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Stigma and Discrimination: The Hurdles on the Way to Ending the Epidemic of HIV/AIDS

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Introduction

Former director of the WHO Global Program on AIDS, late Jonathan Mann identified three phases of HIV/AIDS epidemic: the epidemic of HIV, the epidemic of AIDS, and the epidemic of stigma, discrimination, and denial. According to him, the third phase is as crucial as the infection itself [1]. Stigma and discrimination associated with HIV/AIDS are defined by UNAIDS as: "...a devaluation of people living with HIV/AIDS or associated with them...". Discrimination follows stigma and refers to unfair and unjust treatment based on one's HIV status, whether real or perceived [2]. Various forms and intensities of stigma may be experienced by men and women, which are often exacerbated by existing prejudices and inequalities. Additionally, stigma can also be triggered by discrimination or anticipation of being judged. The stigma associated with HIV/AIDS is particularly debilitating for those who are already marginalized, such as sex workers, homosexual men, IV drug abusers, and prisoners [3,4]. The quality of life is negatively affected by stigma and discrimination through multiple pathways which include barriers to accessing health, social rejection, drowning to low self-esteem, etc [5]. Attempts to tackle stigma and discrimination associated with HIV have been constrained by the deep-rooted nature and complexity of the issue. Notably, the inadequacy of theoretical and methodological tools has limited the development of effective responses to stigma and discrimination associated with HIV/AIDS as the available methods tend to assume that stigmatization and discrimination are individual processes. Stigma and discrimination remain closely related "twin barriers" despite the scientific advances in prevention and treatment, [6,7] and, therefore, remain the major concern of the UNAIDS Global AIDS Strategy.

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Areas of stigma and discrimination

Eliminating all forms of stigma and discrimination is central to achieving the sustainable development goals and targets by 2030. The global partnership aims to catalyse and speed up the implementation of policies and commitments to end stigma and discrimination in the following settings:

1. Healthcare

Perhaps the most apparent context for HIV- stigmatization, discrimination, and denial is the health care sector. The negative attitude of healthcare staff creates anxiety, depression, and fear among people living with HIV. A substantial reason for the non-compliance of HIV preventive behaviours in the health care setting is stigma and discrimination which makes it difficult to access the needed treatment and care. People avoid getting tested for HIV only due to the fear of HIV-positive identification. Consequently, many patients keep their serostatus secret, thus compromising their health and well-being. AIDS-related fear anxiety, and denial of their HIV status, can be traced to traumatic experiences [8].

2. Education

The peer education method has been recommended as a tool for HIV prevention for young people in a number of publications over the last few years. Students seem to benefit from peer education when it comes to promoting risk-reduction behaviour. Education about HIV and AIDS should be considered in surveys designed to determine learning and behavioural changes. In the survey, high levels of background knowledge and knowledge of safer sexual practices among college students should be taken into account [9]. It is important that health education goes beyond traditional methods, especially for young adults.

3. Workplace

Nine out of ten people living with HIV belong to the age group 15 – 49 years, considerably the most productive phase in any society. Media [10], NGO workers, social counsellors and medical practitioners [11] have reported cases of job loss, denial of employment and emotional isolation on the basis of HIV status. The Industrial Response to AIDS (IRTA), an industrial body with a specialized role in coordinating the industry-based problems and initiatives on HIV, has already produced a highly useful booklet on corporate policy and HIV.

4. Legal and Justice systems

According to the global commission on HIV and the law, law enforcement and justice systems can make a significant difference in the lives of people living with HIV. Politics, economics, and society are shaped by the law, through which certain behaviours are prohibited or permitted. The salutary power of national laws is based on the protection of equality of access to health care and the prohibition of discrimination based on health or legal status.

5. Individuals, families and communities

The responses of family members towards the infected member are heavily influenced by community perceptions. Family of HIV-infected individual may fear isolation and ostracism within the community [12,13,14] Consequently, they might conceal their HIV diagnosis which results in considerable stress and depression within the family [14] Nevertheless, misconceptions about the transmission of HIV continue to fuel discrimination.

6. Emergency and humanitarianism

The term humanitarian crises refer to a wide range of events, including environmental disasters, pandemics, and outbreaks of disease, armed conflicts, and large-scale industrial accidents. Humanitarian crisis often aggravates existing inequalities, making communities already susceptible to HIV more vulnerable and people with HIV more likely to lack access to care. Such a case was recently observed during COVID-19.

The way forward: Ending stigma and discrimination

As we have argued, for improving patient-provider interactions, creating a safe and supportive space, improving the quality of care, and in some cases, challenging stigma from family and community members, the reduction of stigma is a vital implication [15]. It is also a first step in creating amenities to address the needs of HIV-positive individuals. In order to achieve this environment, free from stigma & discrimination, some key points stated as under must be followed:

- Focussing on the individual, environmental and policy levels

- Recognition of HIV/AIDS as a workplace issue

- Non-discrimination on the basis of real or perceived HIV status

- Involving all staff members, not just health professionals, in training and in crafting policy

- Providing training on both stigma and universal precautions

- Involving individuals living with HIV in policy making

- Addressing the needs of HIV-infected health workers

- No screening for purposes of exclusion from employment

- Confidentiality of HIV-related personal information

- Continuation of the employment relationship

- Prevention strategies in the workplace

In different socio-cultural settings, there is increasing evidence of the benefit of supportive and de-stigmatizing HIV services. In China, HIV-positive patients appreciate medical and emotional support from healthcare workers, particularly in the face of family isolation due to the stigma surrounding HIV [15].

Conclusion

While UNAIDS, NACO (India) and other organizations have contributed a great deal to HIV/AIDS prevention programs and measures, HIV-positive people still face stigma and discrimination at different stages of their lives, such as at home, at school, and in the health care settings, which may vary from region to region. Globally, advances in medical treatment are available, but a lack of utilization of such facilities by HIV-positive people shows low quality of life and poor mental health, which worsens the condition of those living with HIV/AIDS [16]. It has been possible to move the field forward due to the availability of tested stigma-reduction tools and approaches. In order to scale up the stigma reduction and scale down the discrimination activities worldwide, political will and resources are required. Stigma has a detrimental effect on individuals' health and well-being as well as public health outcomes, making it clear that we must address not only HIV but also the epidemic of stigma, discrimi-

nation, and denial. Thus, ending stigma and discrimination will unambiguously trigger the efforts toward ending the epidemic of HIV/AIDS.

References

1. Mann J. Statement at an informal briefing on AIDS to the 42nd Session of the United Nations General Assembly, 1987; 20: New York.

2. UNAIDS: UNAIDS fact sheet on stigma and discrimination. 2003.

3. Link BG, Phelan JC: Conceptualizing Stigma. Annual Review of Sociology. 2001; 27: 363-385.

4. Parker R, Aggleton P. HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. Social Science & Medicine. 2003; 57: 13-24.

5. Lazarus JV, Safreed-Harmon K, Kamarulzaman A, Anderson J, Leite RB, Behrens G, et al. Consensus statement on the role of health systems in advancing the long-term well-being of people living with HIV. Nat Commun. 2021; 12: 4450.

6. Nyblade L, Mingkwan P, Stockton MA. Stigma reduction: an essential ingredient to ending AIDS by 2030. Lancet HIV. 2021; 8: e106-13.

7. Stackpool-Moore L, Nkosi S, Kasune Zulu P, Presley J, et al. Addressing stigma and discrimination at scale: uniting for a common vision while acknowledging local realities. J Int AIDS Soc. 2022; 25: e258938.

8. Bharat S. Facing the challenge: household and community response to HIV/AIDS in Mumbai, India. Geneva, UNAIDS / Mumbai, TISS. 1996.

9. Schneider D, Greenberg MR, Devanas M, Sajja A, Goodhart F, et al. Evaluating HIV/AIDS education in the university setting. Journal of American College Health. 1994; 43: 11-14.

10. Chinai R. Linking jobs to HIV. Nexus. 1995; 3-4.

11. Bhave G. Trends of HIV 1 & 2 infection in STD patients and pattern of transmission to their spouses in Bombay, India. International Conference on AIDS, Vancouver, Canada. 1996; 11: 141.

12. McGrath JW, Ankrah EM, Schumman DA, Nkumbi S, Lubega M. AIDS and the urban family: its impact in Kampala, Uganda. AIDS Care. 1993; 5: 55-70.

13. Warwick I, Bharat S, Castro R, Garcia R, Leshabari M, et al. Household and community responses to AIDS in developing countries. Critical Public Health. 1998; 8: 291-310.

14. Bharat S, Aggleton P. Facing the challenge: household responses to AIDS in Mumbai, India. AIDS Care. 1999; 11: 31-44.

15. Nyblade L, Stangl A, Weiss E, Ashburn K. Combating HIV stigma in health care settings: what works? J Int AIDS Soc. 2009; 12: 15.

16. Chen W-T, Starks H, Shiu C-S, Fredriksen-Goldsen K, Simoni J, et al. Chinese HIV-positive patients and their healthcare providers: contrasting Confucian versus Western notions of secrecy and support. Advances in Nursing Science 2007; 30: 329-342.