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## LITERATURE REVIEW

# STIs/HIV Stigma and health: A short review<sup>☆</sup>

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### KEYWORDS

Stigma;  
STI/HIV;  
Health psychology;  
Stigma-reduction  
intervention

**Summary** The review focuses on stigma as an impediment to health and specifies HIV characteristics among all medical conditions. The impact is detailed according to impacted sphere: public health priority (screening, adherence) psychosocial vulnerabilities (comorbidities) and institutional challenges (stigma in healthcare).

**Conclusion.** – Stigma affects both public health priorities (screening, adherence) and the well-being of people living with HIV. The difficulty in building tailored intervention targeting cultural and/or local preoccupations remains an impediment to public health improvement. However, providers should be able to offer support and counselling services at the earliest opportunity, empowering people living with HIV. Psychosocial stigma reducing interventions should remain a priority. Further investigation is needed to anticipate and prevent internalised stigma among people living with HIV.

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## Introduction

Health and sexuality are now theorized from an ecological point of view, integrating psychosocial components. The syndemic model of health (Singer and Clair, 2003) and sexological system theory (Jones et al., 2011) define three levels of determinants and interventions:

- the structural level or the social environment defining local contexts (i.e. law, policies, access to healthcare);
- the behavioural level (a behaviour or an absence of behaviour having an impact on health or sexuality);
- the biological level (biomedical treatment).

HIV-related stigma is defined as devaluing, shaming and prejudicial thoughts and actions towards HIV and/or people living with HIV (Herek et al., 2003). STIs/HIV stigma occurs at both structural and behavioural levels and impacts on the ability to:

- medically address the pandemic;
- screen, treat and follow-up people (Hodgson et al., 2014).

This critical review is a narrative analysis and explores STIs and HIV stigma consequences through the scope of health care.

DOI of original article:

<http://dx.doi.org/10.1016/j.sexol.2016.03.006>.

<sup>☆</sup> La version en français de cet article, publiée dans l'édition imprimée de la revue, est disponible en ligne: <http://dx.doi.org/10.1016/j.sexol.2016.03.006>.

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<http://dx.doi.org/10.1016/j.sexol.2016.03.005>

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## Stigma theories and types of stigma

### Stereotype and prejudice

At the core of social representations theory (Moscovici, 1976), stereotypes are thought, values, images implicitly shared by members of a community. Whether positive (socially valued) or negative, implicit (automatic) or explicit (deliberate) stereotypes are social clues guiding social perception and attitudes (Devine, 1989). As culturally dependent phenomena, stereotypes and social representations differ from one group to another (Goodwin et al., 2003).

Negative stereotypes lead to prejudicial thoughts, attitudes and behaviours. Prejudice (Allport, 1954) is the result of a cognitive and conative process involving social representations and groups' relationships. Stereotypes operate within certain group contexts and differentiate in-groups and out-groups. The in-group refers to groups of affiliations (membership) and provides individuals with social references (i.e. social values, norms, status). The out-group refers to the social group a person rejects any affiliation with.

In the early years of the pandemic, HIV was mostly associated with homosexuality, which is itself stigmatised (Joffe, 1995). HIV stigma relates to the negative perception of its routes of transmission, namely unsafe sex and drug use practices (Herek, 1999; Herek et al., 2003).

### Stigma models and typologies

Goffman (1963) gave the first typology of stigma consisting of two criteria:

- the nature of the stigmatized element (body deformity, personality or tribal stigma);
- the degree of visibility of the stigmatised element.

Another way to categorize stigma focuses on enacted stigma and the different levels of experienced stigma (Link and Phelan, 2001).

Enacted stigma is expressed through actions or the absence of actions that openly discriminate such as verbal abuse. A second form of enacted stigma, silent and distinct from discrimination, consists of avoidance strategies of the potential target and related reactions when avoidance strategies fail (i.e. non-verbal attitude, relational ambivalence).

The experience of stigma ranges from effective stigma (victim of enacted stigma), to perceived stigma (acknowledgment of an external stigmatising norm), to internalised stigma.

Anticipated stigma (Quinn and Chaudoir, 2009) refers to the degree to which people expect to be stigmatised because of a specific trait. It is associated with perceived stigma (Pascoe and Smart Richman, 2009) which is the acknowledgment of an external stigmatising norm or possible norm.

The experience of stigma ranges from effective stigma (victim of enacted stigma), to perceived stigma (acknowledgment of an external stigmatising norm), to internalised

stigma. Internalised stigma, also referred to as internalised shamefulness (Goffmann, 1963) self-hate (Allport, 1954) and self-stigma (Corrigan et al., 2009) is one's acknowledgment and validation of stigma about oneself.

Finally, relatives, partners and professionals in contact with stigmatised persons might experience stigma by association (Pryor et al., 2012; Östman and Kjellin, 2002).

HIV stigma models are either present within existing models such as power dynamics, (Parker and Aggleton, 2003), multi-layered experience and processes (Swendeman et al., 2006), social dominance (Sidanius and Pratto, 1999) or constructed from persons living with HIV experiences and qualitative social representations studies (Earnshaw et al., 2013). This leads to concrete models on a given area and/or population, and to identify local trends or dimensions (Holzemer et al., 2007) and tailor stigma-reducing interventions.

### STIs/HIV stigma as a psychosocial impediment to health

Living with HIV as a long-term condition (since HAART) did not lead to the decrease of stigma and shame (Lowther et al., 2014). The following section synthesises findings on stigma affecting both public and sexual health.

### Cumulative stigma and access to health care

HIV stigma reflects and sometimes catalyses other stigmas such as social class, gender inequalities (Parker and Aggleton, 2003) sexual orientation and ethnicity (Novick, 1997; Joffe, 1998). Health care access highly depends upon health care facilities system and structural factors (WHO, 2013). A worldwide study recently showed criminalization of homosexuality ('legal stigma') is related to a poor service and access to HIV care (Arreola et al., 2015).

### Screening impediment

Stigma interferes with HIV prevention and screening. Two thirds of American men having sex with men are unaware of their HIV status (Stall et al., 1996) and HIV/AIDS-related stigma was part of their decisions not to test. This trend is enduring and more studies have found that feelings of shame and perceived social stigma impede gonorrhoea and HIV screening (Fortenberry et al., 2002).

### Routine testing and adherence

The fear of stigma is invoked as the first reason for non-disclosure and failure to seek assistance among women living with HIV in Sub-Saharan Africa (Kilewo et al., 2001). Women raise social concerns about being seen at the clinics, social condemnation and potential discrimination. Women report personal concerns relating to being reminded of one's condition and related risks. The psychosocial factors have a relationship with non-adherence. HIV stigma compromises psychological well-being and impairs social support leading to internalized stigma and concealment for both adults (Katz et al., 2013) and adolescents (Martinez et al., 2012) living

with HIV. Routine testing and adherence for people living with HIV is decreased when they experience stigma in health care.

### HIV Stigma in wider health care

Stigma in health care permeates all services (i.e. primary care) women living with HIV pursuing pregnancy report a strong feeling of being judged (Wagner et al., 2010). Despite neutrality and aspirations of non-judgment, professionals' stigmatizing views can be pervasive (Eaton et al., 2015; Stutterheim et al., 2014). Perception of patients oscillates from the innocent patient (i.e. born with) to the guilty patient (Infante et al., 2006). Nyblade et al. (2009) reports three types of prejudicial beliefs (conscious or otherwise) among professionals: the fear of being transmitted HIV associated with a strong lack of knowledge, the lack of awareness of stigma, its process and consequences, and the attribution of transmission to immoral behaviours.

In developing countries, trust and satisfaction with HIV care providers was associated with fewer depressive symptoms and higher adherence (Langebeek et al., 2014).

### Social, relational and psychological vulnerability

In unsupportive contexts (social, family), people living with HIV show poorer social support and mental health (Logie and Gadalla, 2009) and more psychiatric symptoms (Tavakkoli et al., 2014). Experience stigma can lead to internalized stigma and alters one's self-perception, leading to accepting situations otherwise unbearable. Higher prevalence intimate partner violence among female living with HIV is found (Dhairyawan et al., 2013).

### HIV stigma-reducing interventions

Aimed at reducing stigmatizing attitudes and supporting stigmatized persons, these interventions draw upon the contact hypothesis (the direct or indirect familiarity with an out-group member reduces prejudice, Allport, 1954), which had been effectively confirmed by meta-analysis (Pettigrew and Tropp, 2006). Despite the methodological difficulties to compare interventions and assess efficiency (Stangl et al., 2013), stigma-reducing interventions are becoming common practice (i.e. diversity training).

### Target groups

Interventions have been led among key populations, such as people living with HIV, experiencing stigma and/or self-stigma (Barroso et al., 2014), community member to reduce social prejudice (Kerr et al., 2015; French et al., 2014) professionals such as care providers and teacher (Li et al., 2015; Mak et al., 2015).

### Type of interventions

Following Brown et al.'s (2003) interventions strategies are classified in four types:

- information/enlightenment strategy: the didactic approach consists of providing people with information about inequalities, their consequences and promoting equality; showing its benefits. Information strategies show limited efficiency (Pendry et al., 2007) not addressing the emotional component (shame, fear, anger) resisting to facts or rationales (Dovidio et al., 2004) and sometimes reinforcing negative attitudes towards the out-group members (Doosje et al., 2002);
- skill building: training professionals or communities to make them aware of their own automatic biases. Main techniques used are the empathetic/perspective-taking interventions and structured role-plays (Abrams, 2010). However, its effectiveness depends upon participants' reflexivity and willingness to engage. Additionally, certain conditions have the counter-effect of reinforcing negative emotions for participants (Pendry et al., 2007);
- skills-building, counselling and/or therapeutic approaches for persons living with HIV: this field promotes individual and collective interventions either addressing internalized stigma-dimensions (i.e. shame, self esteem) or promoting global well-being (Sengupta et al., 2011);
- contact/interaction with persons living with HIV: this consists usually of testimonials, interaction between with the general public, based on the contact hypothesis.

### Conclusion

Stigma affects both public health priorities (screening, adherence) and the well-being of people living with HIV. The difficulty in building tailored intervention targeting cultural and/or local preoccupations remains an impediment to public health improvement. However, providers should be able to offer support and counselling services at the earliest opportunity, empowering people living with HIV. Psychosocial stigma reducing interventions should remain a priority. Further investigation is needed to anticipate and prevent internalised stigma among people living with HIV.

### Disclosure of interest

The authors declare that they have no competing interest.

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