International Journal of Science and Research (IJSR)
ISSN (Online): 2319-7064
Index Copernicus Value (2013): 6.14 | Impact Factor (2013): 4.438

Factors Related to the Stigma Associated with HIV / Aids Patient

Namrata Mohite[1], Mahadeo Shinde[2]

[1]Clinical Instructor ,Krishna Institute of Nursing Sciences ,Karad Dist-Satara, Maharashtra, India

[2]Professor, Krishna Institute of Nursing Sciences, Karad Dist-Satara, Maharashtra, India

Abstract: ***HIV/AIDS related stigma (H/A stigma) is invoked as a persistent and pernicious problem . The manifestation of H/A stigma not only varies by cultural/national setting, but also by whether one is considering intrapersonal versus societal levels of stigma. Objectives -To assess the factor related to the personal & perceived community stigma.and to find the association between the factors related to stigma associated with HIV / AIDS patient and selected demographic variable.Methods: descriptive research approach with Single group non experimental research design was used for 30- HIV / AIDS samples from tertiary care hospital. Results: Majority (73.33 %) were in the age group 20-45yrs.Most of the patients were Male (70%) and (96.7%) were married as well as (90%) patients were illiterate. community stigma according to blame and judgment people were affected with this factor i.e,83.3%Maximum& ,interpersonal distance factors also affected with 86.7% ,and value items 60%was affected. community stigma according to blame and judgment factors were significant with HIV/AIDS patients, But interpersonal distance & value items are not significant so persons with HIV are living in society with their own lifestyle.Conclusion: This result concluded that there were no need to help this client to overcome stigmatization and discrimination. That means these people are living their own happily in the society.***

Keywords: Stigma, HIV, AIDS, Patients, Community

1. Introduction

Globally, stigma and discrimination impede HIV prevention, testing and treatment efforts. Yet research by ICRW and others shows that stigma and discrimination can be reduced in different contexts, such as the community and health facilities, thus contributing to the success of HIV programs and services.

AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV and AIDS. The consequences of stigma and discrimination are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage, and a negative effect on the success of HIV testing and treatment.

India's National AIDS Control Organisation (NACO) recognizes HIV-related stigma as a key challenge to controlling the epidemic. With support from the United Nations Development Program (UNDP) and in collaboration with NACO, ICRW designed and tested a **strategic framework** and implementation guidelines for stigma reduction in multiple settings in India. The framework built on one previously developed by a **global working group** made up of stigma experts and led by ICRW. The framework for India identifies key entry points for stigma-focused programming and measurement [1].

Internationally, there has been a recent resurgence of interest in HIV and AIDS-related stigma and discrimination, triggered at least in part by growing recognition that negative social responses to the epidemic remain pervasive even in seriously affected communities. Yet, rarely are existing notions of stigma and discrimination interrogated for their conceptual adequacy and their usefulness in leading to the design of effective programmes and interventions. Taking as its starting point, the classic formulation of stigma as a 'significantly discrediting' attribute, but moving beyond this to conceptualize stigma and stigmatization as intimately linked to the reproduction of social difference, this paper offers a new framework by which to understand HIV and AIDS-related stigma and its effects. It so doing, it highlights the manner in which stigma feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality. It highlights the limitations of individualistic modes of stigma alleviation and calls instead for new programmatic approaches in which the resistance of stigmatized individuals and communities is utilized as a resource for social change [2].

HIV-related stigma is a multidimensional concept which has pervasive effects on the lives of HIV-infected people as well as serious consequences for the management of HIV/AIDS. In this research three parallel stigma scales were developed to assess personal views of stigma, stigma attributed to others, and internalised stigma experienced by HIV-infected individuals. The stigma scales were administered in two samples: a community sample of 1,077 respondents and 317 HIV-infected pregnant women recruited at clinics from the same community in Tshwane (South Africa). A two-factor structure referring to moral judgment and interpersonal distancing was confirmed across scales and sample groups. The internal consistency of the scales was acceptable and evidence of validity is reported. Parallel scales to assess and compare different perspectives of stigma provide opportunities for research aimed at understanding stigma, assessing the consequences or evaluating possible interventions aimed at reducing stigma[3].

Internationally, there has been a recent resurgence of interest in HIV and AIDS-related stigma and discrimination, triggered at least in part by growing recognition that negative social responses to the epidemic remain pervasive even in

seriously affected communities. Yet, rarely are existing notions of stigma and discrimination interrogated for their conceptual adequacy and their usefulness in leading to the design of effective programmes and interventions. Taking as its starting point, the classic formulation of stigma as a 'significantly discrediting' attribute, but moving beyond this to conceptualize stigma and stigmatization as intimately linked to the reproduction of social difference, this paper offers a new framework by which to understand HIV and AIDS-related stigma and its effects. It so doing, it highlights the manner in which stigma feeds upon, strengthens and reproduces existing inequalities of class, race, gender and sexuality. It highlights the limitations of individualistic modes of stigma alleviation and calls instead for new programmatic approaches in which the resistance of stigmatized individuals and communities is utilized as a resource for social change [4].

Stigma may also vary depending on the dominant transmission routes in the country or region. In sub-Saharan Africa, for example, heterosexual sex is the main route of infection, which means that AIDS-related stigma in this region is mainly focused on promiscuity and sex work.

The epidemic of fear, stigmatization and discrimination has undermined the ability of individuals, families and societies to protect themselves and provide support and reassurance to those affected. This hinders, in no small way, efforts at stemming the epidemic. It complicates decisions about testing, disclosure of status, and ability to negotiate prevention behaviours, including use of family planning services."[5]

HIV-related stigma and discrimination severely hamper efforts to effectively fight the HIV and AIDS epidemic. Fear of discrimination often prevents people from seeking treatment for AIDS or from admitting their HIV status publicly. People with (or suspected of having) HIV may be turned away from healthcare services and employment, or refused entry to a foreign country. In some cases, they may be forced from home by their families and rejected by their friends and colleagues. The stigma attached to HIV/AIDS can extend to the next generation, placing an emotional burden on those left behind.

Denial goes hand in hand with discrimination, with many people continuing to deny that HIV exists in their communities. Today, HIV/AIDS threatens the welfare and wellbeing of people throughout the world. At the end of the 2011, 34 million people were living with HIV and 1.7 million had died from an AIDS-related illness that year[6]. Combating stigma and discrimination against people who are affected by HIV/AIDS is vital to preventing and controlling the global epidemic.

So how can progress be made in overcoming this stigma and discrimination? How can we change people's attitudes to AIDS? A certain amount can be achieved through the legal process. In some countries people living with HIV lack knowledge of their rights in society. In this case, education is needed so they are able to challenge the discrimination, stigma and denial that they encounter. Institutional and other monitoring mechanisms can enforce the rights of people with HIV and provide powerful means of mitigating the worst effects of discrimination and stigma. "We can fight stigma. Enlightened laws and policies are key. But it begins with openness, the courage to speak out. Schools should teach respect and understanding. Religious leaders should preach tolerance. The media should condemn prejudice and use its influence to advance social change, from securing legal protections to ensuring access to health care." - *Ban Ki-moon, Secretary-General of the United Nations[7]*.

2. Problem Statement

"A Study to Asses Factors Related to the Stigma Associated with HIV / Aids Patient Admitted in Tertiary Care Hospital."

OBJECTIVE

1) To assess the factor related to level of HIV/AIDS knowledge.
2) To assess the factor related to the personal & perceived community stigma.

Assumption

The sigma with HIV /ADIS patient may have Inadequate knowledge & improper attitude towards HIV / AIDS affect quality care take himself.

Operational definition

2) Assessment:- Assessment involves the use of empirical data on patient learning o refine programs and improve patient learning.

3) Stigma:- HIV is an infection which many people have fears, prejudices ornegative attitudes about. Stigma can result in people with HIV being insulted, rejected, gossiped about and excluded from social activities.

4) HIV:- H – Human – This particular *virus* can only infect human beings.**I** – Immunodeficiency – HIV weakens your *immune system* by destroying important cells that fight disease and infection. A "deficient" immune system can't protect you.**V** – Virus – A virus can only reproduce itself by taking over a cell in the body of its host.

5) HIV Positive Status:- HIV Positive having a positive reaction on a test for the human immunodeficiency virus; used to indicate that an individual has been infected with the human immunodeficiency virus but does not yet have AIDS. Persons who are HIV-positive require sensitive counseling, information regarding transmission of the virus, and close supervision of their health status.

6) HIV:- The human immunodeficiency virus is a lentivirus that causes the acquired immunodeficiency syndrome, a condition in humans in which progressive failure of the immune system allows life-threatening opportunistic infections and cancers to thrive.

Delimitations

These are the delimited study to the community people. Who know the asses factors related to the stigma associated with HIV/ADIS Patient admitted in Krishna Hospital.

3. Research Methodology

Research methods are techniques used by researcher to structure a study and together and analysis information relevant to the research question. [8]

Research Approach

Selection of an appropriate research Approach that involves a general set of orderly disciplined procedure to Acquired information is of at most importance in research study.
Focusing on the nature of research problem of present study and objectives to be fulfilled an evaluative research Approach was suitable for study.

Research Design

Research design is the researcher overall plan for answering the research question. As the study involves evaluation of effectiveness of planned for knowledge assessing the HIV/ AIDS STIGMA patient.

Variable Under Study :-
*Independent variables know ledge assessing the HIV /AIDS STIGMA patient.
*Dependant variable gain in knowledge score is the dependant variable.

Research Setting :-
Setting are the more specific places where the actual data collection occurs based on the nature of Question and type of information needed to address the setting selected for the present study was KRISHNA HOSPITAL KARD.

Sample:- A sample chosen for study of HIV AIDS STIGMA PATIENT FROM KRISHNA HOSPITAL KARD

Sample Size And Sample Technique :-

The sample size 30 HIV/ AIDS STIGMA patient simple random Technique was Used.

Inclusion Criteria

- Those who are willing to participate in the study.
- All age of HIV patient. –Both male and female HIV patient are included.

Exclusion Criteria

- Those who are not interested and not willing.
- HIV patients who are not available during data collection.

Sample Characteristics

A simple random sample 30 was taken from study of HIV patient for data collection. The sample characteristics include age, sex, marital status. & educational level.

4. Description of Tool

Part 1:- Demographic data.

Part 2:-Questionnaires on knowledge about the HIV patient.

5. Data Collection

The ethical clearance &formal permission was obtained from principal mam of KINS & MEDICAL DIRECTOR of krishna hospital. The steps are used for data collection ,
1) Introduction and explanation of purpose of study.
2) The assessing HIV patient on date :4/12/2014 to 31/12/2014
3) Data collection was tabulated analysis.

6. Results

The demographical information below were based on a total of 30 respondents from Krishna hospital karad. Respondents were grouped according to gender, age, marital status and educational level.

Table 1: Frequency & Percentage distribution of HIV/AIDS patients according to demographic variables

S	Particulars		Freq	%
1	Gender	female	9	30.0
		Male	21	70.0
2	Age	20-45	22	73.3
		46-70	8	26.7
3	Marital status	single	1	3.3
		married	29	96.7
4	Education	illterate	3	10.0
		litrate	27	90.0

Table no 1: Shows the distribution HIV/AIDS Patients according to their demographic characteristics where in the majority (73.33 %) were in the age group 20-45yrs.Most of the patients were Male (70%) and (96.7%) were married as well as (90%) people were illiterate.

7. Personal Stigma

In order to understand the personal stigma the responses on the individual items are given in following table The categories are “agree” (stigmatising answer) and “disagree” (non-stigmatising).

Table 2: Personal Stigma as Blame and judgment

S n	Particulars	Agreed		Disagreed	
		Freq	%	Freq	%
1.	Getting HIV is a punishment for bad behavior	11	36.7	19	63.3
2.	Having HIV is bad luck	11	36.7	19	63.3
3.	Think less of someone because they have HIV	11	36.7	19	63.3
4.	People with HIV have themselves to blame	6	20.0	24	80.0
5.	If you have HIV you must have done something wrong to deserve it	5	16.7	25	83.3
6.	People with HIV should be ashamed of themselves	18	60.0	12	40.0
7.	If a family member has HIV I will keep it a secret	25	83.3	5	16.7
8.	People with HIV should be isolated	21	70.0	9	30.0
9.	Names of HIV/AIDS patients should be made public to avoid getting AIDS	25	83.3	5	16.7

10.	AIDS patients do not deserve free medication	16	53.3	14	46.7

Responses to the personal stigma items in the sample of 30 are presented in table no 2

36.7% of respondents responded that Getting HIV is a punishment for bad behavior and Having HIV is bad luck. 36.7% of respondents responded that Think less of someone because they have HIV. 20.0% People with HIV have themselves to blame. 16.7% of them responded to If you have HIV you must have done something wrong to deserve it. 60.0% responded that People with HIV should be ashamed of themselves. While 83.3% responded that If a family member has HIV I will keep it a secret. 70.0% of respondents responded that People with HIV should be isolated. 83.3 of respondents responded that Names of HIV/AIDS patients should be made public to avoid getting AIDS. 53.3% of respondents responded that AIDS patients do not deserve free medication.

Table 3: Personal Stigma as interpersonal distance

S n	Particulars	Agreed		Disagreed	
		Freq	%	Freq	%
1.	Would not like to sit next to someone with HIV in public or private transport	26	86.7	4	13.3
2.	Would not like someone with HIV to be living next door	17	56.7	13	43.3
3.	Would not like to be friends with someone with HIV	26	86.7	4	13.3
4.	Not date a person with HIV	13	43.3	17	56.7
5.	Afraid to be around people with HIV	9	30.0	21	70.0
6.	Would not hire someone with HIV to work for them	18	60.0	12	40.0
7.	Would not drink from a tap if a person with HIV had just drunk from it	16	53.3	14	46.7
8.	Feel uncomfortable around people with HIV	26	86.7	4	13.3
9.	Not like children with AIDS in same school as my children	12	40.0	18	60.0
10.	Is safe for a person with HIV to look after somebody else's children	13	43.3	17	56.7

Tha above table shows that 86.7% of respondents responded that they Would not like to sit next to someone with HIV in public or private transport. 56.7% of them they were not like someone with HIV to be living next door while 86.7%Would not like to be friends with someone with HIV and 43.3% were Not date a person with HIV. 30.0% of respondents responded that they Afraid to be around people with HIVwhile 60.0% feels that Would not hire someone with HIV to work for them and 53.3%Would not drink from a tap if a person with HIV had just drunk from it 86.7%Feel uncomfortable around people with HIV 40.0%Not like children with AIDS in same school as my children 43.3%Is safe for a person with HIV to look after somebody else's children

Table 4: Personal And Perceived Community Stigma as value items

S n	Particulars	Agreed		Disagreed	
		Freq	%	Freq	%
1.	People with HIV deserve as much respect as anyone else	18	60.0	12	40.0
2.	Would care for family member sick with HIV	12	40.0	18	60.0
3.	Have a right to quality medical care	17	56.7	13	43.3

Tha above table shows that 60.0% of respondents responded that People with HIV deserve as much respect as anyone else while 40.0% responded that they Would care for family member sick with HIV and 56.7% of respondents responded that they Have a right to quality medical care.

Table 5: Descriptive Statistics of personal stigma

	N	Mini.	Maxi.	Mean	Std. Deviation
Blame And Judgement	30	3	8	4.97	1.586
Interpersonal Distance	30	4	7	5.87	1.137
Value Items	30	1	4	1.83	1.117

The mean score of personal stigma 4.97 for Blame And Judgement while 5.87 for Interpersonal Distanceand 1.83 for Value Items.

8. Conclusion

However, no policy or law can alone combat HIV/AIDS related discrimination. Stigma and discrimination will continue to exist so long as societies as a whole have a poor understanding of HIV and AIDS and the pain and suffering caused by negative attitudes and discriminatory practices. The fear and prejudice that lie at the core of the HIV/AIDS-related discrimination need to be tackled at the community and national levels, with AIDS education playing a crucial role. A more enabling environment needs to be created to increase the visibility of people with HIV/AIDS as a 'normal' part of any society. The presence of treatment can make this task easier; where there is the opportunity to live a fulfilling and long life with HIV, people are less afraid of AIDS; they are more willing to be tested for HIV, to disclose their status, and to seek care if necessary. The task is to confront the fear-based messages and biased social attitudes, in order to reduce the discrimination and stigma of people living with HIV and AIDS.

References

[1] http://www.icrw.org/where-we-work/strategic-framework-and-implementation-guidelines-reducing-hiv-related-stigma-india
[2] http://academic.research.microsoft.com/Publication/40596369/hiv-and-aids-related-stigma-and-discrimination-a-conceptual-framework-and-implications-for-action
[3] ink.springer.com/article/10.1007/s10461-008-9363-7
[4] http://www.sciencedirect.com/science/article/pii/
[5] ICRW (2005), 'HIV-related stigma across contexts: common at its core'
[6] UNAIDS (2012) 'Global Report: UNAIDS Report on the Global AIDS Epidemic 2012'
[7] Ban Ki-moon op-ed (2008, 6th August), 'The stigma factor', The Washington Times
[8] SHINDE, M., & ANJUM, S. (2007). Introduction to Research In Nursing. Sneha Publication India(Dombivili).

Author Profile

Mrs. Namarta C Mohite is Clinical Instructor in Krishna institute of nursing sciences karad, Krishna Institute of Medical Sciences deemed University Karad (Maharashtra State) India

Mr. Mahadeo Shinde is Professor in Krishna institute of Nursing Sciences karad, Krishna Institute of Medical Sciemces deemed University Karad (Maharashtra State) India