



National HIV/AIDS Anti-Stigma Initiative



Selected Literature 2004-2008

Introduction

This annotated bibliography was developed for the National HIV/AIDS Anti-Stigma Initiative, administered by the Academy for Educational Development's Center on AIDS & Community Health (AED-COACH), with support from the Ford Foundation. For more information on the Initiative, please visit our Web site at www.hivaidsstigma.org.

This annotated bibliography on HIV/AIDS-related stigma and discrimination is limited to articles published since 2004 that were not previously included in our July 2004 annotated bibliography. This publication is not designed to be comprehensive. Rather, the articles were chosen for their currency and contribution to the body of literature on HIV/AIDS and stigma. Articles were selected from literature searches conducted in the MEDLINE database, Google Scholar, and other online journal databases. Different combinations of HIV and each category were used as search terms for the literature search. Original annotations were written and/or modified by project staff for most citations. Author abstracts are reproduced for some citations.

The literature selected for this annotated bibliography covers discussions, interventions, and strategies that deal with issues pertinent to HIV/AIDS-related stigma and discrimination. A number of themes emerged from the literature. The themes and a brief description of each are provided below:

- **Age** – Includes articles with a focus on a particular age group, e.g., adolescents, and/or those with significant findings pertaining to a specific age group.
- **African American Population** – Includes articles specifically focusing on African Americans and those with significant findings pertaining to the African American population.
- **Asian & Pacific Islander (A&PI) Population** – Includes articles specifically focusing on A&PI populations and those with significant findings pertaining to A&PI populations.
- **Community Response** – Includes articles that discuss the response and attitudes within a community based on associated cultural and social norms to HIV/AIDS and the related stigma faced by members of the community living with or at risk of contracting HIV/AIDS.
- **Confidentiality & Privacy** – Includes articles that discuss the importance of confidentiality and privacy as they relate to HIV/AIDS stigma.
- **Disclosure** – Includes articles related to disclosure, how it is affected by stigma, and how both stigma and decisions about disclosure affect individuals and the community.
- **Domestic (U.S.) Setting** – Includes articles that specify a focus on a population residing in the United States and/or that clearly identify a U.S. geographic setting.

- **Gender** – Includes articles related to the role of gender in HIV/AIDS-related stigma and articles with significant findings pertaining to gender.
- **Health Care Setting or Clinical Trials** – Includes articles that discuss HIV/AIDS-related stigma in the health care setting, including but not limited to the affect on clients seeking care and adherence to treatment. This category also includes articles related to clinical trials.
- **Homophobia** – Includes articles related to the role homophobia plays in HIV/AIDS-related stigma and articles with significant findings pertaining to the impact of homophobia.
- **Immigration** – Includes articles that identify immigration or immigration status as playing a significant role in HIV/AIDS-related stigma.
- **Individual, Family, and Community** – Includes articles that highlight the interaction and norms of the individual, their families, and community around the issue of HIV/AIDS and the role and affect of related stigma on decisions and behaviors of those living with HIV/AIDS.
- **Injection Drug Use (IDU)** – Includes articles specifically focusing on IDU populations and those with significant findings pertaining to IDU populations.
- **Instruments for Measuring Stigma** – Includes articles that examine instruments, tools, and scales for measuring stigma, as well as adaptations and application of these instruments, tools, and scales.
- **International (Non-U.S.) Setting** – Includes articles that specify a focus on a population residing outside of the United States and/or that clearly identify a geographic setting outside of the United States.
- **Latino/Latina (Hispanic) Population** – Includes articles specifically focusing on Latino/Latina (Hispanic) populations and those with significant findings pertaining to these populations.
- **Men who have Sex with Men (MSM)** – Includes articles specifically focusing on MSM populations and those with significant findings pertaining to these populations.
- **Mental Health** – Includes articles that highlight mental health issues as a significant outcome of HIV/AIDS-related stigma, as well as the impact of mental health issues on an individual's perception of stigma.
- **Native American/Alaska Native Population** – Includes articles specifically focusing on Native American/Alaska Native populations and those with significant findings pertaining to these populations.

- **Policy Change, Policy Formation, & Legal Reform** – Includes articles that discuss the need for and potential outcomes of policy change, policy formation, and legal reform to combat HIV/AIDS-related stigma.
- **Providers' Willingness to Treat PLWHA** – Includes articles related to health care and health service providers' willingness to treat people living with HIV/AIDS (PLWHA), as well as the impact of providers' attitudes and behaviors on clients.
- **Race** – Includes articles related to the role of race and its impact on HIV/AIDS-related stigma. This may include, for example, racism and associated discrimination and its effect on people living with HIV/AIDS, seeking testing, and disclosure. This category also includes articles that identify significant findings differentiated by race.
- **Religious and Moral Beliefs** – Includes articles that identify religious and/or moral beliefs of an individual and/or the community as playing a significant role in HIV/AIDS-related stigma.
- **Women** – Includes articles specifically focusing on women and/or those with significant findings pertaining to this group.

The articles included in this report are first categorized within each theme. The articles are again cited (along with the annotations) in an alphabetical list at the end of the document.

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April 2008

Age

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- Hillman, J. (2007). Knowledge and attitudes about HIV/AIDS among community-living older women: Reexamining issues of age and gender. *Journal of Women & Aging*, 19(3-4), 53-67.
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- Lam, P.K., Naar-King, S., & Wright, K. (2007). Social support and disclosure as predictors of mental health in HIV-positive youth. *AIDS Patient Care & Studies*, 21(1), 20-9.
- Miles, M.S., Holditch-Davis, D., Pedersen, C., Eron, J.J., Jr., & Schwartz, T. (2007). Emotional distress in African American women with HIV. *Journal of Prevention & Intervention in the Community*, 33(1-2), 35-50.
- Rao, D., Kekwaletswe, T.C., Hosek, S., Martinez, J., & Rodriguez, F. (2007). Stigma and social barriers to medication adherence with urban youth living with HIV. *AIDS Care*, 19(1), 28-33.
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- Wong, V., & Wong, L. (2006). Management of stigma and disclosure of HIV/AIDS status in healthcare settings. *Journal of Health Organization & Management*, 20(2-3), 95-114.
- Wright, K., Naar-King, S., Lam, P., Templin, T., & Frey, M. (2007). Stigma scale revised: Reliability and validity of a brief measure of stigma for HIV+ youth. *Journal of Adolescent Health*, 40(1), 96-8.

African American Population

- Brooks, R.A., Etzel, M.A., Hinojos, E., Henry, C.L., & Perez, M. (2005). Preventing HIV among Latino and African American gay and bisexual men in a context of HIV-related stigma,

discrimination, and homophobia: Perspectives of providers. *AIDS Patient Care and STDs*, 19(11), 737-44.

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Foster, P.H. (2007). Use of stigma, fear, and denial in development of a framework for prevention of HIV/AIDS in rural African American communities. *Family & Community Health*, 30(4), 318-27.

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Asian & Pacific Islander Population

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Confidentiality & Privacy

Grusky, O., Roberts, K.J., Swanson, A.N., Joniak, E., Leich, J., McEvoy, G., et al. (2005). Anonymous versus confidential HIV testing: Client and provider decision making under uncertainty. *AIDS Patient Care and STDS*, 19(3), 157-166.

Disclosure

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- Ostrom, R.A., Serovich, J.M., Lim, J.Y., & Mason, T.L. (2006). The role of stigma in reasons for HIV disclosure and non-disclosure to children. *AIDS Care, 18*(1), 60-5.
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- Skinner, D., & Mfecane, S. (2004). Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa. *Journal of Social Aspects of HIV/AIDS Research Alliance, 1*(3), 157-64.
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Domestic (U.S.) Setting

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- Buseh, A.G., & Stevens, P.E. (2006). Constrained but not determined by stigma: Resistance by African American women living with HIV. *Women & Health, 44*(33), 1-18.
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Gender

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Health Care Setting or Clinical Trials

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Mental Health

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Providers' Willingness to Treat PLWHA

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Abel, E. (2007). Women with HIV and stigma. *Family & Community Health, 30*(1 Suppl), S104-6.

Type: Questionnaire, personal writing, and stigma scale

Background: Women (especially minority women) are the fastest-growing population living with HIV/AIDS, and they often experience HIV stigma within the context of poverty. Previous research found that the fear of HIV-related stigma was more of a concern than the fear of dying among women living with HIV. The devastating consequence of HIV-related stigma and the need for interventions have been highlighted in other research.

Methods: In this Institutional Review Board-approved pilot study, an experimental design evaluated the impact of emotional writing disclosure (EWD) on self-perceived HIV-related stigma in women. Women living with HIV were recruited to participate in this study. Some were randomly assigned to an experimental group where they wrote about their feelings related to having HIV; others were assigned to a control group where they wrote on a neutral topic for three consecutive days for 20 minutes each day. If a woman met prescreening criteria, she was included if she was 18 years or older, on antiretroviral drugs, had no major illnesses, was able to speak and write English, and consented to be in the study. All women had six contacts: questionnaires on perception of stigma on the first visit, writing on visits two through four, and stigma questions at the fifth and sixth visits. Linguistic Inquiry and Word Count (LIWC), a text analysis software program, evaluated the cognitive reorganization illustrated in the writing for both groups. The Stigma Scale, designed for individuals diagnosed with HIV/AIDS, consisted of 13 items on a 1 to 4 ordinal scale that evaluated fear, avoidance, and perceived negative responses related to HIV status.

Results/Findings: Participants were older than expected; experimental group (n = 21) average age was 43 years, control (n = 23) group's was 45. The average education was the 12th grade for both groups. Seventy-four percent of the participants were African American, suggestive of an ethnically representative sample. The experimental group compared with the control group reported greater cognitive reorganization ($F = 14.235$, $P = 0.001$) and significantly improved perceived HIV-related stigma scores from visit one (week 1) to visit six (12 weeks). Average intervention essays contained 2% negative emotion words and 3.1% positive emotion words, compared with 0.6% negative and 1.2% positive emotion words in control groups.

Conclusions: The results of the study imply a positive influence on perception of stigma. The author suggests further studies with a larger sample, over a longer time, and with a booster for the future research. Considerations should address the potential for contamination between the two groups; participants who knew each other likely discussed the study despite instructions to the contrary. The author asserts EWD, an inexpensive and convenient intervention that changed the perception of stigma positively for women with living HIV in the experimental group, is a promising finding to advance the health of women.

Abell, N., Rutledge, S.E., McCann, T.J., & Padmore, J. (2007). Examining HIV/AIDS provider stigma: Assessing regional concerns in the islands of the Eastern Caribbean. *AIDS Care, 19*(2), 242-7.

Type: Survey

Background: HIV/AIDS provider stigma has been understudied in the context of prevention, testing, and treatment. Results of a survey of persons associated with HIV/AIDS education, health care, and social service delivery in the Eastern Caribbean are described in this article.

Methods: Reliable constructs were observed for warmth towards PLWHA, comfort in association with them, tendencies to distance from or condemn PLWHA, beliefs in viral transmission myths, and perceived capacity to counsel effectively.

Results/Findings: Most discrimination was directed towards MSM and IDUs. Providers whose roles were likely to involve touching clients felt less comfortable around PLWHA and more likely to create distance from and condemn their clients with HIV as compared to providers whose roles were not likely to involve touch.

Conclusions: The authors indicate that improved measurement and incorporation of mindfulness techniques in stigma intervention are needed.

Baiden, F., Akanlu, G., Hodgson, A., Akweongo, P., Debpuur, C., & Binka, F. (2007). Using lay counsellors to promote community-based voluntary counselling and HIV testing in rural northern Ghana: A baseline survey on community acceptance and stigma. *Journal of Biosocial Science*, 39(5), 721-33.

Type: Questionnaire survey

Background: Access to voluntary counseling and HIV testing (VCT) remains limited in most parts of Ghana with rural populations being the least served. Services remain facility-based and employ the use of an ever-dwindling number of health workers as counselors. This study assesses the approval of using lay counselors to promote community-based voluntary counseling and testing for HIV and the extent of HIV/AIDS-related stigma in the Kassena-Nankana district of rural northern Ghana.

Methods: A cross-sectional questionnaire survey was conducted. Logistic regression was used to identify predictors of the tendency to stigmatize people living with HIV/AIDS (PLWHA). Focus group discussions were held and analytical coding of the data performed. The majority (91.1%) of the 403 respondents indicated a desire to know their HIV status.

Results/Findings: Most (88.1%) respondents considered locations outside of the health facility as preferred places for VCT. The majority (98.7%) of respondents approved the use of lay counselors. About a quarter (24%) of respondents believed that it was possible to acquire HIV through sharing a drinking cup with a PLWHA. About half (52.1%) of the respondents considered that a teacher with HIV/AIDS should not be allowed to teach, while 77.2% would not buy vegetables from a PLWHA. Respondents who believed that sharing a drinking cup with a PLWHA could transmit HIV infection (OR 2.50, 95%CI 1.52-4.11) and respondents without formal education (OR 2.94, 95%CI 1.38-6.27) were more likely to stigmatize PLWHA. In contrast, respondents with knowledge of the availability of antiretroviral (ARV) drugs were less likely to do so (OR 0.40, 95%CI 0.22-0.73).

Conclusions: Findings from the thirteen focus group discussions reinforced approval for community-based VCT and lay counselors but revealed concerns about stigma and confidentiality. In conclusion, community-based VCT and the use of lay counselors may be acceptable options for promoting access. The authors conclude that intervention studies are required to assess feasibility and cost-effectiveness.

Bharat, S., & Mahendra, V.S. (2007). Meeting the sexual and reproductive health needs of people living with HIV: Challenges for health care providers. *Reproductive Health Matters*, 15(29), 93-112.

Type: Author abstract

Background: A trained health service workforce is critical to ensuring good quality service delivery to people with living with HIV (PLWH). There is only limited documented information on the challenges and constraints facing health care providers in meeting the sexual and reproductive health needs of HIV-positive women and men.

Methods: This paper reviews information on providers' attitudes, motivation and level of preparedness in addressing the sexual and reproductive health needs of people living with HIV in the context of the human resources crisis and emerging treatment and prevention strategies.

Results/Findings: The authors found that there is a need for significant investment in improving the health infrastructure and providers' ability to take universal precautions against infection in health care settings. Additionally, there is need for comprehensive and appropriate training for health care providers to build their capacity to meet the requirements and expectations of different sub-populations of HIV-positive people. This includes not only physicians but also nurses and midwives, who are the primary caregivers in many resource-poor settings.

Conclusions: Supportive and knowledgeable providers are crucial for helping PLWH seek and adhere to treatment, prevent sexually transmitted infections, unintended pregnancies, and vertical transmission of HIV and support positives living free from stigma and discrimination. Providers, some of whom may themselves be HIV-positive, can make an important difference, especially if they are supported in their working conditions, are knowledgeable about HIV and sexual and reproductive health, and have the skills to provide good quality care.

Bodenlos, J.S., Grothe, K.B., Kendra, K., Whitehead, D., Copeland, A.L., & Brantley, P.J. (2004). Attitudes toward HIV Health Care Providers Scale: Development and validation. *AIDS Patient Care and STDs*, 18(12), 714-20.

Type: Evaluation of a stigma measurement tool

Background: Patient attitudes toward their health care providers can play an important role in determining health behavior change. The frequency of contact with health care professionals and disease stigma makes assessing patients' perception of this relationship of particular interest in an HIV medical population. While past general satisfaction and attitude tools have been used to assess this construct, there is a need for an assessment tool specific to patient attitudes in an HIV setting.

Methods: This study was designed to validate the Attitudes toward HIV Health Care Provider scale (AHHCP) in an HIV medical population.

Results/Findings: Principal components analysis of the AHHCP yielded a two-factor structure accounting for 53.3% of the total variance in attitudes toward health care providers. The two factors represented items concerning Professionalism and Emotional Support. The AHHCP was found to have good internal consistency (0.92) and convergent validity with a measure of patient satisfaction ($r = 0.59$).

Conclusions: The results of the present study suggest that the AHHCP is a reliable and valid instrument for use in assessing patient attitudes toward their health care providers.

Brooks, R.A., Etzel, M.A., Hinojos, E., Henry, C.L., & Perez, M. (2005). Preventing HIV among Latino and African American gay and bisexual men in a context of HIV-related stigma, discrimination, and homophobia: Perspectives of providers. *AIDS Patient Care and STDs*, 19(11), 737-44.

Type: Outcomes from a symposium

Background: HIV-related stigma, discrimination, and homophobia impede community-based efforts to combat HIV disease among Latino and African American gay and bisexual men.

Methods: This commentary highlights ways to address these social biases in communities of color in Los Angeles, California, from the perspectives of staff from HIV prevention programs. Information was collected from HIV prevention program staff participating in a 2-day symposium.

Results/Findings: The outcomes from the symposium offer strategies for developing and implementing HIV prevention services for Latino and African American gay and bisexual men, which include: (a) addressing social biases present in a community that can hinder, and even prohibit, utilization of effective HIV prevention programs; (b) recasting HIV prevention messages in a broader social or health context; (c) developing culturally appropriate HIV prevention messages; (d) exploring new modalities and venues for delivering HIV prevention messages that are appropriate for gay and bisexual men of color and the communities in which they live; and (e) broadening the target of HIV prevention services to include service providers, local institutions and agencies, and the community at-large.

Conclusions: The author found that the strategies for preventing HIV underscore the need to consider the social and contextual factors of a community when designing and implementing HIV prevention programs.

Brooks, R.A., Newman, P.A., Duan, N., & Ortiz, D.J. (2007). HIV vaccine trial preparedness among Spanish-speaking Latinos in the US. *AIDS Care*, 19(1), 52-8.

Type: Focus groups

Background: Latinos are under-represented in HIV/AIDS medical research in the United States. Although they are disproportionately impacted by HIV/AIDS, the researchers hypothesize that Latinos may be reluctant to participate in HIV vaccine trials.

Methods: Three focus groups were conducted with 32 Spanish-speaking Latinos recruited from two community-based healthcare organizations in Los Angeles, California. A qualitative focus group interview guide was developed to explore concerns, motivators, and intentions in regard to participation in HIV vaccine trials.

Results/Findings: The results indicate that mistrust and fear of government emerged as important themes related to reluctance to participate in an HIV vaccine trial. Specific concerns regarding trial participation included: (a) fear of vaccine-induced HIV infection, (b) physical side effects, (c) stigma and (d) false-induced HIV-positive test results and their social repercussions. Motivators for enrolling in an HIV vaccine trial included: (a) incentives, (b) convenience of participating in a study, (c) sufficient and appropriate study information, (d) personal benefits, and (e) altruism.

Conclusions: The article concludes that interventions to facilitate participation by Latinos in HIV vaccine trials should address mistrust and fear of government-sponsored HIV/AIDS

medical research, increase access to and convenience of clinical trials, address fear of vaccine-induced infection, combat HIV/AIDS stigma, and raise awareness of the relevance of HIV/AIDS to Latino communities.

Bunn, J.Y., Solomon, S.E., Miller, C., & Forehand, R. (2007). Measurement of stigma in people with HIV: A reexamination of the HIV Stigma Scale. *AIDS Education & Prevention, 19*(3), 198-208.

Type: Evaluation of a stigma measurement tool

Background: Stigma associated with HIV infection can unfavorably impact the lives and behavior of people living with HIV/AIDS (PLWHA). The HIV Stigma Scale was designed to measure the perception of stigma by those who are HIV infected.

Methods: Reanalysis of the psychometric properties of this scale was conducted in a new sample of 157 individuals living with HIV/AIDS in rural New England.

Results/Findings: This resulted in revision of the scale: shortening it from 40 to 32 items and retaining the original four factors but renaming one: Enacted Stigma (formerly Personalized Stigma), Disclosure Concerns, Negative Self-image, and Concern with Public Attitudes. These four subscales have been refined such that each consists of unique items. Cronbach's alphas for the subscales ranged from .90 to .97, and .95 for the overall scale, indicating internal consistency. Correlations with other scales confirmed the validity of the HIV Stigma Scale in another sample of people living with HIV/AIDS.

Conclusions: A more refined conceptualization and measurement of stigma (i.e., enacted stigma, disclosure concerns, negative self-image, and concern with public attitudes) may enable those who provide care to develop interventions to meet the needs of the affected population. In addition, an understanding of the lived experiences of PLWHA, including the stigma they report, may enhance the knowledge, empathy, and understanding of non-stigmatized providers and improve their ability to offer comprehensive, culturally competent care.

Buseh, A.G., & Stevens, P.E. (2006). Constrained but not determined by stigma: Resistance by African American women living with HIV. *Women & Health, 44*(33), 1-18.

Type: Longitudinal qualitative study

Background: HIV/AIDS-related stigma is widely regarded as a major obstacle to effective HIV prevention, risk reduction, testing, and treatment. Research is urgently needed to anticipate, understand, and combat HIV stigma in the African American cultural context because African Americans have the highest HIV incidence, HIV/AIDS prevalence, and HIV mortality. This article explores African American women's narratives of living with HIV to understand how they experienced and responded to HIV stigma.

Methods: Twenty-nine HIV-positive African American women participated in a longitudinal qualitative study. Each narrated her life since HIV diagnosis in ten open-ended interviews conducted over the course of two years. A multi-staged narrative analysis was used on the resulting data.

Results/Findings: Results of the study show the African American women who participated in the study experienced HIV/AIDS-related stigma on multiple levels, manifested internally as existential despair, socially as shunning and callousness, and institutionally as disregard.

Conclusions: While participants were constrained by this multi-layered hegemonic cultural negativity about HIV, the study indicates they refused to be determined by it. The women's stories demonstrate how they resisted stigma. Over time, by enlisting support, facing the illness, disclosing only at strategic times, redefining stigma as ignorance, and becoming advocates, the authors argue the women were able to challenge and oppose the shame and discredit which HIV infection had brought into their lives. The elements of stigma resistance described in this study may be starting points for designing participatory interventions for and with African American women living with HIV.

Cao, X., Sullivan, S.G., Xu, J., Wu, Z., & China CIPRA Project 2 Team. (2006). Understanding HIV-related stigma and discrimination in a "blameless" population. *AIDS Education & Prevention, 18*(6), 518-28.

Type: In-depth, qualitative interviews

Background: HIV/AIDS-related stigma and discrimination are major barriers to the successful prevention efforts. Stigma is associated with the disease, as well as the behaviors that lead to infection. The authors seek to identify the reasons, sources, and types of HIV/AIDS-related stigma prevalent in rural China.

Methods: Through a qualitative study, 80 in-depth interviews were conducted with people living with HIV/AIDS (PLWHA), their family members, health care providers, and other villagers in rural areas of China.

Results/Findings: The authors found that stigmatizing behaviors were primarily associated with fear of HIV rather than with the route of infection. The evidence indicates that the main source of stigma and discrimination were villagers who were not living HIV. However, health care workers and family members were also found to hold some stigmatizing attitudes. The results suggest that the primary concern for PLWHA in these villages is protecting their families, especially their children, from discrimination. Secondary stigma extended to HIV-negative members of the same village.

Conclusions: The authors indicate that these results should be used to develop an intervention to reduce fear of HIV transmission through casual contact, and therefore, to reduce stigma in these communities.

Carr, R.L., & Gramling, L.F. (2004). Stigma: A health barrier for women with HIV/AIDS. *Journal of the Association of Nurses in AIDS Care, 15*(5), 30-9.

Type: In-depth interviews and observation

Background: The authors contend that the stigma experienced by women with HIV/AIDS is much like that of Hester Prynne in *The Scarlet Letter*. At the time of diagnosis, women already are aware of the stigma associated with the disease. They immediately see themselves differently and believe others do as well. The purpose of this article is to explore the multidimensional effect of stigma on women's efforts to promote, maintain, and enhance their health.

Methods: An ethnographic methodology with repeated interviews and observation–participation was used to gather data. A purposive sample of nine European-American women with HIV/AIDS was recruited using volunteer and networking sampling techniques. In-depth interviews regarding the participants’ health-promoting lifestyles and observation–participation (Wilson, 1989) were conducted during a two-year period (1995 to 1997).

Results/Findings: The experiences of the women in this study tell of rejection by family members, friends, health care providers, employers, and church members. The authors indicate this rejection caused by stigma affects access to health care, medication adherence, social interaction, and social support.

Conclusions: The authors conclude interventions are needed to decrease the impact of stigma on women with HIV/AIDS so they can achieve a higher level of wellness, increase their life span, continue in the workforce, and improve their quality of life.

Chenard, C. (2007). The impact of stigma on the self-care behaviors of HIV-positive gay men striving for normalcy. *Journal of the Association of Nurses in AIDS Care, 18*(3), 23-32.

Type: Individual interviews and focus group

Background: Since the beginning of the AIDS epidemic in 1981, persons diagnosed with HIV have been the target of stigma. This is particularly significant for HIV-positive gay men who are also stigmatized because of negative societal views of homosexuality. The purpose of this grounded theory study was to examine the impact of stigma on the self-care behaviors of HIV-positive gay men.

Methods: A theoretical sample of 20 HIV-positive gay men participated in this study, consisting of 15 individual interviews and a focus group with 5 men.

Results/Findings: These men responded to HIV/AIDS stigma by using various stigma management strategies. Striving for normalcy emerged as the central theme. Participants saw HIV status disclosure as the main route to an affirming social support system and ultimately as a way to resolve any incongruence between self-view and reflected appraisals.

Courtenay-Quirk, C., Wolitski, R.J., Parsons, J.T., Gomez, C.A., & Seropositive Urban Men’s Study Team. (2006). Is HIV/AIDS stigma dividing the gay community? Perceptions of HIV-positive men who have sex with men. *AIDS Education & Prevention, 18*(1), 56-67.

Type: Questionnaire and semi-structured interviews

Background: Stigma surrounding HIV/AIDS has existed since the beginning of the epidemic, but little is known about HIV/AIDS-related stigma within the gay community and how it affects men who have sex with men (MSM) living with HIV. A better understanding of the effects of stigma on this population is needed to reduce it and its harmful effects.

Methods: This study created a questionnaire to collect data from 206 HIV-positive MSM and semi-structured interviews to collect qualitative data from 250 HIV-positive MSM to document beliefs about HIV/AIDS stigma within the gay community and to measure its effects on sexual risk behaviors, substance use behaviors, serostatus disclosure, and mental health.

Results/Findings: The results showed that stigma was associated with increased levels of anxiety, loneliness, depressive symptoms, engaging in avoidant coping strategies, and history of

suicidal ideation. HIV/AIDS-related stigma exists within the gay community and has a negative effect on the mental health of people living with HIV.

Conclusions: The authors contend that HIV/AIDS-related stigma in the gay community should be researched further and monitored closely to assess how it presents itself in the community, how it is experienced by HIV-positive MSM, how it is perceived and expressed in HIV-negative MSM. Through further research, the authors believe such information will lead better understand of how to create policy and programmatic interventions to mitigate the harmful affects of HIV/AIDS-related stigma.

Craft, S.M., Delaney, R.O., Bautista, D.T., & Serovich, J.M. (2007). Pregnancy decisions among women with HIV. *AIDS & Behavior, 11*(6), 927-35.

Type: Interviews and questionnaire

Background: Nearly 80% of women currently living with HIV are of childbearing age. As women of childbearing age continue to be at risk of contracting HIV, there will be an increased need for choices about whether or not to have biological children. The purpose of this exploratory study was to investigate the influence of partners, physicians, and family members on pregnancy decisions, as well as the impact of HIV stigma on these decisions.

Methods: Participants for this study came from a larger, longitudinal study of HIV disclosure and mental health. To be included, participants must have been women who were HIV-positive or had AIDS and were age 18 or older at the time of enrollment and must have been within the childbearing ages of 14–45 when diagnosed and completed all relevant questionnaires. A total of 81 women completed the questionnaire but only 74, or 91%, met the criteria for inclusion in the data analysis. Participants completed an initial interview and questionnaire to begin the study. Between each yearly wave of data collection, participants filled out a questionnaire every six months for 3 years.

Results/Findings: Results indicated that most women chose not to become pregnant since learning their HIV diagnosis and the woman's age at the time of diagnosis is significantly associated with this decision. Additional factors included fear of transmitting HIV to her child, personal health-related concerns, and desire to have children. Women with a procreative inclination were more likely to choose to become pregnant, which outweighed social support and personal health concerns.

Conclusions: Heterosexual women of childbearing ages represent the fastest rising at-risk group for HIV infection. The results of this study suggest that women chose not to become pregnant post diagnosis and the woman's age at the time of diagnosis is significantly associated with this decision. Additional factors included fear of transmitting HIV to her child, personal health-related concerns, and desire to have children. The study found women with a procreative inclination were more likely to choose to become pregnant, which outweighed social support and personal health concerns. The authors conclude clinicians should be aware of these issues and cognizant that patients and clients may be struggling with pregnancy related decisions. Accurate information delivered by informed professionals could be both helpful and reassuring to women.

Díaz, R.M., Ayala, G., & Bein, E. (2004). Sexual risk as an outcome of social oppression: Data from a probability sample of Latino gay men in three U.S. cities. *Cultural Diversity and Ethnic Minority Psychology, 10*(3), 255-67.

Type: Interviews

Background: Approximately 70% of new HIV infections are among African American and Latino individuals, two racial/ethnic groups that together constitute only 25% of the U.S. population (CDC, 2000). The present article investigates and documents the relation between individual experiences of oppression—both social discrimination and financial hardship—and sexual risk for HIV among a probability sample of Latino gay men in the United States.

Methods: Based on data from a probability sample of 912 Latino gay men in three U.S. cities, a multivariate model of sexual risk was tested, including experiences of homophobia, racism, and poverty as predictors. Interviews were conducted in person with 300 men in each city.

Results/Findings: Participants reported multiple instances of verbal and physical abuse, rude mistreatment, and discrimination on account of their sexual orientation and their race or ethnicity. Many reported experiences of poverty, such as inability to pay for basic necessities of food or shelter. Men who reported more instances of social discrimination and financial hardship were more psychologically distressed and more likely to participate in “difficult” sexual situations, as predicted. The findings suggest that the social and sexual lives of Latino gay men are affected not only by homophobia in their ethnic communities, but also by racism in a mostly White and middle-class mainstream gay community.

Conclusions: The findings suggest that participation in difficult sexual situations mediates the effects of social oppression and psychological distress on sexual risk behavior. The authors conclude that denouncing, resisting, and abolishing discriminatory practices are a clear path toward a more just and healthy society and perhaps the most important tool to fight diseases like HIV/AIDS that breed on social injustice, prejudice, and inequality. Potential interventions should emphasize the importance of situational factors as predictors of sexual risk in this population.

Elliott, R., Csete, J., Wood, E., & Kerr, T. (2005). Harm reduction, HIV/AIDS, and the human rights challenge to global drug control policy. *Health Human Rights, 8*(2), 104-38.

Type: Legal analysis

Background: The practice of unsafe drug injection is one of the principal drivers of the global HIV/AIDS pandemic, adding HIV infection to the list of harms associated with drug use.

Methods: This article brings together public health evidence and legal analysis as a contribution toward changing the global drug control regime to a more health-friendly, human rights-based system.

Results/Findings: HIV/AIDS has highlighted ways in which prohibitionist drug policy causes or contributes to such harms and focused attention on the international regime of illicit drug control. At the same time, HIV/AIDS has catalyzed the “health and human rights movement” to articulate legal and policy responses that both represent sound public health policy and fulfill human rights obligations recognized in international law; this necessarily includes scrutinizing the interpretation and implementation of the UN drug control conventions.

Conclusions: The authors suggest that joining human rights law with public health evidence can help shift global drug control policy away from the current, failed emphasis on prohibition to a more rational, health-promoting framework that is both pragmatic and principled.

Emler, C.A. (2007). Experiences of stigma in older adults living with HIV/AIDS: A mixed-methods analysis. *AIDS Patient Care & Studies*, 21(10), 740-52.

Type: Mixed method study

Background: Older adults are increasingly becoming impacted by HIV disease, both as newly infected individuals and as long-term survivors of HIV/AIDS living into older age. HIV-related stigma impacts the quality of life of all persons with HIV/AIDS. However, little is known about HIV-related stigma in older adults because many studies do not include older subjects or ignore age as a variable.

Methods: This mixed methods study examines the experiences of HIV-related stigma in a sample of 25 older adults with HIV/AIDS from the Pacific Northwest. Quantitative methods measured HIV-stigma and depression, while in-depth qualitative interviews captured the lived experiences of these individuals.

Results/Findings: Stigma was positively and significantly correlated with depression ($r = 0.627$, $p = 0.001$) and stigma was found to be significantly higher in African American, as compared to White, informants ($\chi^2(2) = 4.16$, $p = 0.041$). Qualitative interviews yielded 11 themes that correspond to the four categories constructed in the stigma instrument. Rejection, disclosure concerns, stereotyping, protective silence, and feeling “other” were all common experiences of these individuals.

Conclusions: The article contends that HIV stigma should be routinely assessed when working with older, HIV-positive clients and interventions should be tailored to the individual experiences of stigma.

Emler, C.A. (2006). An examination of the social networks and social isolation in older and younger adults living with HIV/AIDS. *Health Social Work*, 31(4), 299-308.

Type: Structured interviews

Background: This study examines social networks and social isolation in older (50 years or more) and younger (ages 20 to 39) adults with HIV/AIDS.

Methods: Interviews were conducted from 2000–2003 in collaboration with an AIDS services organization in the Pacific Northwest. A total of 88 individuals living with HIV/AIDS participated.

Results/Findings: Both groups’ social networks had similar patterns; however, older adults were more likely to live alone. More than 38 % of older adults and 54 % of older adults of color were at risk of social isolation compared with 25 % of those 20 to 39 years of age. Older men and older adults of color had significantly lower scores on the social network scale than others.

Conclusions: The author concludes that having a confidant and receiving instrumental support were significantly correlated with reduced HIV stigma. The author discusses the implications for social work practitioners and ways in which they can normalize HIV with this population.

Emlert, C.A. (2006). A comparison of HIV stigma and disclosure patterns between older and younger adults living with HIV/AIDS. *AIDS Patient Care and STDs*, 20(5), 350-8.

Type: Mixed method study

Background: Previous literature has suggested that older age is associated with increased HIV stigma and less disclosure of HIV status. This study examines the relationships between age, HIV-related stigma, and patterns of disclosure.

Methods: This mixed methods study examines the experiences of HIV-related stigma in a sample of adults with HIV/AIDS from the Pacific Northwest. Quantitative methods measured HIV-stigma and depression, while in-depth qualitative interviews captured the lived experiences of these individuals. Eighty-eight individuals, 44 between the ages of 20 and 39 and 44 aged 50 and over were recruited for the study. Subjects in each group were matched as closely as possible by gender, ethnicity, HIV exposure, and diagnosis.

Results/Findings: In a comparison of socio-demographic characteristics, older adults (50+) were significantly more likely to live alone and to be retired. Younger adults were significantly more likely to be never married/partnered, unemployed, and be recipients of Medicaid. Bivariate analysis revealed no significant differences in overall stigma scores between groups; however, younger adults were more likely to fear losing their jobs because of HIV. Older adults were less likely to disclose HIV to relatives, partners, mental health workers, neighbors, and church members than those 20–39 years of age. Pearson product moment correlations found disclosure to be significantly associated with time since diagnosis, heterosexual exposure, ethnicity, use of HIV services, and having a confidant. Stigma was associated with ethnicity, having a confidant, and instrumental social support. In a multiple regressions analysis, 48.4% of the variance in disclosure accounted for by time since first diagnosis, service use, and having a confidant. Service use was the only independent variable significantly associated with stigma, accounting for 21.6% of the variance.

Conclusions: The author concludes that generalizations outside Pacific Northwest cannot be made and additional research, including a larger, more representative sample from a broader geographic region and inclusion of people not currently linked to formal support systems may provide further insight to the relationship between age, disclosure, and stigma.

Fernandez, A.R., Keigher, S.M., & Stevens, P.E. (2006). Risk factors for HIV/AIDS among American Indian/Alaska Native women: One woman's story. *Journal of HIV/AIDS & Social Services*, 4(3), 63–86.

Type: Case study

Background: This article illuminates the main risks that American Indian/Alaska Native women face for contracting HIV and their challenges in living with HIV disease. The article explores potential venues for reaching Native women with culturally relevant prevention and intervention methods, emphasizing the importance of Native culture and spirituality.

Methods: The authors present a case study of one Native woman's experiences. The woman, a member of a Midwestern Indian tribe, was a participant in a larger in-depth qualitative longitudinal study of 55 women living with HIV.

Conclusions: The authors indicate the findings about her path to healing provide insights for understanding and serving this neglected ethnic population. Her words eloquently articulate the struggles of women of color living in dignity with HIV.

Foster, P.H. (2007). Use of stigma, fear, and denial in development of a framework for prevention of HIV/AIDS in rural African American communities. *Family & Community Health, 30*(4), 318-27.

Type: Proposed prevention framework

Background: The epidemiology and demographics of HIV/AIDS have evolved over the last 25 years in the United States to include more women and minority populations, especially Latinos and African Americans. In addition, there has been a shift in HIV/AIDS cases from large northeastern and western metropolitan areas to persons living in rural areas and the south. The reasons for the changes and the shift are unclear, but the author proposes major barriers to primary prevention strategies are most likely socio-cultural.

Methods: The author and her team conducted a multi-city HIV/AIDS outreach educational tour in the Alabama Black Belt region during November 2004 and October 2005. The approach was multifaceted involving all three levels of prevention: (a) primary education aimed at youth, college administrators, faculty, staff, and community persons through town hall meetings, press conferences, high schools and universities, a detention center, and a special health and wellness gospel concert, (b) secondary prevention aimed at early detection of HIV through testing at several events, and (c) tertiary prevention aimed at encouraging those who are HIV infected to lead healthy lifestyles through healthy eating, physical activity, adequate sleep, and compliance with antiretroviral medications. This article further explores stigma, fear, and denial (SFD) and develops a new theoretical framework to address these barriers using community-based, culturally competent approaches for rural African Americans.

Results/Findings: One of the most prominent themes the author identifies from the tour was there were many barriers in delivering HIV/AIDS prevention messages throughout many of the small rural communities; specifically, the themes of stigma, fear, and denial. Based on the experiences of the tour, the author presents a new approach or framework, interventions targeted at African Americans living in rural Alabama, for addressing these barriers. The author argues attention to such barriers must be paramount in design and implementation of programs. The framework is fueled through a prevention engine that supports the need for programs that eliminate SFD in a community-based and culturally competent manner, which favors design and implementation of programs led by community members who live in affected target populations, and that has social action as an important part of the process.

Conclusions: The author proposes this framework could also be used as a model for addressing HIV/AIDS in other communities, as well as addressing health disparities where stigma, fear, and denial may play a role, such as cancer, diabetes, heart disease, immunizations, and infant mortality. Issues of distrust, genocide, and conspiracy have begun to be addressed as barriers in African Americans; however, better characterization of SFD may be key in strategic prevention, particularly for those who reside in rural areas.

Green, D.A., Devi, S., & Paulraj, L.S. (2007). Care center visits to married people living with HIV: An indicator for measuring AIDS-related stigma & discrimination. *AIDS Care*, 19(7), 910-5.

Type: Observation

Background: The authors aim to determine if the presence and/or relationship of those who accompany individuals to an appointment is a indicator of care received or HIV/AIDS-related stigma and discrimination.

Methods: The authors hypothesized the presence and relationship of attendants (i.e. those that accompany upon admission) and visitors to a sample of 230 (128 male, 102 female) married HIV-positive people in an HIV care center provides an indicator of caregiving, AIDS-related stigma and discrimination. Sensitivity to gender, location (urban vs. rural), age (<35 yrs vs. >35) and source of infection (spouse vs. non-spouse) were factors considered to modulate HIV/AIDS-related stigma and assess discrimination.

Results/Findings: HIV-positive people were accompanied by their spouse (53%), mother (14%), father (7%), with only 7% attending alone. Immediate family most commonly accompanied on admission (80%), but visitors were mainly from the “extended” family (32%) with many receiving no visitors (48%). Females (11%) were more likely than males to attend alone (11% vs. 4%; $p < 0.05$). No effect of location, age or infector was obtained. Females were more likely to be visited by their mother (14% vs. 6%; $p < 0.01$) and non-immediate family (39% vs. 27%; $p < 0.05$) than males were. In contrast, fathers (0% vs. 6%; $p < 0.05$) and spouses were less likely (3% vs. 10%; $p < 0.05$) to visit females than males. No effect of location or age upon visitation was obtained. Non-spouse infected persons were less likely than spouse-infected to be visited by their spouse (3% vs. 10%; $p < 0.05$) but more likely to receive “extended” family visitation (43% vs. 24%; $p < 0.01$). Spouse-infected persons had a higher rate of no visitors than persons not infected by their spouse (54% vs. 40%; $p < 0.05$).

Conclusions: The evidence indicates that observation of the presence and relationship of attendants and visitors to HIV-positive people has potential as an indicator of caregiving HIV/AIDS-related stigma and discrimination. The measure appears particularly sensitive to the gender of the HIV-positive person. Such a measure may aid health care professionals to focus resources, such as relational counseling, upon the family and close friends of people experiencing HIV/AIDS-related stigma and discrimination, with the aim of improving the provision of care within the community.

Grusky, O., Roberts, K.J., Swanson, A.N., Joniak, E., Leich, J., McEvoy, G., et al. (2005). Anonymous versus confidential HIV testing: client and provider decision making under uncertainty. *AIDS Patient Care and STDS*, 19(3), 157-166.

Type: Direct field observation, semi-structured interviews, and document and policy analysis

Background: Testing is an important component of prevention programs designed to reduce the spread of HIV. The decision to test anonymously or confidentially is a complex interactional process involving individual clients, health care providers, and their testing organizations. Under anonymous testing identifying information is not collected from clients. To obtain their test results, clients receive unique numbers or codes. Unlike anonymous testing, confidential testing connects a client’s identity to his/her test result. Previous studies have not systematically

examined how HIV testing organizations' influence their health care providers, and, in turn, how the testing organization's requirements and their providers' influence client testing choices. Consequently, we know little about how the HIV testing system and providers influence client decision making with regard to anonymous vs. confidential testing.

Methods: This study undertook six intensive observational studies of HIV testing sites in order to improve understanding of confidential and anonymous testing. Three sites offered only confidential testing (a large health maintenance organization's Urgent Care clinic, the same organization's HIV clinic, and a private medical practitioner's office), one offered only anonymous testing (a free clinic), and two offered a choice of confidential or anonymous testing (a thrift shop alternate testing site and a mobile testing unit). Multiple data collection strategies were used, including direct field observation, semi-structured interviews with clients and providers, and document and policy analysis.

Results/Findings: Using an organizational/interactional uncertainty framework, this study found that the choice between anonymous and confidential testing is a central aspect of the HIV testing process, that some clients are unclear about the differences between anonymous and confidential testing, that alternate testing sites' providers play a significant role in encouraging confidential rather than anonymous testing in order to further their organization's resource needs and public health goals, and that testing counselors may consider that some clients prefer anonymous testing because of fear of stigma, discrimination, or loss of privacy.

Conclusions: The authors conclude that even though individuals may have their own reasons for wishing to test for HIV either anonymously or confidentially their choice may be influenced by the organization where that test occurs. Fear of stigma, discrimination, and loss of privacy are prime concerns for those who opt to test anonymously. Yet, the decision to test either anonymously or confidentially is complex, shaped not only by the needs and perceived fears of clients, but also by testing organizations' policies and rules, as well as by the physicians or testing counselors who carry out such rules while interacting with clients. The authors indicate testing counselors can help their organization obtain needed resources by encouraging confidential rather than anonymous testing.

Hamill, S., & Dickey, M. (2005). Cultural competence: What is needed in working with Native Americans with HIV/AIDS? *Journal of the Association of Nurses in AIDS Care*, 16(4), 64-9.

Type: Program design

Background: American Indian and Alaskan Native (AI/AN) people have a unique culture that is misunderstood by many health care professionals. The myriad ethnicities within the population labeled AI/AN or Native American makes it difficult to identify the scope of the HIV/AIDS problem under today's system of classification. Throughout the evolution of the health care system, AI/AN populations have experienced, as have other minorities, less than adequate attention with regard to specific and culturally appropriate treatment and prevention programs (Dickey, Tafoya, & Wirth, 2003). Perhaps nowhere is this more evident than in the area of HIV/AIDS prevention and treatment. Many health professionals estimate the number of AIDS cases among AI/ANs to be much higher than statistics are currently reporting and that the number of HIV cases could be as much as 10 times greater (Satcher, 2002). As with other

minority populations, there is still a great stigma associated with HIV/AIDS within AI/AN communities.

Results/Findings: This article reviews the risk factors and barriers associated with addressing HIV/AIDS in AI/AN communities and proposes recommendations to not only the risk factors and barriers, but also for program design.

Conclusions: The authors indicate providing health care professionals with avenues to achieve culturally competent health care practices are especially vital amid the current effort to eliminate health disparities. Among the AI/AN population, they indicate these disparities are because of (a) the lack of culturally specific training of health care professionals and health administrators serving these populations, and (b) the lack of funding provided for program development, data determination, and research (Dickey et al., 2003). The authors contend cultural differences affect who participates in health care and the quality of that health care, as well as adherence to medications and patient satisfaction. All of these factors indicate a need for effective risk reduction strategies, especially HIV prevention strategies (Dickey et al., 2003). The authors assert knowing the racial or ethnic background of patients/clients is not only important for understanding cultural characteristics but is also imperative for providing the highest quality of care.

Harawa, N.T., Williams, J.K., Ramamurthi, H.C., & Bingham, T.A. (2006). Perceptions towards condom use, sexual activity, and HIV disclosure among HIV-positive African American men who have sex with men: Implications for heterosexual transmission. *Journal of Urban Health*, 83(4), 682-94.

Type: Semi-structured focus group interviews

Background: Disproportionately high HIV/AIDS rates and frequent non-gay identification (NGI) among African American men who have sex with men or with both men and women (MSM/W) highlight the importance of understanding how HIV-positive African American MSM/W perceive safer sex, experience living with HIV, and decide to disclose their HIV status.

Methods: In this study, 30 predominately seropositive and non-gay identifying African American MSM/W in Los Angeles participated in three semi-structured focus group interviews. A constant comparison method was used to analyze responses regarding condom use, sexual activity after an HIV diagnosis, and HIV serostatus disclosure.

Results/Findings: The researchers identified several common themes as a result of the focus group interviews. Condom use themes included its protective role against disease and pregnancy, acceptability concerns pertaining to aesthetic factors and effectiveness, and situational influences, such as exchange sex, substance use, and suspicions from female partners. Themes regarding the impact of HIV on sexual activity included rejection, decreased partner seeking, and isolation. Serostatus disclosure themes included disclosure to selective partners and personal responsibility.

Conclusions: Comprehensive HIV risk-reduction strategies that build social support networks, condom self-efficacy, communication skills, and a sense of collective responsibility among NGI African American MSM/W while addressing HIV stigma in the African American community as a whole are suggested.

Hillman, J. (2007). Knowledge and attitudes about HIV/AIDS among community-living older women: Reexamining issues of age and gender. *Journal of Women & Aging, 19*(3-4), 53-67.

Type: Author abstract

Background: Although older women face unique risks related to HIV/ AIDS, little empirical data is available regarding HIV/AIDS among women over the age of 65.

Methods: For this study, 160 community-living older women and men completed questionnaires regarding knowledge and attitudes about HIV/AIDS.

Results/Findings: Findings showed that although older women were less likely to talk to their physician about HIV than men, they maintained greater knowledge and generally dispelled myths about viral transmission. However, most older women believed that HIV/AIDS had limited personal relevance, possessed virtually no knowledge of age and gender-specific risk factors, and professed HIV-associated stigma.

Conclusions: These findings highlight the need for gender and age-specific prevention programs.

Holzemer, W.L., Uys, L., Makoae, L., Stewart, A., Phetlhu, R., Dlamini, P.S., et al. (2007). A conceptual model of HIV/AIDS stigma from five African countries. *Journal of Advanced Nursing, 58*(6), 541-51.

Type: Focus groups

Background: This paper is a report on the development of a conceptual model delineating contexts and processes of HIV/AIDS stigma as reported by PLWHA and nurses from African countries. It is part of a larger study to increase understanding of HIV/AIDS stigma. Researchers have defined stigma, explored determinants and outcomes of stigma, and attempted to measure its multiple dimensions. This literature is difficult to synthesize, and often does not distinguish adequately between experiences of stigma and its causes and outcomes.

Methods: Forty-three focus groups were held with PLWHA and nurses in five African countries in 2004. Focus group recordings were transcribed and coded. The data were organized into a conceptual model of HIV/AIDS stigma.

Results/Findings: Two components were identified in the data: contextual factors—environment, healthcare system, agents—that influence and affect stigma and the stigma process itself. The stigma process included four dimensions: triggers of stigma, stigmatizing behaviors, types of stigma, and the outcomes of stigma.

Conclusions: A conceptual model is presented that delineates the dynamic nature of stigma as reported by study participants. The model may be used to identify areas appropriate for the design and testing of stigma reduction interventions that have a goal of reducing the burden of HIV/AIDS stigma.

Holzemer, W.L., Uys, L.R., Chirwa, M.L., Greeff, M., Makoae, L.N., Kohi, T.W., et al. (2007). Validation of the HIV/AIDS Stigma Instrument—PLWA (HASI-P). *AIDS Care*, 19(8),1002-12.

Type: Evaluation of a stigma measurement tool

Background: This article aims to develop and test of quantitative measure of HIV/AIDS stigma as experienced by people living with HIV/AIDS (PLWHA). This instrument was designed to measure perceived stigma, create a baseline from which to measure changes in stigma over time, and track potential progress towards reducing stigma.

Methods: The scale was developed in three phases from 2003-2006: generating items based on results of focus group discussions, pilot testing and reducing the original list of items, and validating the instrument. Data for all phases were collected from five African countries: Lesotho, Malawi, South Africa, Swaziland, and Tanzania. The instrument was validated with a sample of 1,477 PLWHA from all of the five countries.

Results/Findings: The sample had a mean age of 36.1 years and 74.1% was female. The participants reported they knew they were HIV-positive for an average of 3.4 years and 46% of the sample was taking antiretroviral medications. A six-factor solution with 33 items explained 60.72% of the variance. Scale alpha reliabilities were examined and items that did not contribute to scale reliability were dropped. The factors included: Verbal Abuse (8 items, alpha=0.886); Negative Self-Perception (5 items, alpha=0.906); Health Care Neglect (7 items, alpha=0.832); Social Isolation (5 items, alpha=0.890); Fear of Contagion (6 items, alpha=0.795); and Workplace Stigma (2 items, alpha=0.758).

Conclusions: The results indicate that although some features of stigma might be different across countries, core HIV/AIDS stigma is very similar. This also means that it might be possible for the instrument to be used in other African nations and elsewhere.

Kaljee, L.M., Green, M., Riel, R., Lerdboon, P., Tho le, H., Thoa le, T.K., et al. (2007). Sexual stigma, sexual behaviors, and abstinence among Vietnamese adolescents: Implications for risk and protective behaviors for HIV, sexually transmitted infections, and unwanted pregnancy. *Journal of the Association of Nurses in AIDS Care*, 18(2), 48-59.

Type: Qualitative interviews and surveys

Background: As rates of HIV/AIDS increase in Vietnam, there is a need for data on social relations and sexual risk and protective behaviors among Vietnamese adolescents in a context of rapid social and economic changes.

Methods: The authors conducted qualitative interviews with 159 Vietnamese adolescents living in Hanoi, Nha Trang City, and Ninh Hoa District and a survey of 886 adolescents in these same three sites.

Results/Findings: In the qualitative interviews, youths reported a strong adherence to ideals and values regarding abstinence outside of marriage. Youths reported low rates of engagement in vaginal, anal, and/or oral sex with a significant difference in reported behaviors between males (29/469, 6.2%) and females (7/416, 1.7%; $p = .000$). A total of 15 of 32 (46.9%) sexually active youths reported rarely or never using condoms. Females had significantly higher scores for perceived sexual stigma than males ($t = -10.22$ [95% confidence interval (CI); -3.72 to -2.52]; p

= .000) whereas males scored significantly lower than females on a scale of perceived self-efficacy for abstinence ($t = 5.31$ [95% CI; .27 to .59]; $p = .000$).

Conclusions: The stigmatization of sexual relations outside of marriage particularly for young women reinforces abstinence; however, these same values decrease adolescents' ability to obtain accurate information about sexuality and HIV and sexually transmitted infections and engage in safer sex.

Kang, E., Rapkin, B.D., & DeAlmeida, C. (2006). Are psychological consequences of stigma enduring or transitory? A longitudinal study of HIV stigma and distress among Asians and Pacific Islanders living with HIV illness. *AIDS Patient Care and STDs*, 20(10), 712-23.

Type: Longitudinal study

Background: Cross-sectional findings have shed considerable light on the relationships between illness stigma and psychological outcomes among persons living with HIV/AIDS in the United States. However, no studies have examined the possible long-term consequences of illness stigma on mental health among Asians and Pacific Islanders living with HIV/AIDS, a group particularly vulnerable to HIV stigma due to ingrained socio-cultural norms.

Methods: This two-year longitudinal study examined the relationship between five HIV-stigma factors (social rejection, negative self-worth, perceived interpersonal insecurity, financial insecurity, discretionary disclosure) and changes in psychological distress dimensions (self-esteem, hopelessness, dread, confused thinking, sadness, anxiety) among a convenience sample of 44 HIV-seropositive Asians and Pacific Islanders in New York City from 2002 to 2004.

Results/Findings: Researchers found undocumented Asians independently endorsed higher levels of perceived interpersonal insecurity and lower levels of self-esteem than documented participants at both baseline and two-year follow-up. Results from hierarchical multiple regression analyses indicated that baseline social rejection and perceived interpersonal insecurity were significantly associated with changes in self-esteem at two-year follow-up, controlling for baseline self-esteem and physical symptoms at follow-up. The study distinguished an interaction effect between baseline financial insecurity and discretionary disclosure was significantly associated with dread at two-year follow-up.

Conclusions: According to the authors, the findings highlight the importance of stigma reduction interventions that: (a) recognize multiple layers of stigma based sexual orientation, gender, and immigration status; and (b) address both individual and structural constraints that perpetuate HIV-stigma among Asians and Pacific Islanders in the United States.

Kang, E., Rapkin, B.D., Remien, R.H., Mellins, C.A., & Oh, A. (2005). Multiple dimensions of HIV stigma and psychological distress among Asians and Pacific Islanders living with HIV illness. *AIDS Behavior*, 9(2), 145-54.

Type: Cross-sectional study

Background: Asians and Pacific Islanders (APIs) living with HIV/AIDS in the United States are particularly vulnerable to HIV-related stigma largely due to ingrained socio-cultural norms that strongly associate HIV transmission with activities perceived to be immoral.

Methods: This cross-sectional study examined the relationship between five HIV-stigma factors and psychological distress among 54 HIV-seropositive APIs.

Results/Findings: The findings indicate social rejection, negative self-worth, perceived interpersonal insecurity, and financial security were all significantly associated with psychological distress. Results from hierarchical multiple regression analyses indicated that social rejection, negative self-worth, and perceived interpersonal insecurity significantly predicted psychological distress after control for physical symptoms and country of birth. Undocumented Asians endorsed higher levels of social rejection, negative self-worth, and perceived interpersonal insecurity than documented APIs.

Conclusions: The authors indicate the findings from this study are the first they are aware of to examine the psychosocial sequelae of illness stigma among HIV-seropositive APIs in the United States. They emphasize future studies examining mechanisms of psychological distress among HIV-seropositive APIs are needed.

Katz, S., & Nevid, J.S. (2005). Risk factors associated with posttraumatic stress disorder symptomatology in HIV-infected women. *AIDS Patient Care and STDS*, 19(2), 110-20.

Type: Self-report questionnaire

Background: An HIV diagnosis may be viewed as a traumatic event followed by continuous adjustment to a number of social, physical, and psychological losses. Prejudice and stigmatization often follow an HIV diagnosis, which makes HIV unique and unlike any other progressive incurable illness. It is also striking that even though women represent one of the fastest growing groups of people diagnosed with HIV, the majority of HIV-related studies have been conducted on gay, upper-middle class men. In addition, minority group membership predicted significantly poorer physical functioning and work-role functioning in a universally disadvantaged population diagnosed with HIV/AIDS. This study examined risk factors for posttraumatic stress disorder (PTSD) symptomatology in HIV-positive women.

Methods: The sample consisted of 105 HIV-positive women recruited from participating HIV-treatment centers in hospitals and community clinics in the New York City metropolitan area. The women who provided written consent and were at least 18 years of age were asked to complete a series of self-report questionnaires that comprised the study measures. The sample was predominantly minority (66% African American; 19% Hispanic/Latino) and of lower income level (90% < \$29,000 annual household income).

Results/Findings: Researchers found the magnitude of HIV-related PTSD symptoms was associated with a greater number of HIV-related physical symptoms, more extensive history of pre-HIV trauma, less perceived availability of social support, greater degree of perceived stigma, and greater degree of negative life events. Hierarchical multiple regression analysis revealed three individual predictors of PTSD symptomatology: total impact of negative life events, total stigma score, and total number of present symptoms. The authors determined stigma emerged as the strongest individual predictor. Social support failed to moderate relationships between PTSD symptomatology and HIV-related physical symptoms and negative life events.

Conclusions: These findings may inform helping professionals about risk factors associated with PTSD symptomatology in HIV-positive women.

Kaufman, C.E., Shelby, L., Mosure, D., Marrazzo, J., Wong, D., DeRavello, L., et al. (2007). Within the hidden epidemic: Sexually transmitted diseases and HIV/AIDS among American Indians and Alaska Natives. *Sexually Transmitted Diseases*, 34(5), 767-77.

Type: Literature and surveillance data review

Background: Sexually transmitted diseases (STDs) in American Indians and Alaska Natives (AI/AN) are an important public health concern, with reported case rates for Chlamydia, gonorrhea, and syphilis that are two to six times higher than rates in non-Hispanic Whites. Despite the high morbidity and economic costs of STDs for this population, current practices of screening, treatment, and follow-up in AI/AN communities appear to be suboptimal. This article reviews the epidemiology, research, and prevention programs for sexually transmitted diseases in AI/ANs. For the purposes of this article, “STDs” refer to Chlamydia, gonorrhea, syphilis, and HIV/AIDS.

Methods: The authors reviewed the current national and regional trends in STDs for AI/ANs from 1998–2004, peer-reviewed studies from January 1996 through May 2006, and reports, unpublished documents, and electronic resources addressing AI/AN STD prevention and control.

Results/Findings: STD prevalence among AI/ANs remains high. The results pertaining specifically to HIV/AIDS are highlighted. Based on review of surveillance data, researchers found AI/ANs experience a faster time course from initial diagnosis of HIV infection to AIDS-defining illness than any other racial group in the United States. They also experience one of the lowest survival rates after an AIDS diagnosis is made. Researchers indicate the categorization of articles during their literature review demonstrates a growing research effort on many dimensions of HIV/AIDS about AI/AN populations, though the number of articles is small and randomized control studies are all but absent.

Conclusions: The researchers conclude little is known about the application and efficacy of STD screening, treatment, and partner management programs specific to AI/AN communities. Factors that contribute to disparities that affect these communities and need to be considered in assessing these parameters include geographic isolation, poor access to health services, insufficient screening and partner management services, and unique social norms, stigma, and gender dynamics. The researchers assert fear of compromised confidentiality, cultural taboos, and complex financial and service relationships inhibit effective surveillance, prevention, and management. Their recommendations for STD control in this population include improved local surveillance and incorporation of existing frameworks of health and healing into prevention and intervention efforts. Research defining the parameters of cultural context and social epidemiology of STDs is also needed.

Kinsler, J.J., Wong, MD., Sayles, J.N., Davis, C., & Cunningham, W.E. (2007). The effect of perceived stigma from a health care provider on access to care among a low-income HIV-positive population. *AIDS Patient Care & Studies*, 21(8), 584-92.

Type: Prospective study

Background: Perceived stigma in clinical settings may discourage individuals living with HIV/AIDS from accessing needed health care services. Having good access to care is imperative for maintaining the health, well being, and quality of life of people living with HIV/AIDS (PLWHA).

Methods: The prospective study, which took place from January 2004 through June 2006, evaluates the relationship between perceived stigma from a health care provider and access to care among 223 low-income PLWHA in Los Angeles County.

Results/Findings: Approximately one-fourth of the sample reported perceived stigma from a health care provider at baseline and about one-fifth reported provider stigma at follow-up. The study also found that access to care among this population was low, as more than half of the respondents reported difficulty accessing care at baseline and follow-up. Perceived stigma was found to be associated with low access to care both at baseline and 6-month follow-up, even after controlling for socio-demographic characteristics and most recent CD4 count. These findings are of particular importance because lack of access or delayed access to care may result in clinical presentation at more advanced stages of HIV disease.

Conclusions: Interventions are needed to reduce perceived stigma in the health care setting. Educational programs and modeling of non-stigmatizing behavior can teach health care providers to provide unbiased care.

Lally, M.A., Montstream-Quas, S.A., Tanaka, S., Tedeschi, S.K., & Morrow, K.M. (2008). A qualitative study among injection drug using women in Rhode Island: Attitudes toward testing, treatment, and vaccination for hepatitis and HIV. *AIDS Patient Care and STDs*, 22(1), 53-64.

Type: Semi-structured interviews

Background: HIV and hepatitis C virus infection are serious and prevalent health conditions among many women who inject drugs. Among women in the United States, injection drug use is directly associated with 41% of HIV/AIDS cases while heterosexual transmission accounts for 55% of cases. Among injecting drug users (IDUs), HIV prevalence is cited as 25%, while the prevalence of hepatitis C has been cited as high as 90%-98% among persons who have injected drugs for several years. Hepatitis B prevalence among IDUs has been cited between 35%-70%; IDUs compose 15% of the total hepatitis B infection population.

Methods: Researchers conducted qualitative, individual semi-structured interviews with twenty injection drug using women. Women were recruited in 2000 at the women's branch of a state-funded, short-term drug treatment center in Rhode Island that offers treatment for adults seeking detoxification from alcohol, heroin, or other substances. Participants were interviewed by a female research assistant using a semi-structured qualitative interview agenda developed by the researchers. Demographic questions were asked of all participants via scripted questions in the face-to-face interviews.

Results/Findings: Researchers identified six primary barriers and facilitators for testing and receiving results and treatment for hepatitis and HIV, as well as for hepatitis vaccination. The primary barriers were prioritization of drug use; low level of disease-specific knowledge; stigmatization; accessibility of testing, results and treatment; and psychological factors. The primary facilitator was interest in promoting one's health. The authors assert that injection drug using women experience multiple barriers to HIV and hepatitis testing, results, treatment, and vaccination.

Conclusions: The authors describe insight into a hard-to-reach population, but argue further investigation of substance abusing women's readiness for testing and receiving results and treatment for hepatitis and HIV and getting vaccinated for hepatitis is warranted. They suggest

methods need to be utilized for improving the motivators for health, facilitating infectious disease prevention, and decreasing unnecessary disease complications of injection drug using women. These should include strategies that minimize stigma and facilitate accessibility of health care.

Lam, P.K., Naar-King, S., & Wright, K. (2007). Social support and disclosure as predictors of mental health in HIV-positive youth. *AIDS Patient Care & Studies*, 21(1), 20-9.

Type: Clinical intervention trial

Background: Youth between the ages of 15 and 24 years account for nearly half of all new HIV infections worldwide. Enduring serious psychosocial distress during a critical developmental stage, such as adolescence, may have more enduring consequences. HIV-positive youth are not only undertaking the inevitable biologic, cognitive, and social developmental challenges of adolescence and young adulthood, but are also enduring the challenges of managing a chronic illness with myriad physical and psychosocial barriers. This study aims to describe mental health symptoms of HIV-positive youth and evaluates social support, disclosure, and physical status as predictors of symptoms.

Methods: In a sample of 66 HIV-positive youth (ages 16–25), participants were enrolled in a larger clinical intervention trial. The findings presented here report on baseline data, which were collected from January 2002 to May 2003. Participants were recruited from an adolescent HIV clinic within a tertiary care children's hospital located in a major metropolitan area. Data were using the Brief Symptom Inventory (BSI).

Results/Findings: The evidence shows that 50% of the youth scored above the cutoff for clinically significant mental health symptoms, thus highlighting the need for mental health services among this population. Lower social support, higher viral load, HIV-status disclosure to acquaintances, and being gay/lesbian/bisexual (GLB) were all significantly correlated with more mental health symptoms, but disclosure to family and close friends and contact with service providers were not. Furthermore, regression analysis showed that social support, viral load, and disclosure to acquaintances predicted 32% of the variance in mental health symptoms.

Conclusions: The authors found that being GLB was no longer significant, most likely because of shared variance with low social support. Results suggest the importance of mental health interventions, and the potential of social support interventions to improve mental health. The authors conclude further research is warranted addressing the role of HIV-related stigma and homophobia.

Lawson, P.J., Amatya, A., Mahat, E., Lohar, I., Devkota, S., & Pokharel, B. (2004). *Injection drug users as leaders for effective HIV programs and policies*. Paper presented at the International Conference on AIDS, Bangkok, Thailand.

Type: Author abstract

Background: The project described was designed to build leadership and advocacy skills of injection drug users (IDUs) to participate meaningfully in policymaking; support decision makers to improve understanding of IDU issues and build effective partnerships; and increase

understanding of how HIV/AIDS and drug use-related stigma and discrimination impact the provision of services for drug users and HIV/AIDS programs.

Methods: During the 1st National IDU Consultation Meeting, IDUs came together for the first time to discuss the situation and needs in Nepal. Focus groups in eight districts assessed stigma and discrimination and training needs. IDUs developed and implemented a training curriculum by and for IDUs and replicated it in other districts. IDUs organized and advocated for specific policy and service delivery change with the CCM and governmental, donor, and service bodies.

Results/Findings: Based on project evaluations, IDUs perceived, for the first time, that they were valued and needed and had skills to help others. IDUs can be mobilized with extensive support to address behavior change, relapse, HIV, skills, knowledge, and peer support.

Conclusions: The authors conclude that a satisfactory response to the HIV/AIDS epidemic for and from IDUs requires both a large-scale programmatic response and a supportive policy environment that allows exploration and adoption of effective methods. To achieve this, it is critical that IDUs themselves are involved in decision making. Meaningful involvement of IDUs as leaders is essential for changing behavior, perceptions, and stigma and discrimination.

Lekas, H.M., Siegel, K., & Schrimshaw, E.W. (2006). Continuities and discontinuities in the experiences of felt and enacted stigma among women with HIV/AIDS. *Qualitative Health Research* 16(9), 1165-90.

Type: Focused interview

Background: In the post-1996 era, the effectiveness of antiviral therapies (such as highly active antiretroviral therapy [HAART]), which transformed HIV/AIDS into a more manageable disease, raised expectations that the disease's stigma would decrease. Although most of the studies that examine the gender- and race-related differences in stigmatization are based on data collected after the advent of HAART and other effective antiviral therapies, they do not have data from the pre-HAART era and, therefore, cannot contribute to our understanding of why HIV stigma has persisted into the HAART era.

Methods: The authors compared focused-interview data from a pre-HAART (1994 to 1996) and a HAART-era (2000 to 2003) sample of African American, Puerto Rican, and White women living with HIV/AIDS to identify changes in stigma experiences and suggest reasons for continued stigmatization.

Results/Findings: In both eras, researchers identified general stereotypes about HIV/AIDS, as well as gender- and race-related stereotypes about the disease. Internalizing any of these stereotypes was a necessary and sufficient condition for feeling stigmatized. Researchers indicated instances of enacted stigmatization were more frequent and intense in the pre-HAART era. Nevertheless, misinformation and irrational fears of contagion, which triggered stigmatizing behavior, persisted into the HAART era. Researchers recognized that although enacted stigmatization has decreased slightly, felt stigma remains a primary adaptational challenge facing women with HIV/AIDS.

Conclusions: The authors describe two main implications related to the findings. First, by providing an example of how the different meanings groups assign to a situation influence their stigma experience, they promote understanding of the variability in felt stigma among groups that share the same stigmatizing condition. Second, the analysis of the significance of race-

related interpretations of HIV stigma might also contribute to the current debate on whether non-White women with the disease or their White counterparts are more vulnerable to stigmatization because of their race.

Letteney, S., & LaPorte, H.H. (2004). Deconstructing stigma: Perceptions of HIV-seropositive mothers and their disclosure to children. *Social Work Health Care*, 38(3), 105-23.

Type: Stigma scales

Background: This study addressed the perceptions of stigma and disclosure behavior of HIV-seropositive mothers.

Methods: Eighty-eight HIV-seropositive women in New York City completed two independent measures of stigma, the Perceived Stigma Scale and the Devaluation-Discrimination Measure.

Results/Findings: Disclosers (67%) and non-disclosers (33%) were similar in most socio-demographic characteristics—marital status, race, religion and employment, with the exception of age and education. Researchers identified significant differences between disclosure groups in the use of secrecy as a stigma management tool and in perceived devaluation-discrimination associated with an HIV-diagnosis. Non-disclosers to children were significantly more likely than disclosers to use secrecy as a stigma management tool and to feel devalued and discriminated against as a result of HIV serostatus.

Conclusions: Disclosure of parental HIV serostatus to children is an important aspect of continuous care and custody planning. The authors determined that secrecy and perceptions of devaluation and discrimination related to HIV diagnosis should be seen as barriers to disclosure of serostatus to children.

Levy, V., Prentiss, D., Balmas, G., Chen, S., Israelski, D., Katzenstein, D., et al. (2007). Factors in the delayed HIV presentation of immigrants in Northern California: Implications for voluntary counseling and testing programs. *Journal of Immigrant & Minority Health*, 9(1), 49-54.

Type: Interviews

Background: Immigrants to the United States encounter barriers in accessing health care for a variety of reasons. In the case of HIV, later diagnosis postpones access to antiretroviral treatment (ART) and prophylaxis and increases the likelihood of further chains of HIV transmission through prolonged undiagnosed HIV infection. The objectives of this study are to determine if immigrants present later for care compared to other HIV infected persons in San Mateo County, located in northern California, and to describe the possible reasons for delayed presentation as identified in interviews with recently HIV-diagnosed Hispanics. An understanding of the causes of delayed presentation may be used to enhance prevention programs for immigrants.

Methods: To describe the determinants of delayed HIV presentation in one Northern California County, the authors identify persons with an opportunistic infection (OI) at HIV diagnosis. From 2000-2002, a sample of HIV patients attending a public AIDS program (n=391) were identified. They then conducted interviews with 20 newly diagnosed Hispanic patients.

Results/Findings: Immigrants comprised 24% of our sample; 78.7% of immigrants were Hispanic. Immigrants, compared to U.S.-born patients, presented with lower initial CD4+ counts

at diagnosis than U.S.-born patients (287 cells/mm³ vs. 333 cells/mm³, p=0.143), were more likely to have an OI at HIV diagnosis (29.8% vs. 17.2%, p=0.009), and were more likely to be hospitalized at HIV diagnosis (20.2% vs. 12.5%, p=0.064). The researchers found only immigrant status was significantly and independently associated with delayed presentation.

Conclusions: The findings suggest lack of knowledge regarding HIV risk, social stigma, secrecy, and symptom driven health seeking behavior all contribute to delayed clinical presentation. The main precipitants of HIV testing for immigrants were HIV/AIDS-related symptoms and sexually transmitted infection (STI)/HIV diagnosis in a sexual partner. These results support augmentation of STI/HIV voluntary clinical testing and partner notification services along the Mexico-California migrant corridor.

Li, L., Lin, C., Wu, Z., Wu, S., Rotheram-Borus, M.J., Detels, R., et al. (2007). Stigmatization and shame: Consequences of caring for HIV/AIDS patients in China. *AIDS Care*, 19(2), 258-63.

Type: Cross-sectional study

Background: The HIV/AIDS epidemic has increased the demand for medical care worldwide. Health service workers play an important role in the battle against HIV/AIDS by providing testing, care, and treatment for people living with HIV/AIDS (PLWHA). However, HIV/AIDS-related stigma has extended itself to health care providers treating and caring for PLWHA.

Methods: Using a representative sample of 478 doctors, nurses, and lab technicians working with PLWHA, a cross-sectional study was conducted to assess the impact of the AIDS epidemic on medical care systems and service providers in China.

Results/Findings: Correlation analyses showed significant association between internalized shame reported by service providers and their perception of being stigmatized due to working with PLWHA. Multivariate analyses revealed that the perceived level of institutional support for AIDS care was significantly related to the stigmatization and shame reported by the service providers.

Conclusions: The study findings suggest that improved institutional support for AIDS care at the facility level and HIV/AIDS-related stigma reduction intervention are crucial to maintain a high quality performance by the workforce in the health care system.

Mak, W.W., Cheung, R.Y., Law, R.W., Woo, J., Li, P.C., & Chung, R.W. (2007). Examining attribution model of self-stigma on social support and psychological well-being among people with HIV+/AIDS. *Social Science & Medicine*, 64(8), 1549-59.

Type: Prospective design study

Background: HIV/AIDS is considered to be one of the most stigmatized health conditions. The article tested the attributional pathway from perceived control to responsibility to self-blame and, finally, to self-stigmatization among people living with HIV/AIDS (PLWHA). The article also seeks to examine the social and psychological sequelae of stigma among this group.

Methods: The method was a prospective design with a sample of 119 PLWHA in Hong Kong, China.

Results/Findings: Using structural equation modeling, the findings indicated that the model had good fit to the data and the linkage between the attributions of control, responsibility, and self-blame. However, the relationship from blame to self-stigma was not significant. That said, it is important to note that self-stigma was found to dampen social support and led to psychological distress half a year after an HIV-positive diagnosis.

Conclusions: The authors challenged the adequacy of attributional factors in understanding self-stigmatization and demonstrated the impact of stigma on the psychological adjustments among PLWHA.

Mateu-Gelabert, P., Maslow, C., Flom, P.L., Sandoval, M., Bolyard, M., & Friedman, S.R. (2005). Keeping it together: stigma, response, and perception of risk in relationships between drug injectors and crack smokers, and other community residents. *AIDS Care*, 17(7), 802-13.

Type: Survey, observational, in-depth interviews, and focus groups

Background: Sexual relations between injection drug users (IDUs) and crack smokers (CSs), and non-drug users are a major means of HIV transmission to the general public. However there is little literature describing community processes that regulate sexual and social partnerships among these groups. The authors describe the relationships between IDUs and CSs in Bushwick, a low-income, mainly Latino neighborhood in Brooklyn, NY. In this community, IDUs and CSs are heavily stigmatized, both by non-users and by some users. Known IDUs & CSs may find it harder to start and maintain social and sexual relationships and to get jobs or support. Partially as a result of this stigma, IDUs & CSs attempt to “keep it together” and hide either their drug use or its extent from other residents. Nevertheless, other residents believe, sometimes falsely, that they can distinguish users from nonusers. The authors describe some potential negative consequences of these beliefs and interactions, including their effects on risk for HIV and other sexually transmitted infections (STIs).

Methods: Quantitative analyses are based on the Drug Use and HIV Risk Among Youth (DUHRAY) study conducted between 1997 and 2000 in Bushwick, with a population of approximately 100,000. The DUHRAY project surveyed two groups of 18- to 24-year-old residents: a probability sample of household youth, and a targeted sample of youth who use cocaine, heroin, crack, and/or injected drugs. The LOCO (Local Context, Social Control Actions and HIV Risk) project was an ethnographic study conducted in Bushwick between November 2000 and April 2004, and was based on field observations, in-depth interviews, and focus groups. In part because only one group was held for each focus group type, these data were triangulated with the life history interviews and the survey data.

Results/Findings: The concept of “keeping it together” emerged from the focus groups and interviews. Keeping it together is a by-product of the efforts by non-users to identify and isolate users, and efforts by users to remain socially accepted while continuing their use. The majority of young adults in Bushwick view drug users negatively, especially heroin and crack users. This stigma attached to associating with users is even stronger when it comes to romantic or sexual relationships. Many users themselves have negative perceptions and distrust of other users. Residents base judgments about drug users on a variety of factors, including failure to take care of kids, living in particularly poor housing, sporadic selling of household and personal items, poor hygiene, and dirty or unkempt appearance. However, these community-developed methods

of identifying users are based on features and behaviors that characterize the most visible drug users and can be misleading. Similar to strategies used by other groups at risk of being stigmatized (e.g. “the down low” among African American males attempting to “pass” as heterosexual), “keeping it together” is, in part, an attempt by users to “pass” as non-users in order to avoid stigma.

Conclusions: The authors recognize the effects that these community dynamics may have on HIV risk and prevention are difficult to disentangle and assess. They may be positive and negative in terms of their impact on drug use and HIV/STI risk. “Keeping it together” involves managing the amount of drug intake and maintaining social responsibilities. The authors argue it therefore may help to control the impact of drug use on IDUs. However they acknowledge, because “keeping it together” often entails hiding drug use from others, opportunities for community social support and intervention with users are missed, while at the same time the likelihood of unsafe sex between users and non-users remains unchecked. Ironically, the very strategies being used to elude the stigma associated with negative effects of drug use may, in fact, be helping to perpetuate one of its most unfortunate consequences. The authors reflect that by stigmatizing and ostracizing users rather than providing an atmosphere in which this high-risk group can openly ask for and receive appropriate services, non-users may unwittingly be perpetuating not only the users’ risk of HIV and other associated diseases, but their own risk as well.

Melendez, R.M., & Pinto, R. (2007). ‘It’s really a hard life’: Love, gender and HIV risk among male-to-female transgender persons. *Culture, Health & Sexuality*, 9(3), 233-45.

Type: In-depth interviews

Background: Scientific studies demonstrate high rates of HIV infection among male-to-female (MTF) transgender individuals and that stigma and discrimination place MTFs at increased risk for infection. However, there is little research examining how gender roles contribute to HIV risk.

Methods: This paper reports on in-depth interviews with 20 MTFs attending a community clinic. A model illustrating how HIV risk is generated from stigma and discrimination is presented.

Results/Findings: Data reveal that stigma and discrimination create a heightened need for MTFs to feel safe and loved by a male companion and that in turn places them at a higher risk for acquiring HIV. Male-to-female transgender individuals appear to turn to men to feel loved and affirmed as women; their main HIV risk stems from their willingness to engage with sexual partners who provide a sense of love and acceptance but who also may also request unsafe sexual behaviors.

Miles, M.S., Holditch-Davis, D., Pedersen, C., Eron, J.J., Jr., & Schwartz, T. (2007). Emotional distress in African American women with HIV. *Journal of Prevention & Intervention in the Community*, 33(1-2), 35-50.

Type: Article abstract

Background: This study identified factors associated with emotional distress in 109 African American women living with HIV. The relationship of personal factors (demographic, social conflict, social support, and spirituality), health-related factors (perception of health, physical and mental health problems, and years diagnosed), and cognitive/coping responses (stigma, worry, and emotion-focused coping) on depressive symptoms and mood state was examined.

Results/Findings: Researchers found younger age, more social conflict, less social support, lower perception of health, and more HIV-related worry were associated with higher depressive symptom scores. Variables most often affecting various mood states included personal factors (public housing, unemployment, and social conflict) and worry about having HIV.

Moutsiakis, D.L., & Chin, P.N. (2007). Why Blacks do not take part in HIV vaccine trials. *Journal of the National Medical Association, 99*(3), 254-7.

Type: In-depth ethnographic interviews

Background: AIDS is still a major cause of death. To combat this disease, researchers are developing a vaccine. Although African Americans account for most new infections in the United States, they account for a low percent of experimental vaccine recipients. This study, conducted in a mid-sized U.S. city where vaccine trials are held, seeks to learn why.

Methods: Researchers conducted 11 in-depth ethnographic interviews. Two groups were targeted: African Americans who had not participated in HIV vaccine trials and African Americans who had.

Results/Findings: Overall, three major causes of nonparticipation were identified: misinformation, fear/mistrust, and stigma. The study also identified factors that favored participation included having close friends with HIV and being homosexual.

Conclusions: According to the study, HIV is considered by many African Americans to be a gay, White disease. The author asserts steps to increase participation must include efforts to destigmatize the condition and disseminate accurate information. Efforts to address historical causes of mistrust through “education” alone are insufficient. Trust needs to be earned through long-term relationships with African American communities.

Murphy, D.A., Austin, E.L., & Greenwell, L. (2006). Correlates of HIV-related stigma among HIV-positive mothers and their uninfected adolescent children. *Women & Health, 44*(3), 19-42.

Type: Questionnaire

Background: This study examines the degree and impact of HIV-related stigma among HIV-positive mothers and their uninfected children.

Methods: One hundred eighteen HIV-infected mothers and their uninfected early- and middle-adolescent children (mean age=13 years) participated in a study of maternal mental and physical health and child school performance and psychological distress. Mothers and a subset of children (to whom the mother’s HIV status had previously been disclosed) were administered a series of questions to measure stigma related to the mother’s HIV status.

Results/Findings: The authors describe mothers reporting high levels of HIV-related stigma scored significantly lower on measures of physical, psychological, and social functioning. They

also indicate mothers' levels of depression were significantly higher when their levels of stigma were higher. No significant differences were found in children's depression by perceived level of stigma; however, adolescents who perceived high levels of stigma because of their mothers' HIV status were more likely to participate in delinquent behavior, compared with those reporting low HIV-related stigma.

Conclusions: The authors determined the experience of stigma had consequences for many aspects of well-being among the HIV-positive mothers. While their children were aware of and perceived stigma, they appeared to be affected primarily in the realm of delinquent behavior.

Naar-King, S., Bradford, J., Coleman, S., Green-Jones, M., Cabral, H., & Tobias, C. (2007). Retention in care of persons newly diagnosed with HIV: Outcomes of the Outreach Initiative. *AIDS Patient Care and STDS*, 21(1), 40-8.

Type: Medical chart review and interviews

Background: The purpose of this study was to contribute to the limited literature on newly diagnosed persons living with HIV/AIDS (PLWHA) by describing their retention in HIV primary care and changes in barriers to care over 12 months of follow-up subsequent to enrolling in outreach interventions.

Methods: Medical chart review and interview data were collected from 104 newly diagnosed PLWHA at baseline, 6-month, and 12-month follow-up.

Results/Findings: Researchers reported almost all newly diagnosed PLWHA (92%) had an HIV care appointment in the 6 months post-enrollment. Newly diagnosed persons were more likely to have undetectable viral loads at 6- and 12-month follow-up compared to baseline with 45% undetectable by 12 months. Adequate retention in care (at least one appointment in each 6-month window) was significantly associated with reductions in substance use and improvements in insurance coverage. Improvements in mental health status and the elimination of stigma as a barrier were not associated with retention, but those who reported stigma as a barrier at baseline and continued to report stigma at 6 months had less than adequate retention.

Conclusions: The authors determined the results of the study assert the need for early and intensive outreach interventions for newly diagnosed persons. They suggest future directions, which include testing outreach interventions in a randomized clinical trial, evaluating programs that integrate early HIV identification, and intensive outreach to enroll and retain newly diagnosed persons.

Nyblade, L., & McQuarrie, K. (2006). *Can we measure HIV/AIDS-related stigma and discrimination? current knowledge about quantifying stigma in developing countries*. Washington, DC: U.S. Agency for International Development.

Type: Literature review and evaluation of tools to measure stigma

Background: HIV/AIDS-related stigma and discrimination (S&D) have accompanied the epidemic from the start. Fear of and actual experience with stigma and discrimination reduce an individual's willingness to practice prevention, seek HIV testing, disclose his or her HIV status to others, ask for (or give) care and support, and begin and adhere to treatment. As efforts to address S&D increase, so does the need for a set of standard tested and validated S&D

indicators. Yet measures that can both describe an existing environment, and evaluate and compare interventions, are lacking. This report provides examples to quantitatively measure HIV/AIDS-related stigma in an effort to help practitioners, policymakers, and donors evaluate their programs.

Methods: The report is based on findings and recommendations are from a study in Tanzania that tested a number of potential quantitative measures for stigma. Questions that were used in other studies to quantitatively measure HIV stigma were obtained through a review of published literature and from a request for unpublished studies. These questions were reviewed for this report.

Results/Findings: Indicators are organized around four key domains: (a) fear of casual transmission and refusal of contact with people living with HIV and AIDS, (b) values (shame, blame and judgment), (c) enacted stigma (discrimination), and (d) disclosure. These domains are based on the existing body of HIV S&D knowledge and help provide a comprehensive measure of HIV S&D.

Conclusions: The authors conclude that more work is needed to use quantitative measures to describe the state of S&D in any given setting with confidence and clarity or to draw comparisons across settings. In particular, they state the following next steps are necessary: Capture stigma's multiple domains; test the viability of a standard set of quantitative measures; standardize and refine wording of data collection items; design appropriate questions for surveys; and develop indicators for understudied aspects of stigma.

Nyblade, L.C. (2006). Measuring HIV stigma: Existing knowledge and gaps. *Psychology Health & Medicine, 11*(3), 335-45.

Type: Literature review

Background: The growing recognition of the reduction of HIV stigma as central to effective programs across the HIV/AIDS prevention to care and treatment continuum is leading to an increasing number of programs focused on stigma reduction. Correctly evaluating the impact of these programs depends on having a good set of measures that effectively capture and distinguish the complexities of HIV stigma.

Methods: The author reviewed existing literature on HIV stigma measurement and identified key gaps that remain.

Conclusions: The author concludes that there is a need for measures at the general population level that are unambiguous about the cause of the stigmatizing behavior, that capture enacted stigma (discrimination), and that can distinguish compound (layered) stigma. In addition, studies are needed in a wider variety of contexts and on a larger scale that include a comprehensive set of measures to capture the complexity of HIV-related stigma and ensure appropriate evaluation of stigma-reduction programs.

Ogden, J., & Nyblade, L. (2005). *Common at its core: HIV-related stigma across contexts*. Washington, DC: International Center for Research on Women.

Type: Research synthesis

Background: HIV/AIDS-related stigma and discrimination together have long been recognized as the main obstacles to the prevention, care, and treatment of HIV/AIDS. Yet little has been done on a large scale to combat them. There are many reasons for this inaction, including the belief of many policymakers that stigma is hard to define and measure, making it difficult to design and implement interventions. Stigma, it is believed, is too cultural, too context-specific, and too sensitive to be addressed meaningfully.

Methods: This report is a synthesis of findings from research in four countries and presents evidence suggesting that HIV/AIDS-related stigma is far less varied and context-specific than may have been imagined.

Results/Findings: In spite of different contexts, the four countries where the studies took place share key features that shape the nature and forms of HIV/AIDS-related stigma. The authors suggest there are many more similarities than differences across these contexts in the key causes of stigma, the forms stigma takes, and the consequences of stigma.

Conclusions: These findings open a number of important avenues for intervention. It is time to make a concerted effort against stigma and discrimination in order to progress in the fight against HIV/AIDS. The authors offer a discussion of the way forward and an overview of the two anti-stigma toolkits that grew out of the projects' findings: one that is suitable to many African settings; and one that is tailored for Vietnam but suitable for adaptation elsewhere in the Asian region.

Organista, K.C., Carrillo, H., & Ayala, G. (2004). HIV Prevention with Mexican migrants: Review, critique, and recommendations. *Journal of Acquired Immune Deficiency Syndromes*, 37(4), S227-39.

Type: Literature review

Background: Mexican migrants are defined here as individuals from Mexico who come to live and/or work in the United States for varied but generally time-limited stays. In contrast, the term Mexican immigrant refers to those who move to the United States with the intention of permanent settlement. These forms of human movement occur in the context of different rules of sexual and social interaction and pronounced processes of social and cultural change in Mexico and the United States. The complexity of factors that may influence sexual and drug-related behaviors under these circumstances underscores the need for HIV prevention researchers to transcend a sole focus on individual factors, such as HIV knowledge, attitudes, beliefs, motivations, and intentions, so as to consider broader social and cultural phenomena influencing HIV risk in Mexican migrants.

Methods: For this article, the authors reviewed the HIV prevention outcome literature on Mexican migrants to identify gaps and to recommend research directions that build on individual level approaches by considering the social, cultural, and sexual contexts of HIV risk, as well as ways in which structural and environmental factors influence patterns of risk.

Results/Findings: This review of the HIV prevention literature on Mexican migrants reveals an under-researched area with serious gaps in our basic understanding of the structural factors that create risky environments for Mexican migrants.

Conclusions: The following broad observations and conclusion were made from this review: (a) There is little research on this specialized topic of concern; (b) the research that exists reflects an overly individualistic behavioral science approach designed to reduce individual risk factors,

with little regard for structural and environmental factors that influence HIV risk; and (c) there is a compelling need to develop better theoretic frameworks for understanding the complex and dynamic social and cultural processes influencing sexual behavior among Mexican migrants so as to better inform HIV prevention efforts with this unique and diverse Latino(a) population.

Ostrom, R.A., Serovich, J.M., Lim, J.Y., & Mason, T.L. (2006). The role of stigma in reasons for HIV disclosure and non-disclosure to children. *AIDS Care, 18*(1), 60-5.

Type: Questionnaire and guided interview

Background: Given that approximately 80% of women with AIDS are within their reproductive years (Siegel & Schrimshaw, 2001), uncertainty about the future can include concern about who will take care of their children should they become incapacitated or die (Reyland et al., 2002). This additional stress can directly impact both the family and children, particularly when women must 'hide' their illness to protect their children. Mothers living with HIV may also face the realities of the stigma associated with HIV. This study examines how stigma may impact HIV-positive women's disclosure to their children.

Methods: Participants included women living with HIV recruited from AIDS services organizations located in large midwestern cities. Using a questionnaire and guided interview, quantitative data were obtained regarding perceived HIV-related stigma and rates of maternal disclosure to children aged 5–18.

Results/Findings: The authors assert the most strongly endorsed reasons for non-disclosure included thinking the child deserves to have as carefree a childhood as possible, not wanting to scare the child, not wanting the child to worry about the mother, and not wanting the child to be hurt by the reactions of others. According to the Kruskal-Wallis test, comparison between the disclosure groups showed non-significant differences in the total score of HIV stigma. Results suggested there was no difference among women who tell none, some or all of their children to the degree to which they experienced personalized stigma, stigma related to disclosure, negative self-image, or public attitudes.

Conclusions: Previous research has concluded that stigma plays a large part in women's decision to disclose their HIV status (Forsyth et al., 1996; Ingram & Hutchinson, 1999; Moneyham et al., 1996; Murphy et al., 2002; Sowell et al., 1997); however, this claim was not supported in this study. The authors indicate stigma only played a minimal role in the reasons for disclosure and non-disclosure and was not experienced differentially by women in this sample who disclosed to all, some, or none of their children. The authors propose that women are interested in taking the lead role in disclosing to their children and make the decision based on the child's ability to cope with the information, thereby reducing psychological harm. Thus, women are protective of their children and most likely gauge disclosure decisions based on perceived child maturity and emotional stability.

Othieno, J. (2007). Understanding how contextual realities affect African born immigrants and refugees living with HIV in accessing care in the Twin Cities. *Journal of Health Care for the Poor & Underserved, 18*(3), 170-88.

Type: Interviews

Background: The Rapid Assessment, Response, and Evaluation (RARE) portion of the Care System Assessment Demonstration (CSAD) Project in the Twin Cities (Minneapolis-St. Paul, Minnesota) was designed to identify barriers to care faced by African refugees and immigrants.

Methods: Data were collected from cultural experts and African people living with HIV (PLWH) who were out of care, who had newly entered care, or who were in and out of care.

Results/Findings: Findings from RARE can be categorized into five main themes: HIV/AIDS within the African context, experiences of African PLWH, unfamiliarity with HIV and support services that facilitate access to care, cultural and religious dilemmas in seeking or remaining in care, and accessing African PLWH and getting them into care. Most of the issues identified were manifestations of stigma, gender, religion, and/or faith, as well as the two main underlying cross-cutting themes of knowledge and fear. The top barriers to care included fatalistic views about HIV, fear of isolation, fear of deportation, lack of knowledge of the care system and HIV-related services, and employment issues.

Conclusions: Initially, participants seemed to suggest that most African PLWH do not seek care or remain in care due to their lack of knowledge of how to access services through the system of care. However, it became clear in further discussions that although knowledge is a factor, the fear that others might find out about one's HIV status was paramount.

Parsons, S.K., Cruise, P.L., Davenport, W.M., & Jones, V. (2006). Religious beliefs, practices and treatment adherence among individuals with HIV in the southern United States. *AIDS Patient Care and STDs*, 20(2), 97-111.

Type: Questionnaire

Background: Non-adherence with medical treatment is a critical threat to the health of people living with HIV/AIDS. Unfortunately the search for explanatory factors for non-adherence is still not fully developed, particularly in the area of religion and spirituality. Extant literature suggests that church attendance, religious practices, and spiritual beliefs may improve health and generally benefit patients. However, religious beliefs may also play a negative role in treatment adherence due to the stigma attached to HIV disease, particularly in geographical areas and in population subgroups where religious practices are strong.

Methods: The survey instrument was constructed based not only on a comprehensive literature review but also with the assistance of local HIV/AIDS experts. In this exploratory study, HIV-positive individuals (n = 306) in a southern state were surveyed as to their attitudes and beliefs surrounding HIV disease and adherence with medical treatment for the disease.

Results/Findings: The results indicate that multiple factors influence adherence with treatment and that certain religious practices are positively associated with adherence, but certain religious beliefs are negatively related to adherence.

Conclusions: The findings of this study reinforce the importance of remembering and addressing a patient's religious beliefs as a part of medical care. Equally important is educating church leaders about the influence, both good and bad, of the pulpit. This is particularly relevant as current federal government policy promotes faith-based initiatives, giving more resources and power to church-based social service providers. The authors state that the same institutions that helped stigmatize the disease in the past are now being encouraged to reach out to people with HIV by providing services. Africa- American churches, specifically, have been encouraged to join the fight against the growth of HIV in African American communities. While at the surface

level this is certainly encouraging, there is a clear incompatibility between reaching out to people with HIV and continuing to promote from the pulpit the same intolerance that stigmatizes and marginalizes PLWHA. That response, in the authors' opinion, may require a peeling away of the layers of homophobia, denial, and judgmentalism before a real change and meaningful outreach can occur.

Poindexter, C.C. (2005). The lion at the gate: An HIV-affected caregiver resists stigma. *Health Social Work, 30*(1), 64-74.

Type: Narrative technique

Background: This article examines two bounded stories of HIV stigma told by an older woman who took care of her adult son as he died of AIDS. This qualitative report focuses on an older HIV-affected caregiver's experience with stigma.

Methods: The author used a hybrid of Gee's (1985,1986,1991) and Mishler's (1986a) narrative techniques to examine a portion of an interview in which the subject, a White 69-year-old divorced social worker in Massachusetts, recounts two incidents where she felt, reacted to, and resisted associative HIV-related stigma. Narrative methods are instructive in revealing the impact of HIV caregiving through individual accounts, so that deeper levels of understanding can be reached. After framing the work within stigma theory and narrative methods, the author positioned the interviewer and interviewee, presented the transcription in detail, speculated on meanings that narrator and audience may bring, linked this text to narrative and stigma theories, and offered implications for social work.

Results/Findings: Her self-definition as a protector of her dying son was challenged when she encountered ostracism and prejudice. Her words and expressions illuminate her confrontation and resistance to associative stigma.

Conclusions: The author found examining the way in which the two stories are constructed linguistically and structurally has helped illuminate the caregiver's "lion at the gate" persona. The author also contends an expansion of Goffman's view of stigma management is necessary to understand this caregiver's experiences in the face of the larger cultural narrative of HIV stigma: This caregiver did not manage stigma, she actively fought it.

Prachakul, W., Grant, J.S., & Keltner, N.L. (2007). Relationships among functional social support, HIV-related stigma, social problem solving, and depressive symptoms in people living with HIV: A pilot study. *Journal of the Association of Nurses in AIDS Care, 18*(6), 67-76.

Type: Cross-sectional study, self-report questionnaires

Background: A number of published studies suggest that people living with HIV (PLWH) are at high risk for depressive symptoms, with levels twice those reported in the general adult population (Lyon & Munro, 2001; Schrimshaw, 2003). Consequences of depression in this population include faster disease progression (Leserman et al., 1999), poorer disease outcomes (Eller, 2006), decreased quality of life (Eller, 2001), decreased HIV adherence to medication regimens (Bouhnik et al., 2005), and reduced viral resistance (Carrieri et al., 2006; Williams et al., 2006). Because of few previous empirical investigations, this pilot study examined

relationships among functional social support, HIV-related stigma, social problem solving (SPS), and depressive symptoms in PLWH.

Methods: This cross-sectional exploratory study examined a convenience sample of 30 men and non-pregnant women who sought care at two HIV outpatient clinics in the southeastern United States. Participants completed a set of self-report questionnaires at these clinics during scheduled regular visits. Data were analyzed using descriptive statistics.

Results/Findings: Consistent with other HIV studies, participants in this sample were at high risk for depression. Depressive symptoms were associated with more perceived HIV-related stigma, less social support provided by others, and dysfunctional social problem solving.

Conclusions: The authors identified poor functional social support, perceived HIV stigma, ineffective social problem solving, and depressive symptoms as interrelated phenomena with which PLWH live. This pilot provided new data about these relationships. The authors contend while these empirical results are very preliminary they do provide additional insight in identifying potential components for effective interventions to reduce the risk for depression among PLWH.

Preston, D.B., D'Augelli, A.R., Kassab, C.D., & Starks, M.T. (2007). The relationship of stigma to the sexual risk behavior of rural men who have sex with men. *AIDS Education & Prevention, 19*(3), 218-30.

Type: Self-administered questionnaires

Background: Most studies of risky sexual behaviors of men who have sex with men (MSM) have been conducted in cities. However, few studies have documented risky sexual behavior of rural men despite increases in HIV infection in these areas. Fewer research studies have been done to assess stigma and risk. This article explores the effects of stigma on sexual risk behavior among rural MSM. The authors hypothesize that stigma emanating from families, health care providers, and the communities of rural MSM would indirectly affect their sexual risk behavior through their mental health status, specifically self-esteem and internalized homophobia.

Methods: A random sample of rural MSM was not possible because the population being studied is largely hidden. Therefore, a convenience sample of 414 rural MSM obtained through political, health service, and social organizations was used to complete anonymous self-administered questionnaires.

Results/Findings: Over half of the men reported high-risk sexual behavior. Sensation seeking directly affected levels of sexual risk while the effects of stigma on sexual risk behavior were mediated by mental health variables.

Conclusions: The authors conclude that stigma related to respondents' low self-esteem and low internalized homophobia increased risk behavior.

Qian, H.Z., Schumacher, J.E., Chen, H.T., & Ruan, Y.H. (2006). Injection drug use and HIV/AIDS in China: Review of current situation, prevention and policy implications. *Harm Reduction Journal, 3*(4).

Type: Policy review

Background: Illicit drug use and HIV/AIDS have increased rapidly in the past 10 to 20 years in China. This paper reviews drug use in China, the HIV/AIDS epidemic and its association with injection drug use (IDU), and Chinese policies on illicit drug use and prevention of HIV/AIDS based on published literature and unpublished official data. China has become an increasingly important drug consuming market. About half of China's 1.14 million documented drug users inject and many share needles. IDU has contributed to 42% of cumulatively reported HIV/AIDS cases thus far. Drug trafficking is illegal in China and can lead to the death penalty. The public security departments adopt "zero tolerance" approach to drug use, which conflict with harm reduction policies of the public health departments. Past experience in China suggests that cracking down on drug smuggling and prohibiting drug use alone cannot prevent or solve all illicit drug related problems in the era of globalization. In recent years, the central government has outlined a series of pragmatic policies to encourage harm reduction programs; meanwhile, some local governments have not fully mobilized to deal seriously with drug abuse and HIV/AIDS problems.

Methods: The authors reviewed global illicit drug trafficking, drug abuse and its association with HIV/AIDS epidemic in China, and Chinese policies on illicit drug abuse and prevention of HIV/AIDS reviewed unpublished official data, including national reports on illicit drug control and HIV/AIDS sentinel surveillance data.

Conclusions: The authors offer the following strategies to help cope with China's HIV and drug use problem: strengthening government leadership at both central and local levels, scaling up methadone substitution and needle exchange programs, making HIV voluntary counseling and testing available and affordable to both urban and rural drug users, and increasing utilization of outreach and nongovernmental organizations.

Rao, D., Kekwaletswe, T.C., Hosek, S., Martinez, J., & Rodriguez, F. (2007). Stigma and social barriers to medication adherence with urban youth living with HIV. *AIDS Care*, 19(1), 28-33.

Type: Focus groups

Background: Youth adherence to highly active anti-retroviral therapy (HAART) is poor, and little research exists that identifies the reasons youth have difficulty adhering to medications. Given that complete adherence is necessary for favorable health outcomes, it is essential to examine the obstacles youth face in adhering to HAART. The article seeks to identify these barriers and to systematically examine the experiences and attitudes youth have toward medications.

Methods: Twenty-five adolescents and young adults presenting to a public primary care facility for treatment of HIV infection were asked to participate in focus groups to explore their attitudes and experiences around medication adherence.

Results/Findings: Participants provided richly detailed descriptions of the challenges of managing HIV stigma and their efforts to hide their status from friends, family, doctors, and even themselves. Fifty percent of respondents indicated that they skipped doses because they feared family or friends would discover their status.

Conclusions: These results suggest that HIV stigma impacts treatment for youth on several levels, from the accuracy of communication with medical providers to medication adherence, subsequent health outcomes, and the emergence of treatment resistant strains.

Rao, D., Pryor, J.B., Gaddist, B.W., & Mayer, R. (2008). Stigma, secrecy, and discrimination: Ethnic/racial differences in the concerns of people living with HIV/AIDS. *AIDS and Behavior*, 2(12), 265-71.

Type: Evaluation of a stigma measurement tool

Background: The HIV Stigma Scale is a measure that assesses stigmatization perceived and experienced by people living with HIV/AIDS (PLWHA).

Methods: Using Item Response Theory (IRT) methodologies, the study examined HIV Stigma Scale responses from 224 Black and 317 White PLWHA to determine whether cross-cultural differences exist in responses to items of the scale.

Results/Findings: IRT analysis revealed that eleven out of forty items functioned differently across groups. Black respondents had a higher probability of indicating greater stigmatization on items that described situations in which others discriminated against them, and White respondents had a higher probability of indicating greater stigmatization on items that described a resolve to keep their status a secret and fears of interpersonal rejection.

Conclusions: These differences suggest that PLWHA have different experiences of stigma based on their ethnic/racial background, either because of cultural differences or the ways in which the participants interpreted items of the HIV Stigma Scale.

Reidpath, D.D., & Chan, K.Y. (2005). A method for the quantitative analysis of the layering of HIV-related stigma. *AIDS Care*, 17(4), 425-32.

Type: Author abstract

Background: HIV-related stigma is regarded as one of the major barriers in the development of effective prevention and care programs, but the stigma associated with HIV stigma is not a singular entity. The stigma of the infection is layered with other stigmas, such as those associated with the routes of transmission (e.g., sex work and injecting drug use) and personal characteristics (e.g., race, religion, ethnicity and gender). In developing programs and policies to overcome HIV-related stigma, the authors hypothesize cognisance needs to be taken of all the sources of stigma, and how they may interact.

Methods: A novel method was used for examining the layers of HIV/AIDS-related stigma, and secondary data were adapted.

Conclusions: The article concludes understanding the layering of stigma is crucial for the development of effective interventions.

Rhodes, T., Singer, M., Bourgois, P., Friedman, S.R., & Strathdee, S. (2005). The social structural production of HIV risk among injecting drug users. *Social Science & Medicine*, 61(5), 1026-44.

Type: Literature review

Background: There is increasing appreciation of the need to understand how social and structural factors shape HIV risk. The authors seek to describe the social structural production of HIV risk associated with injecting drug use. In the article, the authors adopt an inclusive

definition of the HIV ‘risk environment’ as the space, whether social or physical, in which a variety of factors exogenous to the individual interact to increase vulnerability to HIV.

Methods: For this article, the authors reviewed recently published literature.

Results/Findings: The following factors were identified as critical in the social structural production of HIV risk associated with drug injecting: cross-border trade and transport links; population movement and mixing; urban or neighborhood deprivation and disadvantage; specific injecting environments (including shooting galleries and prisons); the role of peer groups and social networks; the relevance of ‘social capital’ at the level of networks, communities, and neighborhoods; the role of macro-social change and political or economic transition; political, social, and economic inequities in relation to ethnicity, gender, and sexuality; the role of social stigma and discrimination in reproducing inequity and vulnerability; the role of policies, laws, and policing; and the role of complex emergencies, such as armed conflict and natural disasters.

Conclusions: The article argues that the HIV risk environment is a product of interplay in which social and structural factors intermingle but where political–economic factors may play a predominant role. Therefore the evidence emphasizes that much of the most needed ‘structural HIV prevention’ is unavoidably political in that it calls for community actions and structural changes within a broad framework concerned to alleviate inequity in health, welfare, and human rights.

Rintamaki, L.S., Davis, T.C., Skripkauskas, S., Bennett, C.L., & Wolf, M.S. (2006). Social stigma concerns and HIV medication adherence. *AIDS Patient Care and STDs*, 20(5), 359-68.

Type: Interviews

Background: Over the past decade, advances in the pharmaceutical treatment for HIV have greatly increased the health and lifespan of those living with the disease. However, in order for these medications to work effectively they must be adhered to with little or no deviation from prescribed regimens. The threat of social stigma may prevent people living with HIV from revealing their status to others and serve as a barrier to HIV treatment adherence.

Methods: Researchers evaluated the effect of such concerns on self-reported treatment adherence using a short, three-item measure among 204 people living with HIV who were prescribed one or more antiretroviral medications and available for interviews prior to their physician visit at outpatient infectious disease clinics at the Northwestern Memorial Hospital (Chicago site, $n = 97$) and the Louisiana State University Health Sciences Center at Shreveport (LSUHSC, $n = 107$).

Results/Findings: Overall, the mean age of study participants was 40.1 years, 45% were African American, and 80% were male. People with high HIV stigma concerns were 2.5 times less likely to define and interpret the meaning of CD4 count correctly and 3.3 times more likely to be non-adherent to their medication regimen than those with low concerns. Concern over revealing HIV status was the only statistically significant, independent predictor of adherence in multivariate analysis.

Conclusions: The researchers demonstrate how concern over social stigma could influence not just a patient’s psychological experience with HIV infection, but medication practices and, consequently, treatment efficacy and health outcomes. They indicate clinical care directed to individuals living with HIV should therefore include considerations for patient sensitivity to

social stigma, such as modifications to medication schedules and referrals for counseling prior to enrollment in antiretroviral therapies.

Rintamaki, L.S., Scott, A.M., Kosenko, K.A., & Jensen, R.E. (2007). Male patient perceptions of HIV stigma in health care contexts. *AIDS Patient Care & Studies*, 21(12), 956-69.

Type: In-depth interviews

Background: Individuals living with HIV may have a heightened sensitivity to the behaviors of others that may signal bias or discrimination. Identifying and avoiding these potentially problematic behaviors may be especially important for service providers, such as health care personnel, who regularly interact with HIV-positive clientele.

Methods: This study examines the experiences of 50 male American military veterans living with HIV and their perceptions of HIV stigma within health care contexts.

Results/Findings: Participants described a variety of behaviors performed by health care personnel that they perceived to be indicative of HIV stigma, ranging from ambiguous nonverbal cues (e.g., minimal eye contact) to blatant discrimination (e.g., physical abuse of HIV-positive patients). These findings extend previous research on HIV stigma in health care settings by (a) focusing on health care personnel's actual behaviors rather than their attitudes and beliefs about HIV-positive patients, (b) including patients' perceptions regarding the behaviors of both clinical and non-clinical health care personnel, and (c) identifying behaviors patients perceive as stigmatizing that are unique to health care contexts.

Conclusions: These findings provide health care personnel a tangible list of behaviors that should either be avoided or further explained to HIV-positive patients, as they may be interpreted as stigmatizing.

Sandelowski, M., Lambe, C., & Barroso, J. (2004). Stigma in HIV-positive women. *Journal of Nursing Scholarship* 36(2),122-8.

Type: Meta-summary and meta-synthesis of qualitative study reports

Background: This article presents findings on stigma in HIV-positive women.

Methods: Meta-summary and meta-synthesis techniques were used to integrate findings on stigma in 93 reports of qualitative studies conducted between 1991 and 2002 with a total of 1,780 women, mostly from minority groups.

Results/Findings: The authors found both perceived and enacted stigmas were pervasive in the lives of HIV-positive women. HIV-related stigma was intensified in women because they were women. Stigma management largely involved efforts to control information in the service of preserving social relations and maintaining moral identity.

Conclusions: The authors conclude the meta-synthesis reprises and clarifies the connections between recurring themes in primary quantitative studies and meta-studies of HIV-positive people and of stigmatizing diseases and conditions. They indicate the work also shows how affected people's location on key axes of difference can both facilitate and complicate efforts to manage stigma. HIV-positive women experience stigmatization in relationships with others. HIV-related stigma is as much a reflection of these others as it is central to the experience of

HIV-positive people themselves. The authors suggest even those not infected with HIV are still affected by it and as such, are appropriate targets for interventions to reduce its negative effects.

Schuster, M.A., Collins, R., Cunningham, W.E., Morton, S.C., Zierler, S., Wong, M., et al. (2005). Perceived discrimination in clinical care in a nationally representative sample of HIV-infected adults receiving health care. *Journal of General Internal Medicine*, 20(9), 807-13.

Type: In-person interviews

Background: Perceived discrimination in clinical settings could discourage people living with HIV/AIDS (PLWHA) from seeking health care, adhering to treatment regimens, or returning for follow-up care. This study aims to determine whether PLWHA perceive that physicians and other health care providers have discriminated against them.

Methods: Cross-sectional data were collected from 1996 to 1997 by the HIV Cost and Services Utilization Study (HCSUS). HCSUS conducted in-person interviews with a nationally representative probability sample of 2,466 HIV-positive adults receiving health care within the contiguous United States. The questionnaire asked whether their health care providers have been uncomfortable with the respondent, treated them as an inferior, preferred to avoid them, or refused the respondents services. Questions also covered the types of providers who engaged in these behaviors.

Results/Findings: Twenty-six percent of HIV-positive adults receiving health care reported experiencing at least one of four types of perceived discrimination by a health care provider since contracting HIV, including 8% who had been refused service. White respondents (32%) were more likely than others (27%) and Latinos (21%) and nearly twice as likely as African Americans (17%) to report perceived discrimination ($P < .001$). The longer it has been since a respondent first tested positive, the more likely he/she was to report discrimination ($P < .001$). Respondents who reported discrimination attributed it to physicians (54%), nurses and other clinical staff (39%), dentists (32%), hospital staff (31%), and case managers or social workers (8%).

Conclusions: The findings suggest that because many HIV-positive adults believe that their clinicians have discriminated against them, clinicians should make efforts to address circumstances that lead patients to perceive discrimination, whether real or imagined.

Shambley-Ebron, D.Z., & Boyle, J.S. (2006). In our grandmother's footsteps: perceptions of being strong in African American women with HIV/AIDS. *Advances in Nursing Science*, 29(3), 195-206.

Type: Semi-structured interviews

Background: One of the most significant challenges facing the health of African American women in the 21st century is the growing numbers of HIV/AIDS infections. This article discusses the importance of recognizing and supporting cultural strengths of African American women to help manage illness, while remaining cognizant of the context of oppression, discrimination, and stigma that distort cultural traditions and instead penalize women when they are ill.

Methods: The findings presented here are from a larger ethnographic study conducted in the southeastern United States with 10 African American women diagnosed with HIV/AIDS and who had one or more children who were also HIV positive. The age range of the participants was 18–45 years. The study was informed by the concept of culture and based on the assumption that culture is learned and shared among members of a group, and as such can be observed, described, and understood.

Results/Findings: Patterns were constructed in such a manner that they reflected the women's challenges of caring for themselves and their families, which demonstrated strength, and their beliefs about being a strong African American woman. The authors present data to illustrate what the women believed about being strong, examine the patterns of challenges that the women faced that exemplified this strength, and explicate cultural lifeways that served as reservoirs of strength for the women. The authors argue African American women demonstrate a history and legacy of physical, emotional, and psychological strength. This strength has enabled them to survive in less than optimal conditions. They contend African American women with HIV/AIDS believe that they are heirs to this strength, and they enact it in ways that help them live and mother with a life-threatening and chronic condition.

Conclusions: The authors conclude it is important that nurses understand the context in which oppression, discrimination, and stigma have been allowed and sometimes encouraged to stifle and distort cultural traditions in ways that penalize African American women, especially when they have HIV/AIDS and are caring for HIV-positive children.

Simbayi, L.C., Kalichman, S., Strebel, A., Cloete, A., Henda, N., & Mqeketo, A. (2007).

Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa. *Social Science & Medicine*, 64(9), 1823-31.

Type: Anonymous surveys

Background: HIV/AIDS-related stigma interferes with HIV prevention, diagnosis, and treatment and can become internalized by PLWHA. However, the effects of internalized stigma have not been investigated in Africa, home to two-thirds of the more than 40 million people living with HIV/AIDS in the world.

Methods: The article examines the prevalence of discrimination experiences and internalized stigma among 420 HIV-positive men and 643 HIV-positive women recruited from AIDS services in Cape Town, South Africa.

Results/Findings: The anonymous surveys found that 40% of PLWHA had experienced discrimination resulting from having HIV infection. One in five lost a place to stay or a job because of their HIV status. More than one in three participants indicated feeling dirty, ashamed, or guilty because of their HIV status. A hierarchical regression model that included demographic characteristics, health and treatment status, social support, substance use, and internalized stigma significantly predicted cognitive-affective depression. Internalized stigma accounted for 4.8% of the variance in cognitive-affective depression scores over and above the other variables.

Conclusions: These results indicate an urgent need for social reform to reduce HIV/AIDS-related stigma and the design of interventions to assist PLWHA to adjust and adapt to the social conditions of HIV/AIDS in South Africa.

Skinner, D., & Mfecane, S. (2004). Stigma, discrimination and the implications for people living with HIV/AIDS in South Africa. *Journal of Social Aspects of HIV/AIDS Research Alliance*, 1(3), 157-64.

Type: Literature review

Background: Stigma and discrimination play significant roles in the development and maintenance of the HIV epidemic. It is well documented that people living with HIV/AIDS experience stigma and discrimination on an ongoing basis. This impact goes beyond individuals living with HIV to reach broadly into society, both disrupting the functioning of communities and complicating prevention and treatment of HIV.

Methods: This paper reviews the available scientific literature on HIV/AIDS and stigma in South Africa, as well as press reports on the same subject over a period of three years.

Results/Findings: Analysis of this material indicates that stigma drives HIV out of the public sight, and therefore, reduces the pressure for behavior change. Stigma also introduces a desire not to know one's own status, thus delaying testing and accessing treatment. At an individual level, stigma undermines the person's identity and capacity to cope with the disease. Fear of discrimination limits the possibility of disclosure even to potential important sources of support, such as family and friends. Finally, stigma's impact on behavior change limits the possibility of using certain safer sexual practices. Behavior, such as wanting to use condoms, could be seen as a marker of HIV, thus leading to rejection and stigma.

Conclusions: The authors conclude that all interventions need to address stigma as part of their focus. However, the difficulty of eliminating stigma should not be underestimated, as has been shown by the persistence of discrimination based on factors such as race, gender and sexual orientation.

Smith, R.A., & Morrison, D. (2006). The impact of stigma, experience, and group referent on HIV risk assessments and HIV testing intentions in Namibia. *Social Science & Medicine*, 63(10), 2649-60.

Type: Interviews

Background: The authors hypothesize that people's perceptions of their own personal risk for HIV are different than their perceptions of other people's risk. This study examines whether personal beliefs about HIV and experience with people living with HIV/AIDS (PLWHA) influence personal risk assessments of contracting the virus. The study also examines whether the size and characteristics referent group, peers and the general Namibian population, influence others' risk assessments.

Methods: Four hundred people from northern Namibia were interviewed for this study.

Results/Findings: The findings indicate that people with more stigmatizing beliefs about HIV were less likely to perceive themselves at risk. Perceptions of personal risk for HIV increased when a person had more experience with PLWHA. However, these characteristics had no impact on assessments for others' risk. Optimistic biases for personal risk versus others' risk appear with the highest discrepancy emerging between personal and general population risk assessments.

Conclusions: The authors contend, the more HIV/AIDS is aligned with immorality the more likely people will underestimate their personal risk. To increase an individual's personal risk

perception and encourage positive behavior change, the authors recommend discussions with those living with HIV and disassociating HIV with stigmatizing beliefs, such as witchcraft.

Swendeman, D., Rotheram-Borus, M.J., Comulada, S., Weiss, R., & Ramos, M.E. (2006). Predictors of HIV-related stigma among young people living with HIV. *Health Psychology, 25*(4), 501-9.

Type: In-person interviews and computer assisted, self-interviews

Background: Considering the negative impact that stigma and discrimination may have on stigmatized persons, the authors hypothesized that it may be useful to conceptualize stigma as an outcome (Weiner, Perry, & Magnusson, 1988). This may be particularly relevant for HIV stigma because HIV serostatus can often be concealed until later stages of infection. The ability to conceal serostatus highlights the issue of knowledge and attribution of HIV serostatus and subsequent enactments and perceptions of HIV stigma, raising questions about the factors that are likely to predict experiences and perceptions of HIV stigma among PLWH.

Methods: For this study, data were collected by a team of ethnically diverse interviewers using a combination of orally administered computer-assisted protocol interviews on laptop computers and audio computer-assisted self-interview for sensitive information, such as substance use and sexual behaviors. Enacted and perceived HIV stigma were examined among substance-using young people living with HIV (YPLWH) ages 16–29 years old in Los Angeles, San Francisco, and New York City (N = 147). The HIV stigma questions were characterized by factors of avoidance, social rejection, abuse, and shame. In multivariate models, enacted stigma was associated with gay or bisexual identity, symptomatic HIV or AIDS, and bartering sex. Perceived stigma was associated with female gender, symptomatic HIV or AIDS, bartering sex, lower injection drug use, and fewer friends and family knowing serostatus.

Results/Findings: Almost all YPLWH (89%) reported perceived stigma, and 31% reported enacted experiences in the past three months; 64% reported experiences during their lifetime. Gay or bisexual YPLWH who were also HIV symptomatic or AIDS diagnosed experienced more HIV stigma than their heterosexual peers.

Conclusions: The authors conclude that future research using longitudinal data should examine how HIV stigma may predict or mediate outcomes, such as emotional distress, coping styles, social support, serostatus disclosure, and sexual risk behaviors.

Takahashi, L.M., Candelario, J., Young, T., & Mediano, E. (2007). Building capacity for HIV/AIDS prevention among Asian Pacific Islander organizations: The experience of a culturally appropriate capacity-building program in Southern California. *Journal of Public Health Management & Practice Supplement, S55-63*.

Type: Organizational capacity assessment

Background: AIDS case rates for Asian Pacific Islander (API) populations in the United States remain low compared with other communities of color; however, the numbers are steadily rising. One of the largest challenges to HIV prevention among APIs is effectively reducing HIV risk in an extremely diverse population. In southern California, the API population is largely immigrant and represents several continents, more than 50 different languages, and distinct cultural norms.

Researchers have found stigma, racism, homophobia, shame, and linguistic isolation result in a lack of language-specific programs, reduced access to health care, avoidance of HIV testing, and delay of care until later stages of HIV/AIDS among APIs. This article examines whether organizational capacity can be expanded in culturally appropriate ways for HIV prevention.

Methods: The article has two goals: (a) to outline a conceptual model for culturally appropriate HIV prevention capacity building; (b) to present the experiences from a three-year program provided by Asian Pacific AIDS Intervention Team (APAIT) to API organizations in southern California. The participating organizations were lesbian, gay, bisexual, transgender, and questioning (LGBTQ) social organizations and social service agencies not targeting LGBTQ. These organizations were selected because of their commitment to HIV/AIDS issues in API communities. An organizational survey and staff observations were used to explore changes in capacity.

Results/Findings: The organizations were mostly small, targeted diverse populations, served a large geographic area (southern California as a region), and were knowledgeable about HIV. Researchers observed organizations become more viable (more capacity in human resources, financial, external relations, and strategic management), but also more unstable (large growth in paid staff and board members), and showed more capacity in HIV knowledge environments (especially less stigma and more sensitivity to diverse populations).

Conclusions: Based on their findings, the authors suggest that capacity can expand over a short period of time, but as capacity increases, organizational viability/stability and HIV knowledge environments change, meaning that different types of technical assistance would be needed for sustainability. The experiences described in this article suggest that APAIT's program is a useful model for designing culturally appropriate programs for community-based organizations. The model might also be useful in larger institutional settings, such as public health departments and community health centers, and in diverse ethnic communities. The authors also assert however, more research is needed to ascertain the transferability of this conceptual model to other ethnic groups, organizations, and geographic areas.

Ware, N.C., Wyatt, M.A., & Tugenberg, T. (2006). Social relationships, stigma and adherence to antiretroviral therapy for HIV/AIDS. *AIDS Care, 18*(8), 904-10.

Type: Qualitative interviews

Background: Research on adherence to combination antiretroviral therapy has focused largely upon problems of definition and measurement, and on the identification of barriers and supports. This paper examines the intersection between taking HAART and building a life with HIV/AIDS.

Methods: Data consist of 214 qualitative interviews with 52 HIV-positive, active illegal drug users. An interpretive analysis drawing upon stigma and fear of disclosure as analytical constructs was applied to explain working tensions between efforts to develop social relationships on the one hand, and attempts to safeguard health through adherence on the other.

Results/Findings: The author found that the analysis specifies a mechanism through which stigma as a social process results in marginalization and exclusion. The hierarchical organization of multiple stigmas is also noted. Loneliness and the desire for relatedness are intensified by drug use.

Conclusions: Results suggest that persons with HIV/AIDS will not consistently subordinate other interests to prioritize adherence. Interventions aimed at supporting long-term adherence must address experienced conflicts between “health” and “life.”

Waterman, H., Griffiths, J., Gellard, L., O’Keefe, C., Olang, G., Ayuyo, J., Obwanda, E., Ogwethe, V., Ondiege, J. (2007). Power brokering, empowering, and educating: the role of home-based care professionals in the reduction of HIV-related stigma in Kenya. *Qualitative Health Research, 17*(8), 1028-39.

Type: Participatory action research and focus groups

Background: In this article the researchers seek to understand how home-based care (HBC) professionals can be utilized to reduce stigmatizing behavior in Kenya. While this study was part of a larger research project to evaluate the introduction of HBC into the community, understanding the role HBC professionals could play to reduce stigma is crucial to prevent and treat HIV/AIDS. HBC professionals coordinate the delivery of HIV/AIDS services at a district level and educate community-based health workers on the importance and practice of HBC.

Methods: The method of the study was participatory action research, which aims to reflect, investigate, and bring about social and cultural change through a participatory and collaborative relationship between researchers and participants. Fifty HBC professionals participated in 27 focus group interviews over an 18 month period.

Results/Findings: HIV/AIDS-related stigma featured strongly when results of discussions with HBC professionals as a barrier to the introduction of HBC were analyzed. Using sociological theory, the authors organized the data into five themes: power broking and mobilization, stigma as a social construction, community and structural interventions, educating and training people, and historical context.

Conclusions: The article concludes that HBC professionals appear to operate at mostly the individual- and community-level in their efforts to challenge stigma, and in spite of the difficulties, they appear to be having some impact.

Wight, R.G., Aneshensel, C.S., Murphy, D.A., Miller-Martinez, D., & Beals, K.P. (2006). Perceived HIV stigma in AIDS caregiving dyads. *Social Science Medicine, 62*(2), 444-56.

Type: Author abstract

Background: This study examines perceived HIV/AIDS-related stigma in AIDS caregiving dyads in the United States, assessing the measurement of and correlates of personal stigma (among care-recipients living with HIV), courtesy stigma (among caregivers), and dyadic stigma.

Methods: Survey data from 135 dyads in which the caregiver is a midlife or older mother or wife, and the care-recipient is her HIV-infected adult son or husband, are analyzed with individual-level and multilevel regression models.

Results/Findings: The results indicate that: (a) Perceived stigma can be reliably measured among both persons living with HIV (PLWH) and caregivers; (b) personal stigma can be distinguished from courtesy stigma; (c) perceived stigma is relatively low in this sample, and is higher among PLWH than caregivers, higher among caregiving wives than mothers, and similar

between PLWH who are husbands and sons; (d) dyadic stigma is influenced by the caregiver's HIV status, the ethnic composition of the dyad, caregiving duration, and household income; (e) stigma discrepancy within dyads is a function of health discrepancy within dyads; and (f) differences in multivariate correlates of perceived stigma at the individual-level, in comparison to the dyad-level, suggest that dyadic stigma is a unique construct.

Conclusions: The authors conclude that a recognition that perceived stigma bears its own unique influence on the caregiving dyad is important for understanding how best to allocate resources aimed at alleviating stigma among individuals and families impacted by HIV.

Wilson, P.A., & Yoshikawa, H. (2004). Experiences of and responses to social discrimination among Asian and Pacific Islander gay men: Their relationship to HIV risk. *AIDS Education Prevention, 16*(1), 68-83.

Type: Analysis of personal narratives and in-depth interviews

Background: As the HIV/AIDS epidemic enters its third decade, rates of infection continue to rise in ethnic minority populations. Though the prevalence of HIV among Asian and Pacific Islander (A&PI) gay men remains to be clearly documented, research has shown that these men engage in relatively high rates of HIV risk behavior. The social discrimination that minority gay men experience may impact their HIV risk behavior and mental health (Diaz & Ayala, 2001).

Methods: This article examines the experiences of and response to social discrimination among A&PI gay men, and their links to HIV risk behaviors. The study analyzes 166 narrative episodes of discrimination, as well as data on HIV risk obtained from in-depth interviews with 23 A&PI gay men.

Results/Findings: Results showed that A&PI gay men experience types of discrimination across a variety of contexts. Homophobia and anti-immigrant discrimination were linked to confrontation and social network-based responses whereas discrimination based in stereotypes of passivity/submission were linked with self-attribution. A&PI gay men who used confrontational, social network-based or avoidance response types showed less HIV risk than those who did not. Conversely, A&PI gay men who responded to discrimination with self-attribution showed greater HIV risk behaviors.

Conclusions: These findings indicate that experiences of social discrimination and responses to discrimination may impact A&PI gay men's well-being and health. In community-level HIV prevention, the authors suggest that interventions need to be geared toward challenging or rejecting stereotypes within the gay community that threaten A&PI gay men's sense of self. Stereotypes that promote self-attribution may also promote HIV risk among A&PI gay men. In targeting social network-level factors, interventions may benefit from fostering discussions about discrimination within A&PI gay men's social networks. Finally, in targeting individual-level factors, interventions may benefit from increasing the response options Asians and Pacific Islanders have at hand when they experience discrimination in different social settings. The authors state these are promising findings that require further exploration and replication, using both qualitative and quantitative methods.

Wingood, G.M., Diclemente, R.J., Mikhail, I., McCree, D.H., Davies, S.L., Hardin, J.W., et al. (2007). HIV discrimination and the health of women living with HIV. *Women & Health*, 46(2-3), 99-112.

Type: Self-report questionnaire

Background: Women of color living with HIV/AIDS are especially vulnerable to discrimination because of the stigma associated with the disease, as well as their race, gender, and class status.

Methods: To investigate the association between self-reported HIV discrimination and health outcomes among African American and White women living with HIV/AIDS, 366 women were recruited from HIV/AIDS clinics in Georgia and Alabama. For this cross-sectional study, participants completed an interview.

Results/Findings: The authors reported nearly a sixth of the sample experienced HIV discrimination. Women reporting HIV discrimination had higher mean scores for stress, suicidal ideation, depressive symptoms, number of unprotected sexual episodes; they had lower mean scores for self-esteem and quality of life and were more likely to have not sought medical care for HIV/AIDS. In race-specific analyses, none of the relationships between HIV discrimination and health outcomes were significant for White women. African American women who reported HIV discrimination had higher mean scores for stress, suicidal ideation, depressive symptoms, number of unprotected sexual episodes; they had lower mean scores for self-esteem and quality of life and were more likely not to have sought medical care for HIV/AIDS.

Conclusions: The authors' findings indicated that HIV discrimination adversely affects women's mental, sexual, and physical health. However, separate race-specific analyses indicated that compared to White women, African American women were markedly more likely to experience the adverse affects of HIV discrimination. They conclude eradication of HIV discrimination remains an important public health priority.

Wong, V., & Wong, L. (2006). Management of stigma and disclosure of HIV/AIDS status in healthcare settings. *Journal of Health Organization & Management*, 20(2-3), 95-114.

Type: Thematic analysis of focus groups

Background: This paper aims to examine the management strategies adopted by older people living with HIV/AIDS (PLWHA) to conceal their disease status in health care settings, their responses taken, and means used to cope with the stigmatizing and exclusionary effects as a result of the disclosure. According to the authors, this is the first exploratory study of the stigmatization and devaluation suffered by older PLWHA in health care settings in the context of Hong Kong.

Methods: Under the auspices of a local NGO in Hong Kong, a total of seven males aged 55 or above from pre-existing HIV/AIDS self-help groups were recruited for two separate focus groups. A thematic approach was adopted for data analysis and specific themes identification.

Results/Findings: An analysis of the data revealed that older PLWHA did exercise their own agency in preventing against and managing stigma in their access to and use of health care services. Two more specific themes around "sign of disapproval" and "discriminatory practice" as barriers to access were identified.

Wright, K., Naar-King, S., Lam, P., Templin, T., & Frey, M. (2007). Stigma scale revised: Reliability and validity of a brief measure of stigma for HIV+ youth. *Journal of Adolescent Health, 40*(1), 96-8.

Type: Evaluation of a stigma measurement tool

Background: The purpose of this study was to shorten an HIV stigma scale to make it less burdensome for HIV-positive (HIV+) youth without compromising psychometric properties.

Conclusions: The author found that the shortened questionnaire showed good internal consistency and validity, suggesting that a 10-item measure of stigma has promise for assessing this important construct in HIV+ youth.

Zuniga, M.L., Blanco, E., Martinez, P., Strathdee, S.A., & Gifford, A.L. (2007). Perceptions of barriers and facilitators to participation in clinical trials in HIV-positive Latinas: A pilot study. *Journal of Women's Health, 16*(9), 1322-30.

Type: Structured surveys

Background: Women of color comprise a growing proportion of U.S. HIV/AIDS cases and are poorly represented in HIV/AIDS clinical trials. Improved understanding of reasons for low Latina representation in HIV/AIDS clinical trials is needed to promote participation and improve study generalizability. The researchers aim to study the barriers and facilitators to HIV/AIDS trial participation in HIV-positive Latinas in the U.S.-Mexico border region.

Methods: Forty HIV-positive Latinas, 10 HIV/AIDS service providers, and four HIV/AIDS trial recruiters were consented and received interviewer-administered structured surveys. Fisher's exact tests were used to explore differences between women who had and who had not participated in clinical trials.

Results/Findings: Of the Latina participants, 70% Mexican-born (70%), preferred health information in Spanish (62.5%), had a mean age of 38 years (range 21-60), had a household income \leq \$15,000/year (62.5%), crossed the border at least once a month (45%), and reported residing in Mexico (15%). No significant differences were found between women who participated in a clinical trial (60%) and those who had not (40%) across language, age, education, and border crossing ($p > 0.05$). Sixty-three percent of Latinas perceived individual-level barriers (e.g., fear, shame, and stigma), and 10% mentioned system-level barriers (e.g., lack of transportation or language-appropriate services); 70% of providers mentioned system barriers. HIV stigma was not reported as a barrier by providers.

Conclusions: The authors contend that the role of stigma in recruitment of HIV-positive Latinas into clinical trials and differences in perceptions of barriers between Latina participants and service providers merit further exploration. An improved understanding of individual- and system-level barriers to clinical trials participation in a binational context is warranted.