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# Stigma Associated With HIV/AIDS: A Review

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**ABSTRACT**

Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (***HIV/AIDS***) is currently one of the most devastating health conditions affecting the health of millions of people throughout the world. HIV/AIDS affects entire populations, societies, and countries with enormous and tragic consequences at the national, community, family, and individual level. HIV/AIDS-related stigma is a complex concept that refers to prejudice, discounting, discrediting, and discrimination directed at persons perceived to have AIDS or HIV. Many people perceive that the community have negative attitudes towards people who are living with HIV/AIDS. Understanding stigma as a problem of fear and blame, rather than a problem of ignorance, can help us to understand the stigmatization process without resorting to individualism. People often blame and judge those who are living with HIV/AIDS as if they deserve it because HIV/AIDS is associated with unacceptable sexual behavior. The stigma the community attaches to HIV/AIDS.

**Keywords**: Stigma, HIV, AIDS, Socio-demographic factors.

## INTRODUCTION

Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (HIV/AIDS) is currently one of the most devastating health conditions affecting the health of millions of people throughout the world [1-4]. HIV/AIDS affects entire populations, societies, and countries with enormous and tragic consequences at the national, community, family, and individual level. An estimated 25.4 million people are living with HIV/AIDS in Sub-Saharan Africa and approximately 3.1 million new infections occurred in 2004, and the access to care and treatment is severely limited [5].

In 2013, it was estimated that about 35 million people worldwide are living with HIV. Sub-Saharan Africa remains the region most affected by the pandemic, holding more than two-thirds of all infected people. Ethiopia has not escaped the burden with an estimated adult prevalence of 1.5%, large numbers of people living with HIV, and millions of children orphaned due to AIDS. Ethiopia has nine regional states and two city administrations. In 2010, the single point estimate of the country indicated that adult HIV prevalence in Oromia regional state was 1.6, which was slightly higher than the national single point estimate and the total PLWHA (people living with HIV/AIDS) in the region was estimated at 287,301 persons 2010. HIV/AIDS-related stigma is a complex concept that refers to prejudice, discounting, discrediting, and discrimination directed at persons perceived to have AIDS or HIV. As a result, the global commission on HIV/AIDS urged that member countries should take immediate steps to cancel

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punitive laws, prohibit stigma and discrimination, and work toward zero stigma and discrimination. However, almost no country has prioritized activities to reduce or eliminate them in their national AIDS plans or program. HIV stigma continues to have an extremely important role in the AIDS epidemic, not only because of its effects on HIV-infected individuals but also because of the ways in which it might be contributing to the spread of the epidemic. People who experience stigma report a range of negative effects, including loss of income or job, isolation from communities, and inability to participate as a productive member of society. Stigma also hinders adherence to antiretroviral treatment (ART), accelerates disease progression, and develops low self-esteem, accompanied by feelings of anger and revenge, and emotional stress. However, counseling of PLWHA and education of health workers and the community would lead to reductions in this negative self-perception and verbal abuse and in turn improve the quality of life for PLWHA [6].



HIV/AIDS related stigma and discrimination are also linked to gender issues. Females reported less stigmatising attitudes towards people with HIV. HIV/AIDS related stigma and discrimination are closely connected with sexual stigma because HIV is mainly transmitted through sex and blood transfusion and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the norm [7-9].

## RELATING SOCIO-DEMOGRAPHIC FACTORS IN COMMUNITY TO STIGMA

In respect of social psychology and cognitive theory, stigma needs to be considered in a specific social and cultural context. In international research there were some significant associations between demographic characteristics of research samples and the level of stigma associated with HIV: Age: People older than 25 years were found to be more stigmatising. Early sexual debut continues to be common in Ethiopia, especially among women. Eleven percent of young women age 15-24 and 1% of young men age 15-24 had sexual intercourse by age 15. Four in ten young women age 18-24 and 13% of young men age 18-24 had sexual intercourse by age 18. It is important to note that sexual intercourse among young women and men in Ethiopia happens mostly within marriage. Women are married at a median age of 16.5 and men at 23.2. Ninety-five percent of never-married young women and 87% of never-married young men report that they have never had sex. Young women and men are initiating sexual activity later than previous youth. In 2005, 11% of 15-19-year-old women had had sex by age 15 compared to only 7% in 2011. Similarly, 37% of women age 18-19 had had sex by age 18 in 2005 compared to 32% in 2011. One-quarter of young women and men in Ethiopia have had a recent HIV test and received the results. This is a large increase from 2005 when only 2% of young women and 6% of young men had been tested for HIV [10].

### Gender

**HIV/AIDS** related stigma and discrimination are also linked to gender issues. Females reported less stigmatising attitudes towards people with HIV [11] This HIV/AIDS related stigma affects men and women, young and old, rich and poor. It affects people known to have contracted the virus, people suspected of having contracted it or of being vulnerable to the virus, such as homosexual, commercial sex workers, and the families and caregivers of those who are ill. The stigma is therefore born especially from fear, denial, ignorance, lack of knowledge and social judgment. HIV-related stigma persists in Ethiopia. HIV-related stigma persists in Ethiopia. While 82% of women and 93% of men say that they would be willing to take care of a family member with AIDS in their own home, only 32% of women and 47% of men report that they would buy fresh vegetables from a shopkeeper who has the AIDS virus. In addition, about 6 in 10 women and men would not want to keep a secret that a family member was infected with the AIDS virus. Overall, only 17% of women and 28% of men express accepting attitudes on all four indicators [11].

### Sexuality

**HIV/AIDS** related stigma and discrimination are closely connected with sexual stigma because HIV is mainly transmitted through sex and blood transfusion and in most areas of the world, the epidemic initially affected populations whose sexual practices or identities are different from the norm. HIV/AIDS related stigma and discrimination reinforce pre-existing sexual stigma associated with sexually transmitted diseases, homosexuality, promiscuity, prostitution, and sexual deviance. Most women and men in Ethiopia believe that a woman is justified in negotiating safer-sex practices under certain circumstances. The majority of women and men in Ethiopia believe that women are justified in refusing to have sex with their husband if she suspects that the husband has sex with other women. Two-thirds of women and almost 9 in 10 men believe that women are justified in asking husbands to wear a condom if they know the husband has a sexually transmitted infection. These safer-sex negotiations are more Attitudes Towards Negotiating Safer Sex with Husbands Percentage of women and men who believe that a woman is justified in: 83 Women Men 9088 69 Asking that they use a condom if she knows that her husband has an STI Refusing to have sexual intercourse with her husband if she knows he has sex with other women acceptable in urban areas than in rural areas and are much more common among the most educated and wealthy women and men. For

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example, almost all (97%) of women with more than secondary education say that a woman is justified in asking the husband to use a condom if he has an STI compared to only 56% of women with no education. Half of women and three-quarters of men agree that children age 12-14 years should be taught about using a condom to avoid AIDS. Support of condom education varies widely by region. In Somali and Affar, less than 30% of women and about half of men support condom education compared to more than two-thirds of women in Addis Ababa and Tigray [12].

**Education and schools**



Children with HIV/AIDS or associated with HIV through infected family members have been stigmatized and discriminated against in educational settings in many countries. Stigma has led to teasing by classmates of HIV-positive school children. There was a significant difference in personal stigma levels between respondents who knew someone with HIV and those who did not. Less educated people had less knowledge about HIV and more restrictive attitudes [10]. The HIV/AIDS epidemic has developed during a period of globalization and growing polarization between rich and poor. New forms of social exclusion associated with these global changes have reinforced pre-existing social inequalities and stigmatization of the poor, homeless, landless and jobless. As a result, poverty increased vulnerability to HIV/AIDS, and exacerbates poverty. HIV/AIDS is draining the supply of educators, eroding the quality of education, weakening demand and access, drying up the countries' pool of skilled workers, and increasing the sector's costs. However, HIV/AIDS makes a greater impact in those countries where the education system was already struggling to grow, teachers are dying faster than they can be replaced, or are too sick to teach.

## RELATING STIGMA TO HIV/AIDS KNOWLEDGE

Large numbers of people blame people with AIDS for their illness and don't understand how AIDS is spread [13]. The social perception of AIDS is the worst and the most ignorant. This conveys the need for better education about AIDS and its transmission in order to combat such prevalent and paralyzing stigmas. For example, some people still believe that HIV/AIDS transmits through kissing, shaking hands, sleeping together in the same room, and eating together with an affected person. Gaps in knowledge and lack of in-depth information about HIV/AIDS fuel the fear of causal transmission, leading to stigmatising action to avoid them. They are seen as sick therefore the belief that people with HIV/AIDS are non-productive community members. People still need education on the difference between HIV and AIDS, what it means to live with HIV, including the fact that opportunistic infections are treatable. Because the opportunistic infections can kill the person with HIV/AIDS. Knowledge of HIV prevention methods is highest among women and men in urban areas, those with secondary or higher education, and those from the wealthiest households. Women and men living in Tigray are most likely to know the two prevention methods, while those in Somali are least knowledgeable. Knowledge of using condoms to prevent HIV has increased since 2005 among both women and men. However, the knowledge that limiting sex to one uninfected partner prevents HIV has stagnated among both women and men. Knowledge of mother-to-child transmission (MTCT) of HIV has increased in recent years. This is a sizeable increase since 2005 when only 20% of women and 26% of men knew about MTCT. Knowledge of MTCT is unevenly spread throughout Ethiopia. Women living in urban areas are twice as likely to know about MTCT as those living in rural areas. MTCT knowledge is very high among those who have more than secondary education (84%) compared to only 28% among those with no education. MTCT knowledge among women ranges from a low of only 17% in Somali to 81% in Addis Ababa. Despite improvements in HIV-related knowledge, Ethiopia continues to lag behind its neighbours in HIV knowledge. Only one-quarter of young women and one-third of young men have a comprehensive knowledge of AIDS, meaning that they know the two major methods for preventing HIV transmission, know that a healthy-looking person can be HIV-positive, and reject the two most common misconceptions about HIV/ AIDS. Comprehensive knowledge among youth has not changed since [12].

## CONCLUSION

Many people perceive that the community have negative attitudes towards people who are living with HIV/AIDS. Understanding stigma as a problem of fear and blame, rather than a problem of ignorance, can help us to understand the stigmatization process without resorting to individualism. People often blame and judge those who are living with HIV/AIDS as if they deserve it because HIV/AIDS is associated with unacceptable sexual behavior. The perception is that HIV/AIDS is a "bad disease" linked to high-risk behavior such as promiscuity, drug use and people distance themselves from it. Exposure of knowing someone living with HIV/AIDS has a profound impact on individual and community perception of HIV/AIDS. HIV/AIDS is strongly associated with stigmatization, discrimination, blame and judgment. The overall conclusion that can be drawn from this research finding is that there is a high level of stigma associated with HIV/AIDS in a community level. In a personal level people expressed

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negative attitudes towards people who are living with HIV/AIDS. People who express stigmatizing attitudes about HIV/AIDS often have retained misinformation about the transmission of HIV.

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