

Additional Case Studies and Cross-Cutting Issues

7. Stigma

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HIV-related stigma encompasses prejudice, discounting, and discrediting directed at individuals perceived to have HIV/AIDS, as well as towards the individuals, groups, and communities associated with them. This stigma significantly influences people's decisions and behaviours, diminishing their willingness to participate in HIV testing, treatment, and prevention efforts. Over the past three decades, since the onset of the HIV/AIDS epidemic, stigma has consistently posed a formidable obstacle to HIV testing, diagnosis, treatment, and overall care (Yang et al. 2015, p. 1).

Despite the Chinese government's extensive efforts in HIV prevention over the past decades, stigmatisation against people living with HIV/AIDS (PLHIV) persists nationwide.

Li and colleagues (2018, p. 1ff.) utilised the validated Berger HIV Stigma Scale to evaluate HIV-related stigma in Zhenping County, located in Henan province, a region with a significant population of individuals affected by plasma donation-related HIV-infections. The Stigma Scale includes an overall mean score and four subscales: personalized stigma, disclosure concerns, negative self-image, and concern with public attitudes, with scores ranging from 40 to 160. The scores interpretation indicates 0–33% as no or mild stigma, 34–65% as moderate stigma, and values exceeding 66% as severe stigma.

After analysing 239 survey responses from PLHIV, the data revealed that the overall HIV stigma score ranged from 68 to 130 (indicating moderate to severe stigma), with a mean score of 105.92 ± 12.35 (95% CI: 104.34, 107.49; confidence interval [CI] is a statistical concept used to quantify the uncertainty or precision associated with a particular estimate). The scores for the four subscales were as follows: personalised stigma (48.66 ± 6.29), disclosure concerns (26.08 ± 3.48), negative self-image (34.10 ± 3.99), and concern with public attitude (53.47 ± 7.30). The results of the survey showed that participants perceived higher levels of stigma associated with personalised stigma (67.58, 95% CI: 66.47, 68.69) and comparatively lower levels of stigma related to disclosure concerns (65.20, 95% CI: 64.08, 66.30).

The finding that PLHIV in the rural areas of Henan province perceive moderate to high levels of HIV-related stigma is consistent with existing literature from both China and India, which suggest that individuals in rural settings tend to experience more stigma compared to their urban counterparts. Furthermore, the observed level of PLHIV in the rural areas of Henan province is comparatively lower than the stigma reported in a previous study conducted among the men who have sex with men (MSM) population in China. This suggests that rural former plasma donors are generally viewed within the general population with greater sympathy than is the case for those who acquired HIV through other means, such as MSM, people who inject drugs (PWID), and commercial sex workers (CSW) (Li et al. 2016, p. 1398).

Recent research indicates that individuals who contracted HIV through 'blameless' routes (e.g. blood transfusion, sex with stable partners) tend to face less stigma compared to those who acquired HIV through 'blameable' routes (e.g. injection drug use, homosexual behaviour). Consequently, the level of stigma observed in this rural sample is relatively lower than what is seen in other higher risk groups (Li et al. 2018, p. 1ff.).

Despite the fact that male–male sexual relationships have been legal in China since 1997, sociocultural factors still contribute to the stigma and discrimination experienced by this group, leading them to conceal their sexual activities from both partners and healthcare providers. The significant role of family in Chinese culture exerts considerable pressure on MSM, meaning that they have to keep their MSM identity hidden. Consequently, it appears that HIV prevention and testing rates among MSM have remained low, likely because of concerns related to disclosing personal information or facing discrimination (Wu et al. 2019, p. 461f.).

In a study conducted by Li and colleagues in Chongqing and Chengdu in 2019 the objective was to identify barriers to the prevention and control of hepatitis B (HBV) and hepatitis C (HCV), as perceived by local hepatitis patients, residents, and healthcare providers. The study involved 26 participants who participated in in-depth face-to-face interviews. The findings indicated that the participants, on the whole, lacked substantial knowledge about HBV and HCV. Some hepatitis patients held misconceptions about HBV and HCV, with certain individuals erroneously believing HBV to be an inherited condition. Furthermore, the majority of the interviewed residents exhibited apathy towards HBV and HCV and displayed no proactive interest in undergoing screening for these infections (Li et al. 2019, p. 1ff.).

The study also highlighted that several workers from the Centres for Disease Control and Prevention (CDC) and community representatives have pointed out that a significant portion of residents and medical workers in community health service centres have limited knowledge about HBV and HCV. Furthermore, HBV and HCV continue to be associated with serious social discrimination and stigma. Many hepatitis patients reported encountering discrimination in their personal and professional lives to varying extents due to their condition. Workers from community health service centres also mentioned that they had witnessed cases of severe discrimination against HBV patients by their own family members (Li et al. 2019, p. 1ff.).

In summary, efforts to reduce the burden of stigma should strategically target key risk factors associated with this issue. Specifically, interventions need to be tailored to populations experiencing heightened stigma, including urban residents and individuals with depression. The implementation of psychosocial interventions to improve mental health holds promise in terms of mitigating the negative impacts of stigma on the well-being of these individuals. Recommendations encompass refining existing laws, establishing professional insurance mechanisms to protect the rights of medical staff, and addressing concerns related to service provision for HIV and HCV patients.

Additionally, crucial advocacy efforts involve expanding health education, reducing societal stigma, promoting supportive government policies, and securing funding. A significant objective is to provide social support and education for the families of patients, thus strengthening connections with potential support networks. Future strategies should focus on training health professionals and community leaders in empathy-building, stigma reduction, and discrimination elimination. This will contribute to creating a supportive clinical environment for individuals living with HIV and HCV (Yuan et al. 2023, p. 4058).

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