Volume : 3 | Issue : 4 | April 2014 • ISSN No 2277 - 8179

Research Paper

Stigma Among Children Affected by HIV/AIDS

Social Science

KEYWORDS : Stigma, HIV/AIDS, PLWHA, Children affected, perceived level.

Belinda Joselin Jayapaul — PhD Research Scholar, Bishop Heber College

Dr. Albert Relton — Associate Professor & Head, Department of Social Work, Dean for Extension Activities, Bishop Heber College (Autonomous)

ABSTRACT

The global epidemic of HIV/AIDS has accompanied by significant stigma on children affected by HIV/AIDS and their families. Studies suggest that children frequently encounter stigma and discrimination from the extended family members in particular and the community in general. Stigma can affect the quality of life of the children affected by HIV/AIDS in several ways that include anxiety, fear, depression, loneliness, negative self-image and discrimination at school and in the community. This researcher attempted to study the impact of stigma on children affected by HIV/AIDS. HIV Stigma scale (Barbara Berger 1996) was used as a tool to measure the stigma among children affected by HIV/AIDS. The study findings reveal that there is significant difference between the respondent's districts and their perceived level of stigma.

Introduction

Globally stigma associated with HIV/AIDS have created an obstacle in the fight against HIV/AIDS and have negative consequences in life of the of People Living With HIV/AIDS(PLWHA) (Nayamathi et al.,2013).Few researchers have explained about different kinds of stigma. The received or perceived stigma refers to attitudes and behaviours perceived by themselves or others. Negative thoughts and behaviour that arise from oneself because of their negative perception of their experiences is internalized stigma. Real experience of discrimination experienced by the person is enacted stigma. Stigma that results from the association of the person with PLWHA is associative or secondary stigma. Secondary stigma affects the family members of PLWHA including children (Zhao et al., 2010).

Children affected by HIV/AIDS can be impacted by stigma in multiple ways. Stigma can cause anxiety, fear, incomplete disclosure of their parent's illness, reduced ability to express their grief, denied schooling, discrimination and inadequate family and community supports. In addition, because of children's intellectual and emotional immaturity, stigma can have a greater impact on children (Vranda et al., 2013). Literature from Western and Sub-Sharan African nations have found that children of PLWHA have encountered hostility, rejection and lack of access of health care and schooling (Zhao et al., 2010). According to Bauhman et al., (2013) existing literature on the mental health of children affected by HIV/AIDS is very minimal. Therefore, the literature on stigma among children affected by HIV/AIDS is very limited.

On considering the need of understanding the stigma experienced by children affected by HIV/AIDS, the researchers have carried out a quantitative study. The study aims to promote an understanding of the factors and the perception of stigma among children affected by HIV/AIDS.

Method of study

This descriptive study is an attempt to find out the level of stigma and its impact on the life of the children affected by HIV/AIDS. The data were collected from the children affected by HIVAIDS in Tirunelveli and Kanyakumari district, Tamilnadu, India. The children's were connected with the Positive Health Network of Tirunelveli and Kanyakumari District. Informed consent was obtained from the 200 participants who were willing to take part in the study and among them 98 were male and 102 were female between the age of 8-21.

HIV Stigma scale (Barbara Berger 1996) was the tool administered in this study to collect the data. The statements are related to the infected members. In this study, the author modified the statements using the word "I have a family member". The statements are related to some of the experiences, feelings, and opinions as to how children with HIV feel, how they are treated and the impact of disclosure on their life. The items are scored on a 4 point Likert Scales ranging from strongly agree to strongly disagree.

Data Analysis

The researcher with the help of simple tables, t test and one way analysis of variance to analyze the impact of stigma on the children affected by HIV/AIDS.

Results

The results based on the statistical analysis of the data provided by the participants are discussed with Table1, 2, 3.

Table No.1

Difference between the Respondents Districts and their perceived Levels of Stigma

S. No	Districts	Mean	Standard Deviation	df	't' Value
1	Personalized Stigma				
	Tirunelveli	49.8600	5.33449	198	4.068
	Kanyakumari	53.5000	5.52637		P<0.05
2	Disclosure				
	Tirunelveli	24.4800	2.03566	198	8.071
	Kanyakumari	27.0200	1.88971		P<0.05
3	Negative Self Image				
	Tirunelveli	31.7200	2.71985	198	7.583
	Kanyakumari	34.5000	2.06279		P<0.05
4	Public Attitudes				
	Tirunelveli	54.8000	5.71587	198	5.326
	Kanyakumari	59.9000	5.91177		P<0.05
5	Stigma Total				
	Tirunelveli	160.8600	13.63721	198	6.185
	Kanyakumari	174.9200	14.01288		P<0.05

It is seen from the above table that there is significant difference between the respondent's districts and their perceived level of stigma. With regard to the sub dimensions of stigma, a significant difference is found between personalised stigma, self-disclosure, negative self-image and public attitudes. Further, from the mean scores, it is evident that those from Kanyakumari district experience more stigma than those from Tirunelveli district. The mean score of the subdivisions of the stigma reveal that respondents from Kanyakumari district experience more stigma than the respondents from Tirunelveli in terms of personalized stigma, self-disclosure, negative self-image and public attitude.

Volume : 3 | Issue : 4 | April 2014 • ISSN No 2277 - 8179

Table No.2
One Way Analysis of Variance between the Respondents with varied number of Siblings and their perceived levels of Stigma

S. No.	Variables	Mean	Standard Deviation	Sum of Squares	Df	Mean Square	F
1	Personalized Stigma						
	1	G1=51.7857	4.67461	257.366	3	85.789	2.814
	2	G2=50.8659	5.95199	5976.054	196	30.490	P<0.05
	3	G3=49.4884	5.78328				
	4	G4=46.0000	6.96419				
2	Disclosure						
	1	G1=25.5286	2.26326	19.733	3	6.578	1.271
	2	G2=24.9268	2.37154	1014.622	196	5.177	P>0.05
	3	G3=24.8837	2.16255				
	4	G4=24.4000	1.51658				
3	Negative Self Image						
	1	G1=32.9714	2.44340	38.383	3	12.794	1.605
	2	G2=32.2439	3.21478	1562.172	196	7.970	P>0.05
	3	G3=31.9535	2.67220				
	4	G4=31.4000	1.81659				
4	Public Attitude						
	1	G1=57.4857	4.86258	336.322	3	112.107	3.044
	2	G2=55.9878	6.51209	7219.553	196	36.834	P<0.05
	3	G3=54.3953	6.98686				
	4	G4=52.2000	5.06952				
5	Stigma Total						
	1	G1=167.7714	12.26775	1929.930	3	643.310	2.945
	2	G2=164.0244	16.17419	42814.945	196	218.444	P<0.05
	3	G3=160.7209	15.91843				
	4	G4=154.0000	12.22702				

G1=1,G2=2,G3=3,G4=4

The above table reveals that there is significant difference among the respondents with varied number of siblings and their perceived levels of stigma. It is also evident from the table that the sub dimensions personalized stigma and public attitude has elicited a significant difference between the number of siblings and personalized stigma and public attitude. The other two subdivisions of stigma disclosure and negative self-image have no significant difference between the numbers of siblings. Furthermore, the mean score indicates that respondents with two siblings experience more stigma.

Table No.3
One Way Analysis of Variance between the varied frequency of Respondents attending School and their perceived levels of Stigma

S. No.	Variables	Mean	Standard Deviation	Sum of Squares	Df	Mean Square	F
1	Personalized Stigma						
	Daily	G1=51.1503	5.09679	283.390	4	70.848	2.322
	Mostly	G2=48.1875	6.33739	5950.030	195	30.513	P<0.05
	S.D.O	G3=48.5000	12.21065				
	Sometimes	G4=45.0000	8.18535				
	M.H	G5=54.0000	.00000				
2	Disclosure						
	Daily	G1=25.0578	2.10677	37.329	4	9.332	1.825
	Mostly	G2=25.9375	2.86284	997.026	195	5.113	P>0.05
	S.D.O	G3=24.0000	4.60435				
	Sometimes	G4=24.3333	1.52753				
	M.H	G5=28.0000	.00000				
3	Negative Self Image						
	Daily	G1=32.3815	2.46466	85.734	4	21.434	2.759
	Mostly	G2=33.5000	2.98887	1514.821	195	7.768	P<0.05
	S.D.O	G3=30.6667	7.63326				
	Sometimes	G4=29.6667	4.72582				
	M.H	G5=36.0000	.00000				
4	Public Attitude						
	Daily	G1=56.4277	5.69799	330.424	4	82.606	2.229
	Mostly	G2=54.0625	6.79675	7225.451	195	37.054	P>0.05
	S.D.O	G3=54.5000	11.51955				
	Sometimes	G4=47.6667	11.93035				
	M.H	G5=59.0000	.00000				
5	Stigma Total						
	Daily	G1=165.0173	13.45599	1716.490	4	429.122	1.945
	Mostly	G2=161.6875	16.80761	43028.385	195	220.658	P>0.05
	S.D.O	G3=157.6667	35.65202				
	Sometimes	G4=146.6667	25.42309				
	M.H	G5=177.0000	.00000				

G1=Daily, G2=Mostly, G3=Some Days Only (S.D.O), G4=Sometimes, G5=Mostly at Home (M.H)

The above table reveals that there is no significant difference among the respondents with varied frequency of attending school and their perceived level of stigma. However, the sub dimensions personalized stigma and negative self-image reveals significant difference with regard to the frequency of the respondent attending school. In addition the mean score of the perceived stigma indicates that the respondents at home experience increased level of stigma than those respondents who attend school more frequently.

Discussion
In this study, 46.5% of the respondents shared that they have not disclosed to anyone that they have a family member living with HIV/AIDS. 68% of the respondents agree that they feel guilty as they have a family member living with HIV/AIDS. People's attitude makes 78.5% of the participants feel worse. Disclosing to someone that respondents are living with someone with HIV/AIDS is perceived to be risky by 73.5%. 79% reported that most people believe that person affected by HIV/AIDS is dirty. 71.5% of respondents believe that it is easier to avoid new friendship that to worry about telling someone that they have a family member infected by HIV. Disclosing that respondents have a family member with HIV/AIDS is considered as a mistake by 82%. Moreover, 82% of the respondents agreed that people were afraid of others after knowing that they have a family member living with HIV/AIDS.

From the above tables and the discussion on the results of the simple tables reveal that children experience significant level of stigma in their perspective. From this study, it is also evident that there is significant difference between the respondent's districts and their perceived level of stigma. Therefore, level of stigma perceived by children affected by HIV/AIDS cannot be generalized as it differs from place to place. There are several limitations of the study as the current study may not be a representative of children affected by AIDS in other parts of Tamilnadu and India. The current study focussed on personalized stigma, disclosure, negative self-image and public attitude. Research in the future can focus on other potential manifestations of stigma against children affected by AIDS. Therefore, there is a need to understand stigma in relation to other contributing factors. Further research in the area would help to develop a holistic understanding of the psychosocial problems of children. As a result, programs and better care for children affected by HIV/AIDS in the community can be developed.

Conclusion
The present study has revealed the perceived level of stigma in two districts of Tamilnadu, India. Despite the increase in interventions for HIV/AIDS for PLWHA, children affected by HIV/AIDS go unrecognized and unattended. This eventually increases psychosocial problems among children affected by HIV/AIDS. Therefore, it is essential for the community programs, schools and other health care providers to focus on the interventions to reduce the perceived stigma level and to promote mental health, which can result in better quality of life for children affected by HIV/AIDS.

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