BARRIERS - STIGMA AND DISCRIMINATION IN HIV-POSITIVE PEOPLE

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БАРИЕРИТЕ - СТИГМА И ДИСКРИМИНАЦИЯ ПРИ ХИВ СЕРОПОЗИТИВНИТЕ

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БАРЬЕРЫ - СТИГМА И ДИСКРИМИНАЦИЯ У ВИЧ-ПОЗИТИВНЫХ ЛЮДЕЙ

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АННОТАЦИЯ

Стигма и дискриминация, связанные с ВИЧ / СПИДом, определяются как процессы девальвации людей, живущих с ВИЧ или СПИДом или связанных с ними.

Целью настоящего исследования было изучение отношения к стигме и дискриминации медицинского персонала и ВИЧ серопозитивных.

Материал и методы. В ходе анонимного опроса было опрошено 230 медицинских работников с различными профессиональными обязательствами (практикующими врачами и студентами) в отношении ВИЧ-позитивного отношения и 100 ВИЧ-позитивных в отношении поведения и их социальной адаптации. Результаты были обработаны с помощью SPSS v. 20,0, с использованием вариационного, сравнительного, корреляционного и анализа рисков.

Результаты. Чуть более половины респондентов (58,00%) рассказали о рискованном поведении, которое привело к ВИЧ-инфекции. Из опрошенных специалистов только врачи обнаружили меньшую относительную долю тех, кто будет обслуживать ВИЧ-положительного пациента (68,10%). Основным мотивом отказа от передачи ВИЧ-статуса у 90,00% респондентов является страх дискриминации. Значительная часть ВИЧ-позитивных людей имеет врача общей практики (76,00%), только 36,00% врачей общей практики знают о ВИЧ-статусе пациента, а 74,00% не сообщают о своем ВИЧ-статусе при посещении. их личный стоматолог или другой медицинский работник.

Вывод: Стигма и дискриминация являются важной эпидемиологической, клинической и психологической проблемой у пациентов с ВИЧ и СПИДом, которые блокируют доступ к услугам по тестированию и лечению.

ABSTRACT

HIV / AIDS-related stigma and discrimination are defined as the processes of impairment of people living with or associated with HIV and AIDS.

The aim of this study is to investigate the attitudes toward stigma and discrimination of nursing staff and HIV seropositives.

Materials and methods: Anonymous questionnaire surveyed 230 medical professionals with different professional involvement (practitioners and students) regarding attitudes to serving HIV seropositive and 100 HIV seropositive about their behavior and social adaptation. The results were processed with SPSS v. 20.0 using variational, comparative, correlation and risk analyzes.

Results: Just over half of the respondents (58,00%) are sharing the risky behavior that led to their HIV infection. From all of the specialists examined, only the physicians found a lower relative proportion of those who would serve an HIV seropositive patient (68,10%). The main reason for not sharing HIV status in 90,00% of the respondents is fear of discrimination. A significant proportion of HIV seropositives have an elected physician (76,00%), with only 36,00% of GPs aware of the patient's HIV status and 74,00% not reporting their HIV status when they visit different from their GP, Denta or Medical specialist.

Conclusion: Stigma and discrimination are an important epidemiological, clinical and psychological problem in HIV and AIDS patients, which blocks access to testing and treatment services.

Ключевые слова: дискриминация, эпидемиология, ВИЧ / СПИД, социальные факторы, стигма, страх

Keywords: discrimination, epidemiological, fear, HIV / AIDS, social factors, stigma

Introduction: Myths and misinformation increase the stigma and discrimination associated with HIV and AIDS. A cyclical link between stigma and HIV has been established. People who receive stigma and discrimination are marginalized and more vulnerable to HIV, while those living with HIV are more vulnerable to stigma and discrimination.

Society reacts with a double stigma. AIDS is still perceived as a terrible and disgraceful disease, with the formation of a negative attitude, with less respect and underestimation of personality and association with "deadly diseases" and "sexually transmitted diseases", including cancer and others. People living with HIV are perceived as "dangerous, dirty, stupid, worthless" compared to people with cancer or stroke [8]

HIV / AIDS-related stigma and discrimination are defined as the processes of impairment of people living with or associated with HIV and AIDS. [16] Globally, key populations and high-risk groups such as transgender, migrant, men who have sex with men (MSM) or sex workers, facing particularly high levels of stigma and discrimination. [12]

Most research studies that examine stigma typically fall into one of three broad categories:

1.enacted stigma, where people experience and report stigma first hand,

2.anticipated stigma, where people anticipate stigma on disclosure of HIV status and

3.internalized stigma, where people absorb and start to believe negative attitudes about themselves.

Experiences with enacted stigma and its associations with treatment delays and poor mental health outcomes are reported in multiple conducted studies.[2, 3,11,14,15,18] . Ekstrand and others found that 89% of doctors, 88% of nurses and 73% of nursing staff were reporting, that they would discriminate the people living with HIV / AIDS in situations of high likelihood of exposure. [5]

The purpose of this study is to investigate the attitudes toward stigma and discrimination of nursing staff and HIV seropositives.

Materials and methods: Anonymous questionnaire surveyed 230 medical professionals with different professional involvement (practitioners and students) regarding attitudes to serving HIV seropositive and 100 HIV seropositive about their behavior and social adaptation. The results were processed with SPSS v. 20.0 using variational, comparative, correlation and risk analyzes.

Results: The characteristics of the HIV seropositives studied are presented in Table.

Table. 1.

Characterization of HIV-infected seropositives

Socio - demographic factors		N/ %
Gender	Men	72/ 72,00 %
	Women	28/ 28,00 %
Age group	< 19 г.	12/ 12,00 %
	20 – 24 г.	26/ 26,00 %
	25 – 29 г.	30/ 30,00 %
	30 – 39 г.	14/ 14,00 %
	40 – 49 г.	10/ 10,00 %
	> 50 г.	8/ 8,00 %
Education	without education	4/ 4,00 %
	Primary education	20/ 20,00 %
	Secondary education	8/ 8,00 %
	High school	58/ 30,00 %
	University	10/ 10,00 %
Ethnic origin	Bulgarian	66/ 66,00 %
	Roma	14/ 14,00 %
	Turkish	16/ 16,00 %
	Other	4/ 4,00 %

The results shows that men (72.00%), persons aged 20-29 (56,00%) with high school (58,00%) and Bulgarian ethnicity (66,00%) predominate.

Just over half of the respondents (58,00%) are sharing the risky behavior that led to their HIV infection (MSM, followed by IUN and representatives of the group of prostituted men), while others do not identify their behavior as risky or are afraid to admit it because of the risk of discrimination.

In the analysis of gender risk behavior, we found a significant difference between men and women ($\chi 2$ = 30,51; p <0,001) (Figure 1). A strong correlation between gender and risk behavior was found (ρ=0,552; p < 0,001). Gender forms about 30.50% of the risky behavior of individuals.

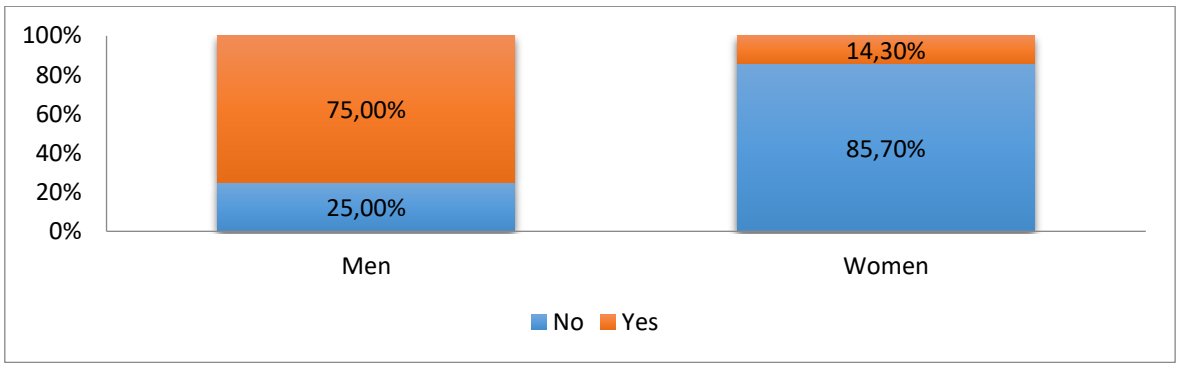

Figure 1. Affiliation to risky group by gender

The HIV seropositives we study belong to five risk groups,respectively of MSM, represented by 42%, followed by IDUs by 15% and only 1% are the representatives of the group of prostituted men (Figure 2).

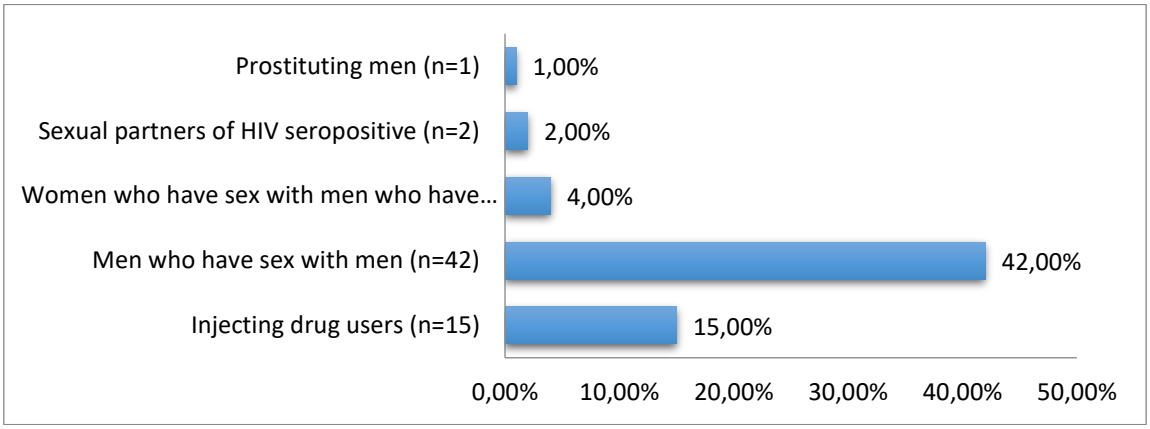

Figure 2. Affiliation to risk groups

In more than 1/3 (38,00%) of cases, the duration of HIV infection is between 1 and 2 years between 2-5 – 20% , > 10 - 18%, 5-10 – 14% and for months 10%.

In 64,00% of the respondents, the incidence of HIV infection was found in CAFRH (Cabinet for anonymous and free research for HIV), in 24% of different laboratories and medical centre about another disease in 12%. There is no significant difference in the results according to socio-demographic factors. AIDS stigma and discrimination are a growing problem in healthcare institutions around the world . They have a decisive impact to the lives of people living with HIV / AIDS and they are an important barrier for voluntary test and consultations.

HIV testing is done with the consent of the patient, and as with any other medical study or test, physicians cannot force a patient to do so. The physician cannot refuse to treat an HIV positive patient or patient who refuses to take the test.

The average age of the medical professionals participating in the survey is 34,9 years ± 12,7 years, with a minimum age of 20 years and a maximum age of 81 years. The majority of persons are 24 years old (19,10%) and 25 years (13,90%). Over half of the respondents indicated that they would serve HIV seropositive patients (59,60%) (Figure 3).

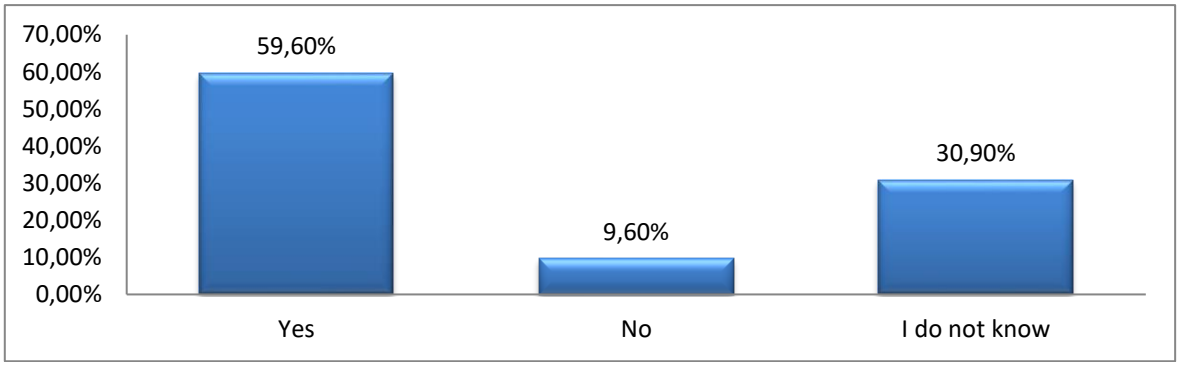

Figure 3. Care of HIV seropositive patients

In examining the results between the practitioners and students, we found a significant difference ($\chi 2$ = 19,63; p <0,001), with the practitioners being more explicit in their positive response (Figure 4).

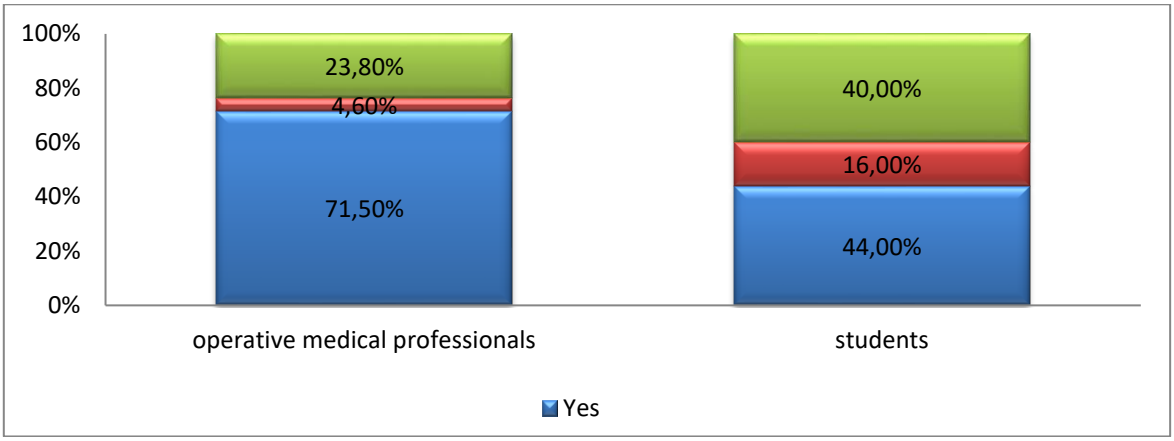

Figure 4. Comparative analysis of the readiness to serve HIV seropositive patients

From all of the specialists examined, only the physicians found a lower relative proportion of those who would serve an HIV seropositive patient (68,10%), nurses (77,60%), laboratory assistants(75,00%) . Impressionmakes the high relative share of specialists who do not know how they would react in such a situation about 25%.

About 2/3 of the respondents (65,70%) support the idea for mandatory HIV testing for all patients who seek medical help (Figure 5).

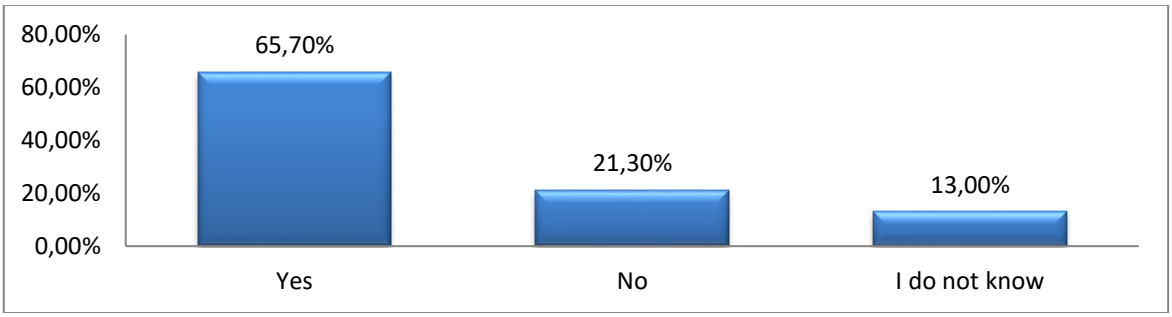

Figure 5. Support for conducting a compulsory HIV test

No significant difference was found in the opinion of current medical professionals (68,50%) and students (62,00%), which support the compulsory nature of HIV testing. 57,40% from doctors, 79,30% by nurses and 75,0% by laboratory assistants supporting the idea.

A significant proportion of HIV seropositives have their chosen physician (64,00%), with only 36,00% of GPs aware of their patient's HIV status. In 74,00% of HIV, seropositives do not disclose their HIV status when they visit a healthcare professional or dental doctor other than their GP. In general, respondents prefer only the doctors at the specialized treatment center to know about their condition.

Their biggest fear is that the secret of their illness would not be kept. On the one hand, the respondents белиеце that they should report their health status to the medical professionals for "moral reasons" and to receive more adequate care and treatment, but on the other hand, they either did not inform or selectively report. Most of the respondents said that they were not obliged to disclose their status, because the medical personnel had to use personal protective equipment to ensure their mutual safety. According to one of the respondents, their GP does not have the necessary competence in the problem and will not bring them any benefit and it is not necessary to announce their status.

The main reason for not sharing HIV status in 90,00% of the respondents is fear of discrimination, expressed in a change in attitude towards them, from the deterioration of the quality of the medical care provided or directly from the refusal of medical care. The respondents, they cite offensive qualifications as examples of unprofessional treatment, curiosity about how they are infected with HIV, or refusing medical care, especially in the field of dental healthcare. Most do not report their HIV status or say they have hepatitis B or C. It is paradoxical that for healthcare professionals there is no problem in the care and treatment of patients with these much more contagious infectious diseases. Discrimination among health care services against people living with HIV / AIDS is serious, but it is also the only problem for people living with HIV / AIDS.

Half of the seropositives studieddisagree with the HIV study (52,00%) as part of the compulsory study package when providing medical assistance (Figure. 6). Only 4,00% support the idea that HIV testing is a mandatory element in seeking medical help.

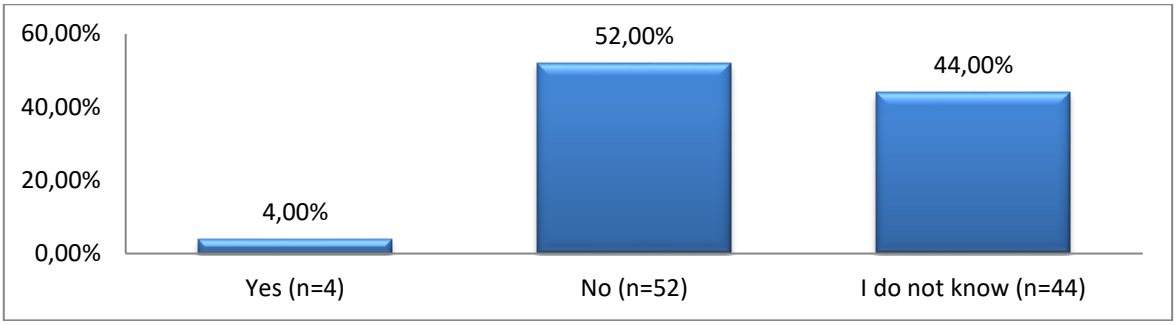

Figure 6. Support for making HIV testing mandatory

In examining the conection between consent HIV testing to be mandatory and fear of discrimination, we found that 53.30% of those who fear not being discriminated do not support the proposal for mandatory HIV testing.

In a comparative analysis of the responses of HIV-positive individuals and health professionals, we found a significant difference in their opinion, as

($\chi 2 = 131.12$; $p < 0.001$), half (52%) of HIV-positive individuals are not agree, HIV testing to be mandatory for all patients who have sought medical help, while a significant proportion (65,60%) of healthcare professionals believe that HIV testing should be mandatory for all patients who have sought medical help.

A significant proportion of the respondents (90.0%) think that it is necessary to introduce a preventive, periodic HIV test for the medical staff.

Discussion: In the seropositive respondents, age group 20-29, secondary education, Bulgarian ethnicity and male predominate, with half sharing about risky behavior (MSM followed by IDUs and representatives of the group of prostituted men), while the rest do not define their behavior as risky or afraid to recognize it because of the risk of discrimination.

Concerns about the risk of contracting HIV infection in medical students, physicians, and other healthcare professionals are well documented in the medical literature . In various researches among health professionals, it has been confirmed that lower levels of HIV / AIDS knowledge are associated with higher levels of stigmatization of PLHIV(people living with HIV). Most HIV positives do not report their HIV status to their GPs or other healthcare professionals because of fear of discrimination, resulting in a change in attitude towards them, a deterioration in the quality of medical care provided, or a direct refusal of such care. In the process of inquiring about barriers to accessing care and treatment, this study uncovered both covert and overt forms of stigma and discrimination in the healthcare system. Fear of stigma and rejection from society further compounds the problem of refusal and referrals of PLHA in the healthcare system. [9] We have found that accepted stigma is common in people living with HIV / AIDS and discrimination at the hospital level impedes access to healthcare. One of the major drivers of stigmatizing behaviors is a pervasive fear of HIV among medical professionals, including ward attendants, nurses, junior doctors and senior doctors, regarding occupational exposure to HIV. [1, 3, 7, 17]

Fear of stigma and rejection from society further compounds the problem of refusal and referrals of PLHA in the healthcare system. [9] The routine testing of patients for HIV does not reduce the risk of occupational exposure. Testing patients routinely for HIV as a precondition to accessing care is both stigmatizing and unreliable as a measure, given that patients may be in the window period during the clinical presentation and other blood transmitted diseases could be missed by this measure. Current practices contribute to frequent referrals of patients, irrespective of medical need, and a pervasive fear of occupational exposure to HIV. Compulsory HIV testing has a psychological effect on healthcare professionals. They make the necessary manipulations more calmly after being well informed. From this point of view, mandatory HIV testing reduce the stress in treatment of the patients, which health professionals felt in the absence of information about HIV status. [12] Strict adherence of the requirements that ensure complete safety and protect healthcare professionals from becoming infected with HIV is an important anti-epidemic factor. Stigma and discrimination are an important epidemiological, clinical and psychological problem in HIV and AIDS patients, which blocks access to testing and treatment services.

It is important to develop and validate the necessary health documents to regulate a number of AIDS responsibilities and activities. It is particularly important to comply with the requirements that ensure the complete safety and protection of healthcare workers from HIV infection.

Conclusion:

Stigma and discrimination are important epidemiological, clinical and psychological problem in patients with HIV and AIDS that block their access to testing and treatment services. Various studies described in the literature, similar to our study, found that lack of training and knowledge are barriers to the care and treatment of patients with HIV and AIDS. Creating stigma and discrimination against people living with HIV / AIDS in their health care is a prerequisite for their risky behavior such as hiding their HIV status. Avoiding health care due to stigmatization leads to negative consequences for people living with HIV and for the entire population because it increases morbidity and mortality *(4).* The effectiveness of epidemiological control in the field of healthcare and public structures largely depends on the efforts to overcome this phenomenon. Improving the knowledge about HIV transmission and the application of

universal precautions in all medical institutions in our country are necessary to reduce stigma and discrimination and to ensure proper control of infections.

References:

1.Charles B , Jeyaseelan L , Pandian AK , et al . Association between stigma, depression and quality of life of people living with HIV/AIDS (PLHA) in South India - a community based cross sectional study. BMC Public Health 2012;12:463.doi:10.1186/1471-2458-12-463

2.Datta S , Bhattacherjee S , Sherpa PL , et al . Perceived HIV related stigma among patients attending art center of a tertiary care center in rural West Bengal, India. J Clin Diagn Res 2016;10:VC09–12.doi:10.7860/JCDR/2016/21366.8669

3.Earnshaw VA , Bogart LM , Laurenceau J-P , et al . Internalized HIV stigma, art initiation and HIV-1 RNA suppression in South Africa: exploring avoidant coping as a longitudinal mediator. J Int AIDS Soc 2018;21:e25198.doi:10.1002/jia2.25198

4.Emmanuel N Kontomanolis, Spyridon Michalopoulos, Grigorios Gkasdaris, and Zacharias Fasoulakis, The social stigma of HIV–AIDS: society's role HIV AIDS (Auckl). 2017; 9: 111–118.

5.Ekstrand ML , Ramakrishna J , Bharat S , et al . Prevalence and drivers of HIV stigma among health providers in urban India: implications for interventions. J Int AIDS Soc 2013;16:18717. doi:10.7448/IAS.16.3.18717

6.Golub SA , Gamarel KE . The impact of anticipated HIV stigma on delays in HIV testing behaviors: findings from a community-based sample of men who have sex with men and transgender women in New York City. AIDS Patient Care STDS 2013;27:621–7.doi:10.1089/apc.2013.0245

7.Joglekar N , Paranjape R , Jain R , et al . Barriers to ART adherence & follow ups among patients attending ART centres in Maharashtra, India. Indian J Med Res 2011;134:954.doi:10.4103/0971-5916.92642

8.Juliano.Caliari , S. Teles, R.Reis et All, Factors related to the perceived stigmatization of people living with HIV Rev. esc. enferm. USP vol.51 São Paulo 2017 Epub Oct 09, 2017

9.Mahajan AP , Sayles JN , Patel VA , et al . Stigma in the HIV/AIDS epidemic: a review of the literature and recommendations for the way forward. AIDS 2008;22:S57–65.doi:10.1097/01.aids.0000327438.13291.62

10.Maretha j. Visser, Jennifer d. Makin, Alain Vandormael,et all

1.HIV/AIDS stigma in a South African community. AIDS Care. 2009 Feb; 21(2): 197–206.

11.Mohit Nair, Pragya Kumar, Sanjay Pandey, Amit Harshana, Shahwar Kazmi, Laura Moreto-Planas, Sakib Burza Refused and referred-persistent stigma and discrimination against people living with HIV/AIDS in Bihar: a qualitative study from India, Published online 2019 Nov 25. doi: 10.1136/bmjopen-2019-033790

12.National AIDS Control Organization. National integrated biological and behavioural surveillance (IBBS) 2014-15 high risk groups, 2015. Available: http://www.aidsdatahub.org/sites/default/files/highlight-reference/document/India_IBBS_report_2014-15.pdf

13.Nour S, Hsieh YH, Rothman RE, et al. Patients Can Accurately Perform Their Own Rapid HIV Point-of-Care Test in the Emergency Department. Point Care. 2012;11(4):176–179

14.Rice WS , Crockett KB , Mugavero MJ , et al . Association between internalized HIV-related stigma and HIV care visit adherence. J Acquir Immune Defic Syndr 2017;76:482–7 doi:10.1097/QAI.0000000000001543

15.Steward WT , Bharat S , Ramakrishna J , et al . Stigma is associated with delays in seeking care among HIV-infected people in India. J Int Assoc Provid AIDS Care 2013;12:103–9.doi:10.1177/1545109711432315

16.The Joint United Nations Programme on HIV/AIDS. Fact sheet stigma and discrimination, 2018. Available: http://data.unaids.org/publications/fact-sheets03/fs_stigma_discrimination_en.pdf

17.Thomas BE , Rehman F , Suryanarayanan D , et al . How stigmatizing is stigma in the life of people living with HIV: a study on HIV positive individuals from Chennai, South India. AIDS Care 2005;17:795–801.doi:10.1080/09540120500099936

18.Turan B , Budhwani H , Fazeli PL , et al . How does stigma affect people living with HIV? the mediating roles of internalized and anticipated HIV stigma in the effects of perceived community stigma on health and psychosocial outcomes. AIDS Behav 2017;21:283–91.doi:10.1007/s10461-016-1451-5

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