

HUMAN IMMUNODEFICIENCY VIRUS/ACQUIRED IMMUNE DEFICIENCY SYNDROME STIGMA AND DISCRIMINATION AMONG THE GENERAL PUBLIC IN SELECTED RURAL COMMUNITY, KANCHEEPURAM DISTRICT, INDIA

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ABSTRACT

Objective: The objective of the study was to assess the HIV/acquired immune deficiency syndrome stigma among the general public.

Methods: Quantitative approach and descriptive research design were adopted for this study. The study was conducted in Vallanchery a selected rural village of Kattankulathur. The sample size for this study was 300. Three-point rating scale was used to assess the HIV/stigma and discrimination.

Result: This study findings revealed that among 300 samples none of them reported severe stigma, 50 (16.7%) participants reported moderate stigma, and 250 (83.3%) participants reported low stigma.

Conclusion: Stigma blocks access to HIV testing and treatment services, making onward transmission more likely. The removal of barriers to these services is key to end the global HIV epidemic.

Keywords: Human immunodeficiency virus, Acquired immune deficiency syndrome, Stigma, Discrimination, Rejection.

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INTRODUCTION

Human immunodeficiency virus (HIV) infection and acquired immune deficiency syndrome (AIDS) in India remain a major public health crisis. India is the most populous nation and is home to more people living with HIV than any other country in the world, except South Africa [1]. The prevalence rate has increased progressively since the first reported case of HIV in India. According to the National AIDS Control Organization of India, the prevalence of AIDS in India in 2013 was 0.27, which is down from 0.41 in 2002 [2]. While the National AIDS Control Organization estimated that 2.39 million people lived with HIV/AIDS in India in 2008-2009 [3], a more recent investigation by the Million Death Study Collaborators in the British Medical Journal (2010) estimates the population to be between 1.4 and 1.6 million people [4].

The last decade has seen a 50% decline in the number of new HIV infections [5]. According to the more recent National AIDS Control Organization data, India has demonstrated an overall reduction of 57% in estimated annual new HIV infections (among adult population) from 0.274 million in 2000 to 0.116 million in 2011, and the estimated number of people living with HIV was 2.08 million in 2011 [6].

In 2005, the international community embraced the goal of universal access to HIV prevention, treatment, care and support by 2010 [7,8]. To achieve this goal, national HIV/AIDS programs need to strengthen their health systems and block all barriers to treatment and prevention programs. India has taken various strategies to limit the spread of this disease. Due to global initiatives like the US Presidential Emergency Plan for Aids Relief program, there has been a substantial increase in the number of people living with HIV/AIDS (PLWHAs) who are on antiretroviral therapy (ART), as a result of having taken an HIV test [9]. In addition, there are many more antenatal women with HIV positivity who have received ART to prevent mother to child transmission of HIV [10]. The challenges many of these global and national programs face in a multi-diverse socio-cultural society like India are the problems of stigma on HIV. The issues of stigma described by Jonathan Man as the third phase

of the HIV pandemic poses a serious threat to prevention and treatment. Therefore, for India to achieve her national policy on HIV/AIDS, aimed at controlling the spread of the infection and its impact, the issue of stigma needs to be addressed. Significant research and knowledge on HIV-related stigma in many ethnic and cultural settings that constitute India are an important tool in understanding this "hidden factors" that are impediments to effective prevention and treatment. Incorporating these findings into national prevention strategies will go a long way in reducing the transmission of the virus in the population [11].

Stigma is often associated with discrimination and human right and has been defined in various ways Erving Goffman defined stigma as an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society [12]. Stigma can stem from a particular characteristic, such as a physical deformity, or from negative attitudes toward a group, such as homosexuals or prostitutes. Under Goffman's definition, society labels an individual or group as different or deviant. Jones *et al.* defines stigma as an attribute that links a person to undesirable characteristics [13]. Crocker *et al.* indicated that stigmatized individuals are believed to possess some attributes or characteristics that convey a social identity that is devalued in a particular social context [14]. Others have defined stigma as societal processes that are linked to societal power structures. Stigmatization can lead to prejudicial thoughts, behaviors, and actions on the part of governments, communities, employers, health care providers, coworkers, friends, and families [15,16].

Stigma has been classified by several authors. Some divide stigma into felt, or perceived stigma and enacted stigma [17]. AIDS stigma by association with someone who is HIV positive is classified as secondary stigma or "courtesy stigma" which can affect family and friends of PLWHAs, as well as health-care workers [18].

Stigma and discrimination are major obstacles to effective HIV/AIDS prevention and care, globally. S&D in the context of HIV/AIDS is unique

when compared to other infectious and communicable diseases. It tends to create a "hidden epidemic" of the disease based on socially-shared ignorance, fear, misinformation, and denial [19,20]. This is particularly more intense in sub-Saharan Africa, including Nigeria, where a combination of weak health systems is entangled with poor legal and ethical framework [21]. Significant and relevant research studies are needed to thoroughly understand the consequences of S&D at the three levels and its effect on HIV prevention, treatment and care as it is directly related in the different socio-cultural settings in India.

RESEARCH METHODOLOGY

Quantitative approach and descriptive research design were adopted for this study. The variables studied were study variables and demographic variables. The study variable was HIV/AIDS stigma and discrimination whereas the demographic variables includes age, gender, education, marital status, and religion. The study was conducted in Vallanchery a selected rural village of Kattankulathur. The accessible population includes the general public those who are above 18 years. Sample consisted of general public residing in Vallanchery village who full filled the inclusion criteria. The sample size for this study was 300.

Nonprobability convenient sampling technique was adopted to select the samples for the study. Inclusion criteria which include: (i) General public those who are residing in Vallanchery village, general public those who belong to the age group 18 and above, general public who are willing to participate in this study. Public who can understand Tamil or English, General public includes both genders. The exclusion criteria include public those who are not cooperative. The tool used for data collection comprises two sections

Section A - Structured questionnaire to elicit demographic data of general public which comprises of 5 questions.

Section B - 3 point rating scale to assess the HIV/stigma and discrimination contains 22 items which measure shame/blame/social isolation, perceived discrimination and equity.

The content of the tools was established on the basis of the opinion of one medical expert and three nursing experts. Suggestions were incorporated in the tool. The reliability of the tool was established by test-retest method. The r value obtained was 0.8 which indicates the positive correlation. The proposed study was approved by the dissertation committee of SRM College of Nursing, SRM University, Kattankulathur, Kancheepuram District permission was obtained from the Dean, SRM College of Nursing. An informed consent was obtained from each participant for the study before starting data collection. The assurance was given to the subjects that anonymity of each individual would be maintained are free to withdraw from the study at any time.

After obtaining formal approval from administration of SRM College of Nursing, the investigator explained the objectives and methods of data collection. Data collection was done within the given period of 6-week in selected village. The data collection was done during the day time. Self-introduction about the investigators and details about the study was explained to the samples and their consent was obtained. HIV/AIDS stigma and discrimination among general public were assessed using the 3 point rating scale. The confidentiality about the data and finding were assured to the participants, the participants took 15-20 minutes to complete the tool and their cooperation was imperative. Descriptive statistics such as frequency and percentage distribution was used to analyze the data collected. Inferential statistics - Chi-square was used to find out the association.

RESULTS

Table 2 shows that among 300 samples none of them reported severe stigma, 50 (16.7%) participants reported moderate stigma and 250 (83.3%) participants reported low stigma.

Table 3 shows that there is significant association of HIV/AIDS stigma among general public with the demographic variable of age, sex, and educational status. There is no association with respect to other demographic variables.

DISCUSSION

Community-level stigma and discrimination toward people living with HIV are found worldwide, with people forced to leave their home, change their daily activities such as shopping, socializing or schooling, face rejection, and verbal and physical abuse [22].

To address this issue, health-care workers need to be made aware of the negative effect that stigma can have on the quality of care patients receive. They should have accurate information about the risk of HIV infection and should be encouraged not to associate HIV with immoral behavior.

This study findings revealed that among 300 samples none of them reported severe stigma, 50 (16.7%) participants reported moderate stigma and 250 (83.3%) participants reported low stigma.

A similar study was conducted on stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. Data from a 1999 national telephone survey with a probability sample of English-speaking US adults (N=1335) were used to assess how support for HIV surveillance policies is related to AIDS stigma and negative attitudes toward groups disproportionately

Table 1: Frequency and percentage distribution of demographic variables related to the general public in the selected community (N=300)

Demographic variables	Distribution N (%)
Age	
18-30	158 (52.7)
31-40	51 (17)
41-50	57 (19)
>50	34 (11.7)
Gender	
Male	219 (73)
Female	81 (27)
Marital status	
Married	269 (77.9)
Divorce	31 (22.1)
Religion	
Hindus	242 (80.7)
Muslims	34 (11.3)
Christians	24 (8)
Education	
Graduates	20 (6.7)
Intermediate	22 (7.3)
HS	38 (12.7)
Middle school	63 (21)
Primary	76 (25.3)
Illiterate	81 (27)

Table 2: Assessment of HIV/AIDS stigma and discrimination among the general public (N=300)

Level of stigma	Frequency (%)
Low stigma	250 (83.3)
Moderate stigma	50 (16.7)
Severe stigma	0 (0)

HIV: Human immunodeficiency virus, AIDS: Acquired immune deficiency syndrome

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Table 3: Association of level of knowledge on HIV/AIDS among general public in selected rural community (N=300)

Demographic variables	Level of stigma N (%)			Chi-square test
	Severe stigma	Moderate stigma	Low stigma	
Age				
18-30	0 (0)	32 (64)	126 (50.4)	$\chi^2=8.504$
31-40	0 (0)	11 (22)	40 (16)	p=0.037
41-50	0 (0)	6 (12)	51 (20.4)	Significant
>50	0 (0)	1 (2)	33 (13.2)	
Sex				
Male	0 (0)	42 (84)	177 (70.8)	$\chi^2=3.68$
Female	0 (0)	8 (16)	73 (29.2)	p=0.05
Marital status				Significant
Married	0 (0)	42 (84)	227 (90.8)	$\chi^2=2.079$
Divorced	0 (0)	8 (16)	23 (9.2)	p=0.149
Religion				NS
Hindus	0 (0)	40 (80)	202 (80.8)	$\chi^2=0.397$
Muslims	0 (0)	5 (10)	29 (11.6)	p=0.82
Christians	0 (0)	5 (10)	19 (7.6)	NS
Education				
Graduates	0 (0)	0 (0)	20 (8)	$\chi^2=25.172$
Intermediate	0 (0)	3 (6)	19 (7.6)	p=0.000
Higher secondary	0 (0)	12 (24)	26 (10.4)	Significant
Middle school	0 (0)	19 (38)	44 (17.6)	
Primary	0 (0)	11 (22)	65 (26)	
Illiterate	0 (0)	5 (10)	76 (30.4)	

HIV: Human immunodeficiency virus, AIDS: Acquired immune deficiency syndrome, NS: Non-significant

affected by the epidemic. Anonymous reporting of HIV results to the government was supported by a margin of approximately 2-to-1, but name-based reporting was opposed 3-to-1. Compared with other respondents, supporters of name-based surveillance expressed significantly more negative feelings toward people with AIDS, gay men, lesbians, and injecting drug users. More than one-third of all respondents reported that concerns about AIDS stigma would affect their own decision to be tested for HIV in the future [23].

Another study reported that stigma as a Fundamental Cause of Population Health Inequalities that bodies of research pertaining to specific stigmatized statuses have typically developed in separate domains and have focused on single outcomes at the first level of analysis, thereby obscuring the full significance of stigma as a fundamental driver of population health. Authors provide illustrative evidence on the health consequences of stigma and present a conceptual framework describing the psychological and structural pathways through which stigma influences health. Because of its pervasiveness, its disruption of multiple life domains (e.g., resources, social relationships, and coping behaviors) and its corrosive impact on the health of populations, stigma should be considered alongside the other major organizing concepts for research on social determinants of population health [24].

A similar study was conducted on stigmatization of Newly Emerging Infectious Diseases: AIDS and SARS. They conducted a random-digit-dialed survey of 928 residents of the New York City. Questions added for this study concerned respondents' knowledge of, worry about, and support of stigmatizing actions to control AIDS and SARS. Results revealed that respondent with greater personal resources (income, education, and social support) and better mental health status had more knowledge, were less worried, and were less likely to stigmatize. Personal resources and mental health factors are likely to influence the public's ability to learn about, rationally appraise the threat of, and minimize stigmatization of emerging infectious diseases such as AIDS and SARS [25].

CONCLUSION

Among 300 samples none of them reported severe stigma, 50 (16.7%) participants reported moderate stigma and 250 (83.3%) participants reported low stigma. Hence, the use of specific HIV, AIDS, and sexual reproduction education programs that emphasize the rights of people living with HIV is a well-documented way of eradicating stigma. As well as being made aware of their rights, people living with HIV can be empowered to take action if these rights are violated. Ultimately, adopting a human rights approach to HIV and AIDS is in the public's interest. Stigma blocks access to HIV testing and treatment services, making onward transmission more likely. The removal of barriers to these services is key to ending the global HIV epidemic. Thus, interventions based on community organizing and building among PLHA as well as potentially sympathetic social and community entities, that aim to "unleash the power of resistance on the part of the stigmatized," are important avenues for the root causes of HIV/AIDS stigma and discrimination.

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REFERENCES

1. WHO/UNAIDS. AIDS Epidemic Update; Special Report on HIV/AIDS. Geneva: WHO/UNAIDS; 2006.
2. Available from: <http://www.ndtv.com/video/player/news/world-aids-day-india-records-sharp-drop-in-number-of-cases/299798>.
3. Available from: <http://www.nacoonline.org/upload/REPORTS/NACO%20Annual%20Report%202010-11.pdf>.
4. Available from: <http://www.bmj.com/content/340/bmj.c621>.
5. "India sees 50% Decline in New HIV Infections: Un Report". Hindustan Times. Available from: <http://www.hindustantimes.com/delhi/india>. [Last retrieved on 2011 Apr 02].
6. Available from: <http://www.ndtv.com/article/india/world-aids-day-india-records-sharp-drop-in-number-of-cases-299730>.
7. United Nations General Assembly, Sixtieth Session, 24 October; 2005, ARES/60/1.
8. Fifty-Ninth World Health Assembly, 27 May; 2005. Resolution WHA59.19.
9. PEPFAR Latest Treatment Results. Available from: <http://www.pepfar.gov/documents/organization/106385.pdf>. [Last accessed on 2008 Nov 21].
10. PEPFAR. Prevention of Mother-to-Child Transmission. Available from: <http://www.pepfar.gov/documents/organization/79663.pdf>; www.pepfar.gov/press/79674.htm. [Last accessed on 2008 Nov 21].
11. Mann J. Statement at an Informal Meeting on AIDS to the 42nd Session of the UN General Assembly, October 20; 1987.
12. Goffman E. Stigma: Notes on the Management of Spoiled Identity. New York: Simon & Shuster Inc.; 1963.
13. Jones E, Farina A, Hastorf A, Markus H, Miller DT, Scott RA, *et al*. Social Stigma: The Psychology of Marked Relationships. New York: Freeman & Company; 1984.
14. Crocker J, Major B, Steele C. Social stigma. In: Gilbert D, Fiske ST, Lindzey G, editors. The Handbook of Social Psychology. 4th ed., Vol. 2. New York: McGraw-Hill; 1998. p. 504-53.
15. Link B, Phelan JC. On Stigma and Its Public Health Implications. Paper Presented at the Stigma and Global Health: Developing Agenda Conference, September. Maryland, USA: Bethesda; 2001. Available from: <http://www.stigmaconference.nih.gov/linkpaper.htm>.
16. Jayaraman KS. Indian state plans compulsory HIV testing, segregation and branding. Nat Med 1998;4(4):378.
17. Malcolm A, Aggleton P, Bronfman M, Galvao J, Mane P, Verral J. HIV-related stigmatization and discrimination: Its form and context. Crit Public Health 1998;8(4):347-70.
18. Scambler G. Stigma and disease: Changing paradigms. Lancet 1998;352(9133):1054-5.
19. Kipp W, Bajenja E, Karamagi E, Tindyebwa D. AIDS-related stigma: Perceptions of family caregivers and health volunteers in Western Uganda. World Health Popul 2007;9(2):5-13.
20. Valdiserri RO. HIV/AIDS stigma: An impediment to public health. Am

- J Public Health 2002;92(3):341-2.
21. De Cock K. Kaiser daily HIV/AIDS Report. Available from: http://www.thebody.com/content/news/art_7478.html. [Last accessed on 2008 Nov 21].
 22. Smit PJ, Brady M, Carter M, Fernandes R, Lamore L, Meulbroek M, et al. HIV-related stigma within communities of gay men: A literature review. *AIDS Care* 2012;24(3-4):405-12.
 23. Herek GM, Capitanio JP, Widaman KF. Stigma, social risk, and health policy: Public attitudes toward HIV surveillance policies and the social construction of illness. *Health Psychol* 2003;22(5):533-40.
 24. Hatzenbuehler ML, Phelan JC, Link BG. Stigma as a fundamental cause of population health inequalities. *Am J Public Health* 2013;103(5):813-21.
 25. Des Jarlais DC, Galea S, Tracy M, Tross S, Vlahov D. Stigmatization of newly emerging infectious diseases: AIDS and SARS. *Am J Public Health* 2006;96(3):561-7.

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