2002). Wohl et al. (2011) also found that the role of gender on HIV/ AIDS stigma had received some attention from the perspective of the targets of stigma; for example, documenting how females confront gender specific experiences when faced with HIV/ AIDS stigma.

Further, Godbole and Mehendale (2005) reported that the main concerns about HIV/AIDS in India are the increase in the number of infected women, stigma, and discrimination. In a study done in South India, Charles et al (2012) found that twenty seven per cent of PLHA had experienced severe forms of stigma. These were severe forms of personalized stigma (28.8%), negative self-image (30.3%), perceived public attitude (18.2%) and disclosure concerns (26%).

CONCLUSION

To conclude, our study revealed that gender differences are associated with HIV stigma. Findings suggest different approaches may be required to address HIV-related stigma based on gender. This study provides the information about various domains of HIV stigma and thus can be useful for targeted interventions to reduce HIV stigma. Further, the two subscales showing gender differences in HIV stigma can help for additional support and interventions needed in HIV positive women.

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