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Abstract

People living with HIV/AIDS (PLWHA) are stigmatized and looked at negatively by people at large. Stigma, discrimination, and prejudice extend its reach to people associated with HIV-positive people such as health providers, hospital staff, as well as family member and friends. Studies demonstrate that, in low-income countries, especially in South Asia and sub-Saharan Africa, health providers' views toward the HIV-positive individuals is not very much different from the general population. The study has been qualitative in nature and conducted among health providers such as physicians and nurses attached to different hospitals. The study was conducted from March 2005 to May 2007. The study shows that 80% of the nurses and 90% of the physicians' behavior with the HIV-positive individuals were discriminatory. They talk to their patients standing far from them. The interview revealed that the spouses of the physicians and nurses in charge of the HIV-positive individuals put pressure to stop serving the patient or even quit the job. The notion that HIV is only transmitted through sexual activities is prevalent among them. Interestingly, although the physicians know well about the routes of transmission, they do not believe it by heart. Therefore, their fear of being infected makes them discriminate against the HIV-positive individuals. HIV-related stigma remains a barrier to effectively fighting this pandemic. Fear of discrimination often prevents people from seeking treatment publicly. There are evidences that they were evicted from home by their families and rejected by their friends and colleagues. The stigma attached to HIV/AIDS can extend into the next generation, placing an emotional burden on them.

Keywords

stigma, health provider, Bangladesh, discrimination, HIV/AIDS

... stigma is a chief reason the AIDS epidemic continues to devastate societies around the world. We must recognize that those who bear the stigma of HIV should not be those who live with the disease. It is those who allow it

Ban Ki-moon

Background

Stigma, generally defined as prejudice, discounting, discrediting, and discriminating¹ is a reality of everyday life for the people living with HIV/AIDS (PLWHA), their families, and the ones directly associated with this pandemic disease, including sex workers, men who have sex with men (MSM), and injecting drug users (IDUs). The issue of stigma carries paramount significance on the contemporary health policy and research agenda and programs on HIV/AIDS because of its marring potential in impeding effective prevention, treatment, care, and support per se.² HIV/AIDS pandemic has evoked a wide range of reactions—stigma being a type of the reactions—from individuals, communities, and even nations; and from sympathy and caring to silence, denial, fear, anger, and even violence.³ Therefore, the 2006 Political Declaration adopted at the UN

High Level Meeting on AIDS attaches emphasis on stigma and discrimination and considers them as a critical element in combating this global pandemic. Stigma has a range of implications, such as delaying HIV testing, restricting use of preventative programs, and hindering the adoption of preventative behaviors, disclosing status, for instances.^{4,5} Although the HIV/AIDS epidemic arrived relatively late in Asia, it is spreading in its rapidest speed. In 2005, the number of AIDS cases in Asia reached 8.6 million, which is compared to approximately 3 million people 10 years prior⁶, and some 960 000 people became newly infected until mid-2007. In addition, from all over the world in 2006 approximately 630 000 died from HIV- and AIDS-related illness. Asia is going through the most

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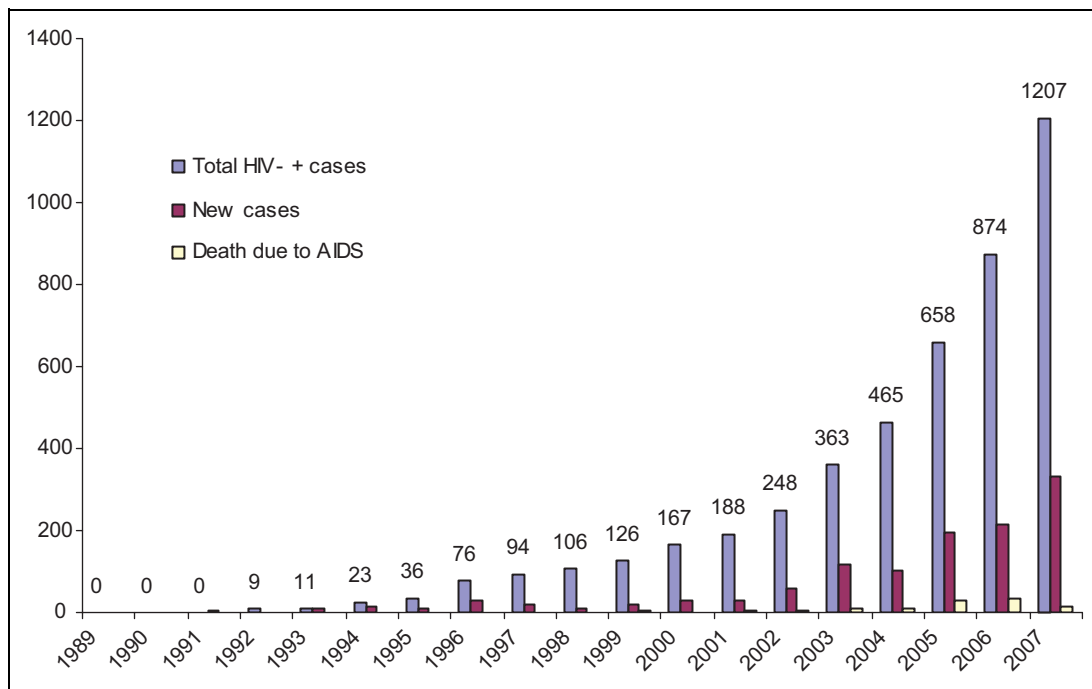


Figure 1. Total HIV-positive cases, new cases, and death due to AIDS from 1989 to 2007. UNAIDS, 2008.¹¹

difficult times in history due to the fact that HIV hits the poor, and women and children are under the hardest strike. This in fact demonstrates a fact that HIV/AIDS poses political, economical, human rights, and governance challenge in the region. The world witnesses a heterogeneous state that people, on one hand, are up for McGregor's highest stage of motivation such as self-actualization, democracy, and justice, and on the other hand, an alarming number of people are struggling and dying because of this pandemic disease. Stigma, discrimination, and the increasing incidences of violation of human rights have, in addition, seriously posed an irony on modern day democracy.

Born out by several studies, stigmatization against the HIV-positive individuals is a common phenomenon in Asia, especially in South Asia, and Bangladesh is no exception due to the fact that most citizens are largely unaware of the risk factors of HIV/AIDS.^{7,8,9,10} Although there are only 1207 officially confirmed HIV-positive cases until 2008, national estimates put the number of PLWHA in the world's eighth most populated nation closer to 7500, but the real number could be several times higher. In Bangladesh, the rate of HIV infection was 16 per 100 000 people in 2007. In 2001, only 25 new cases of HIV were officially recorded.¹¹ Among them, most were male migrant workers who were repatriated to Bangladesh from their host countries following the diagnosis of HIV.⁷ The primary dilemma, however, facing the country's HIV/AIDS prevention and control initiatives is the scanty statistics, coupled with the lack of a coherent HIV prevention policy. Therefore, I would argue that these are all a guesstimate.

In Bangladesh, the first AIDS case was diagnosed in late 80s. During the last 2 decades, the number has steeply peaked

(Figure 1). From the mid-90s, the infection rate took a sharp height in the trend of new infection and death due to AIDS. However, awareness regarding HIV/AIDS prevention and protection remained largely low among vulnerable groups, policy makers, health care providers (HCPs), and population at large. Therefore, discriminatory attitude toward the HIV-infected people has engulfed not only general population but also HCPs, resulting in reluctance in disclosing their serostatus and testing blood for HIV.

What we notice if we look around the neighboring countries is for example, as one of the lowest prevalent country (0.1%), Pakistan is at high risk for an HIV/AIDS epidemic. The dire socioeconomic conditions in Pakistan conducive to the spread of HIV, including extreme poverty, low levels of education, and high unemployment rates, which led to increased exposure to the disease via migration to higher prevalence countries. According to UNAIDS estimates, about 96 000 people were living with HIV in Pakistan at the end of 2007.^{12,13} Pakistan, as compared to its neighbors, has remained relatively safe from any indigenously acquired cases of HIV for about 2 decades. The situation, however, changed in 2004, when Pakistan experienced its first full-fledged HIV outbreak. Similar to its south-east Asian neighbors, the greatest risk of the spread of HIV in Pakistan stems from IDUs. Currently estimated at over 180 000 in number, the ongoing strife in Afghanistan, the world's largest poppy producing country, seems only to swell up this number even more in the future.^{12,13} Previously it was known that there were around 5 million people living with HIV in India. However, a national household survey conducted in 2005-2006, which led to a major revision of the prevalence estimate in July 2007, shows that around 2.3 million people

in India are living with HIV. Of these, an estimated 39% are female and 3.5% are children.¹⁴

Literally, prejudice means to pre-judge or to structure a view on something before facts are revealed^{15,16}, meaning that prejudice is not something based on fact, but rather, on a series of assumptions and guesses. It is based on generalization, on a whole host of qualities that we assume a person has, based purely on the fact that he or she is a member of a particular group. Therefore, prejudice generally is an attitude, and discrimination is the manifestation of that prejudice and a stigma is the result. Stigma is an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society.^{1,15,17} HIV-stigma is layered on top of many other stigmas associated with such specific groups as homosexuals and sex workers and such behaviors as IDU and casual sex.¹⁸⁻²⁰ Stigma is a behavior that unfairly and negatively affects the rights, life, and opportunities of an HIV-positive individual. It is, thus, essentially discrimination based on HIV status. It has an additional connotation to discrimination, namely of strong emotional rejection, over and above structural inequity. In this sense, one would explain the expelling of a woman from her home by her family due to fear-based "stigma," whereas one would hardly be inclined to call it "discrimination," at least not in the common usage of the term. Therefore, stigma is the extreme end of a discrimination continuum. A great deal of prejudice is reflected in the basic stereotyped assumptions about others which may cause discrimination against the society. Eventually, large groups of people within these groups feel isolated.

Scholars in this school of thought suggest that prejudice is a consequence of our natural tendency to categorize the world to make sense of it. Known as Social Learning Theory, having a profound impact on our understanding of why we are prejudiced and what we can do to reduce prejudice in society accepts that individual bigotry is only one part of the explanation behind prejudice and suggests that there are many other factors influencing our behavior toward people. The definition of stigma has been continually developed and reconceptualized since the emergence of it. Although the concept of stigma is broken down into felt or anticipated and enacted,^{3,21} it has been dichotomized into expressive and instrumental forms, where an individual may perceive another negatively but may act according to this prejudice under certain circumstances.²²

Stigma, a social construction, affects the life experiences of the individuals infected with the HIV and their partners, family, and friends.²³ Stigmatization often becomes heavier than the disease itself for the PLWHA. The United Nations, human rights activists, and many other organizations place so much emphasis on these issues with the objectives of reducing the burden of stigmatization and discrimination against the PLWHA. Unfortunately, it is not only the population in general who discriminate the HIV-positive individuals but also the physicians and caregivers. There are abundant researches on different aspects of HIV/AIDS; however, researches have little addressed the issues like stigma and discrimination. Thus, only bare attention was given to such issues in Bangladesh due to the

fact that Bangladesh is still known as a nonprevalent country and more so in the interplay between HIV-positive individuals and HCPs. Therefore, a big knowledge gap persists in this field. This study tries to understand how stigma and discrimination affect the HCP-HIV-positive patient relationships and its consequence in the social life of both groups.

Objectives and Methods

This article is a part of a larger study that was specifically designed to answer a few questions such as what are the discriminatory practices in the health sector that affect the health and well-being of PLWHA; how receptive are health workers and institutions to treating PLWHA; and what underlying factors may contribute to any discriminatory practices? The general questions the study asks are what causes people to behave in a stigmatizing manner? Why are people treating their colleagues, employees, and friends in extreme and inhumane ways? Why is stigma so widespread, regardless of socioeconomic levels? How do those infected contribute to the perpetuation of stigma? In all, 17 HIV-positive patients (12 male and 5 female); 10 general staff (6 male and 4 female); 8 doctors (5 male and 3 female), and 6 nurses (all females) were interviewed from 2 government hospitals and 3 private clinics. In addition to interview, participant and nonparticipant observations were employed in order to validate objectively the information culled through interview. Grounded theory (GT) has been used for the qualitative research technique that explores social processes and reveals how people anticipate and respond to various life experiences. This is very crucial in this research, as it aims primarily to look into the everyday life of the participants. GT seeks to inductively distil issues of importance for specific groups of people, creating meaning about those issues through analysis of theory.²⁴ Case studies (on PLWHA) and in-depth interviews (with physicians) were conducted. Relevant ethical clearance was obtained before the interview was conducted. They all were selected from Dhaka city. They were assured that any kind of identification would not be disclosed in any case. Samples have been selected purposively to generate information. Related secondary sources were also carefully analyzed to supplement data. During the interview, I explained the study, provided information about our study regarding its goals and methodology, and developed trust and rapport with potential participants.

Findings

HIV stigma is globally pervasive and damaging. In Asia, HIV stigma and discrimination (HSD) toward PLWHA is a common phenomenon at individual, family, and the institutional levels, and the health care sector is no exception.²⁵⁻²⁷ The individual is seen within the context of the family, the community, and the larger society. The existing norms and values within families and communities; prejudices based on race, ethnicity, caste and gender; and the socio-economic and political contexts,

including that of power, play a significant role in the way stigma manifests.

Religious beliefs significantly shape individuals' outlooks on living with HIV. Faith practices and beliefs can provide a sense of peace and hope and can also help people to prepare for and accept death. The sexual and moral connotations frequently associated with HIV transmission can also turn the church into a stigmatizing atmosphere for PLWHA. Many of the stigmatizing attitudes toward PLWHA arise from people's beliefs that PLWHA have behaved immorally and fears of acquiring HIV through casual contact with PLWHA. Fears of stigmatization and blame are also closely linked to disclosure intentions.²⁸

Okam korse tai pape dhorse (Sins that they committed are punishing them) is a general comment thrown to an HIV-positive individual in Bangladesh society. Since HIV infection is often associated with particular sexual activities, the implication of stigmatization is generally very powerful. Many people believe that it is only immoral people who get AIDS. Pre- or extramarital sex is considered *bebhichar* (fornication), punishment of which is death or exile from the society. The ingrained belief among general population is that HIV is infected only through sex. The study shows that most family members, general staff of hospitals, nurses, and community members were aware that HIV could not be transmitted through casual contact, but still they remained hesitant to share drinking glasses, utensils, or sit near PLWHA and those who provide treatment to HIV-positive for fear of being infected by any chance. A study on 4 Asian countries (Thailand, Indonesia, India, and the Philippines) shows 54% of the HIV-positive individuals experienced some form of HSD in the health care sector.²⁶ Several previous studies have called attention to the correlation between religion and behaviors that help to protect against contracting HIV. Although several of the religiously motivated behaviors practiced by Muslims are favorable for HIV prevention such as higher rates of circumcision, fewer self-reported instances of extramarital sexual intercourse, and reduced consumption of alcohol (decreasing high-risk sexual activity, there are no scare of evidences that religious fanatics has rather played role in spreading the pandemic. Strong religious beliefs do not always correlate with HIV protective behaviors.²⁸

Stigma and discrimination occurred through being refused admission to and services from government hospitals and private clinics. This study suggests that a significant number of health care professionals (80%) engage in discriminatory behavior. There are also widespread complaints that professionals disclosed confidential information to other people without patient's consent. As many as 29% refused patients with HIV/AIDS admission to private clinics. Two thirds reported being refused by health professionals to care for a patient with HIV/AIDS, and 43% of patients with HIV/AIDS were refused admission to government hospitals. As many as 54% being "neglected" in private and public hospitals combined, and 67% experienced delays in receiving treatment. Staff of government hospitals consider their jobs are more stable than private clinics. Generally believed, there is a lack of accountability in government hospitals, which makes them

reluctant in providing services to those who need it. In overall judgment, private clinics provide a better service than public ones. These findings are not far from the realities in other countries in south-east Asia either. Studies in China, Thailand, and the Philippines found that HIV-positive patients were forced to wait for surgical procedures until those without infectious diseases had been treated.^{29,30} PLWHA are differentially treated by doctors, hospital staff and nurses, friends, family members, and other individuals in one-on-one encounters. Friends are no longer willing to associate with PLWHA for fear of infection or accusations of being HIV positive. Family members do no longer feel comfortable sharing dishes or towels for fear of contagion.³¹ This group normally has different disorder and need to visit doctors frequently, compared to others. Doctors are the people who the patients keep faith in and hope to tell the matters confidential. However, it has been experienced from the PLWHA that doctors are one of the major parts who they are being discriminated and isolated by.^{29,32,33}

The common forms of stigma and discrimination include noting patient rooms with identifiable markers suggesting the individual is HIV positive and requiring repeated HIV testing at the patients' expense. As a result of HSD in the health care sector, most PLWHA are less willing to seek health care. Study of Ainsworth, Beyrer, and Soucat³⁴ also endorses the findings, though their study was conducted in a different setting. Stigma also has consequences for individual economic well-being as well as broader socioeconomic development. All the HIV-positive individuals interviewed was unemployed during the interview. Paxton and colleagues²⁶ found that in India, Thailand, Indonesia, and the Philippines, both men and women had experienced some form of discrimination in the workplace. People living with HIV are subject to job loss, school expulsion, ostracism, violence, lack of care and support, and loss of property.³⁵⁻³⁷ Approximately 7% of individuals from these countries had lost their jobs because of their status and nearly 10% had experienced changes in their job responsibilities after their HIV status became known.³⁸

An AIDS diagnosis changes many aspects of a person's life and changes the life of infected person through the stigmatization by different social actors. Many people develop a timorous attitude about their life, health, and well-being when they find out they have HIV, as its treatment is complicated and expensive. Nahar and Hakim³² found the similar kind of findings that some doctors deny providing medical supports whenever patients disclose their positive status. Thus, they are forced to experience extreme isolation throughout their entire lives. They in the first place deny diagnosing or prescribing them. Doctors and nurses were found to talk to their patients with their face masked. Most of the respondents said that they never get closer to the patients. Observation confirms that they seemed to be staying around the bed of the patients per visit only for a short time. Three-day observation confirms that doctors spend only 1.25 minutes and nurses 2.5 minutes on average. A few of them told that some doctors informed to the police about us. Although, discrimination and stigma are manifested generally in 2 forms: verbal and behavioral, analysis was not done

separately. Disclosure of HIV/AIDS status exposes clients directly or indirectly to discrimination or rejection by family, friends, and community. The stigma surrounding HIV/AIDS—as a sexually transmitted infection (STI) associated with socially unacceptable behaviors—coupled with social and cultural taboos against expression of women's sexuality, in general, increases women's risk for negative consequences following disclosure of HIV status. Many PLWHA are unwilling to be tested. Mitra and colleagues³⁹ found that both practitioners and patients highlighted the issue of stigma and negative outcomes associated with testing that created barriers or contributed to delays in women receiving testing.³⁹ Since people are generally ashamed to be associated with AIDS, people believe he or she is HIV positive if someone is seen entering a clinic giving medical services to HIV positive.

A number of hospital staff admitted that they burn beds that the person with HIV had used during treatment. These practices have crucial implications on many aspects such as hiding the HIV status while getting services from any medical personnel, which might widen the vulnerability of spreading the virus. In the last 3 years, 11 doctors and 14 nurses quitted job from private clinics soon after they were assigned to HIV/AIDS section/division. Some psychologists have explained the conditions of being prejudiced which I agree with is that a person's social identity and how they would like to be seen by their family, friends, or colleagues is directly linked to their personal identity and how they value and view themselves.⁴⁰ Therefore, the more dependent a person is on their social identity for their personal identity, or on their group to give them their feeling of self-esteem, the higher the possibility of them being prejudiced. Families affect and are affected by HIV/AIDS in multiple ways. Families discriminate against their HIV-positive family members and who provide treatment to HIV-positive individuals either because of fear of the infection or because they are ashamed of the behavior that led to the infection. Family members use separate dishes, towels, and tend to avoid washing clothes in the same water as that used by PLWHA. Majority respondents were in the group of 25 of 35 years (75%) and the rest was 35 years and above. Interestingly, 7 (41%) of them were return migrants from different countries. The rest, that is, 4 (24%) were truck drivers, 5 (29%) were sex workers, and 1 was from construction work (Table 1).

A quotation from the United Press International explains the situation more clearly.

... a Bangladesh village was evacuated and a hospital was set on fire when hysterical residents found out that five villagers were diagnosed with HIV. Police detained a suspected AIDS patient in the Sylhet district and took him to an infectious diseases hospital, but the patient fled when protestors threatened to burn down the hospital. The hospital staff also panicked and claimed they would not treat anyone with AIDS. The Persian Gulf sheikdom of Dubai deported the five infected persons in early June after physicians had learned of their HIV-infected status. Three of the infected men did not disclose their conditions while receiving medical treatment because they feared they would be "burned to death by panic-stricken people."

Table 1. General Complaints (Multiple Response)^a

	f (n = 17)	%
Reluctant to clean/change beds ^b	12	71
Suggestive words (they were prostitutes, or visited prostitutes) ^c	9	53
Maintain distance ^c	15	88
Reluctant to respond to any request/call ^c	13	76
Reluctant to get closer ^c	11	65
Insulting by suggestive bad words ^c	9	53
Talk to patients with face covered ^b	13	76
Never hold patients ^b	11	65
You are bad people ^c	12	71
You are sinners ^c	7	41
Food plates are pushed toward us ^b	11	65
They spit many times when they talk to us	9	53

^a Author's survey on HIV-related stigma, 2008.

^b General staff.

^c Doctors, nurses, and general staff.

Many of the Sylhet residents felt that they would be exposed to the virus by just being around the infected patients.... United Press International, August 12, 1991.⁴¹

Not only are PLWHA discriminated and stigmatized but also are the HCPs. Most doctors, hospital staff, and nurses reported to have been excluded from family events, prevented from having contact with their own children, cut-off from the family's financial support, and even forced to leave family residences. One nurse said that her family members re-cleaned their washrooms with a special kind of detergent after she used. Doctors reported that social contacts tremendously shrank; some general staff reported that they were warned by their in-law to stop working for the HIV-positive individuals. Bharat²⁵ also found similar trend and practices within Indian society. Thus, having a family member with HIV can stigmatize the entire family—a phenomenon referred to by Goffman¹ as "courtesy stigma." However, several studies in south-east Asia reported that some communities were generally supportive of families who had a family member with HIV.⁴² The study found that although the prevalence of discriminatory attitudes toward PLWA is high, respondents tend to be less discriminating when the HIV-positive person happens to be a rich family member.

A few nurses and general staff reported that they were forced to move their homes by their tenants. Human Rights Watch⁴³ also observes that HIV-positive individuals or caregivers to HIV-positive individuals in various countries in Asia have been coerced to move from their homes by landlords. This gives a meaning to the fact why HCPs are forced to decline to provide care to the HIV-positive individuals.

... I always find them (doctors) cordoned with nurses and staff talking to each other on the door (I guess about us). They don't enter. I wanted to talk with the doctor many times. ... Sir, please come in ... I want to talk to you ... Doctors pretended that they did not hear me and turned their back....

Consequences of stigmatizations extend to next generation. Many children reported being insulted by their friends because their parents work in HIV clinics. Children whose parents are infected with HIV or work in HIV clinics, however, have faced discrimination in the community, neighborhood, and schools. Many other studies found similar findings that children have even been denied entry into schools because of their HIV status or that of their parents.^{26,44,45} Reis and colleagues⁴⁶ in their study found similar level of discrimination against children for their parents' status. The stigma and discrimination that PLWHA face are unusually multiple⁴⁷ and positive women are doubly stigmatized both as "women" and as PLWHA.⁴⁸ Traditional gender roles held by many of the world's societies are largely responsible for the reluctance to seek health care by women. Discriminatory gender role is also considered a significant barrier to have access to health care services. A number of biological factors may contribute to women's increased vulnerability to HIV/AIDS. Transmission of HIV from a man to a woman is 2 to 8 times more efficient than from a woman to a man. A woman's susceptibility to HIV infection is further increased if she or her partner has an STI, if she has experienced genital trauma, or if her partner is HIV positive and has a high viral load.⁴⁸ Stigmatization in many cases leads to discrimination where people are attacked or treated badly purely on the basis of being positive. Most female respondents said that the hospital staff including doctors thinks that "we were infected because we were sex workers."

... being thought of badly about us is more painful than carrying this diseases. When I told the nurse that I was in pain, she said, well, this is what you deserve for your past. They think we are the worst people on earth. We are here in the hospital to receive emotional support, however we receive the reverse....

Most physicians humbly agreed to say that they are under social and family pressure because of their job. Since HIV is known to be a disease spread through promiscuous sex, people involved in providing them care are looked lowly. Majority of the physicians reported being threatened deterioration and erosion of relationship with their partners and other family members. Some divorce and separation cases were reported for working in the HIV sections/units. Most of the physicians expressed their frustration and distressfulness due to varied ways they were insulted by their relatives, family members, and friends for working for the HIV-positive individuals, which let them behave "this way" with the patients. Surprisingly some physicians said that they might be infected with HIV if they continue working for long time. In general, most of the general staff consider treating HIV-positive patients as a sinful job.

Hospital authority also allows their staff (physicians and nurses) in the way they treat their patients. This is considered being "flexible." They are flexible with their staff to retain them in the hospital; otherwise they will quit the job. The stigma and resulting discrimination that people with HIV/AIDS meet is not just the result of ignorance of the people rather the

Table 2. Perceived Reasons for Discriminatory Attitude (Multiple Response)^a

	f (n = 24)	%
Partners threatened to abandon	18	75
Friends, family members, and relatives insult	11	46
Distance created to friends and relatives	21	88
Enacted stigma	14	58
Fear of being infected	11	46
Fear that treating/helping is sin	9	38

^a Author's survey on HIV-related stigma, 2008.

worst treatment often comes from medical practitioners themselves.^{49,50,51} Foley⁵² also found that the medical and social needs of HIV-positive individuals are poorly understood by the medical community. Providers often felt that they are isolated because they work in the area of HIV/AIDS (Table 2).

Discussions

HCPs theoretically believe that providing health care to HIV-positive individuals in no way could transmit HIV; however, they in most cases failed to hold this truth in heart. Many, in fact, remain 'isolated' from their family members and relatives and friends for providing care to patients with HIV. Among the barriers to greater involvement are the perceptions that stigma is too culturally specific and complicated to address and that knowledge remains insufficient for effective action. Reducing stigma is crucial in the response to HIV/AIDS to make its prevention and awareness programs that Bangladesh government has undertaken a success. To adequately address issues of discrimination, we must involve PLWHA and find out what they feel needs to be done to address stigma and discrimination.

There is abundant evidence of discriminatory policies toward PLWHA across Asia, extending from the health care sector to immigration and marriage laws. These laws often target groups stigmatized as high risk. The myth and misconception about the mode of HIV transmission play an important role in promoting discrimination. Clearly, the existing policy on ensuring privacy and providing support is not working properly. The presence of protective policy and legislation may do little to reduce enacted stigma and discrimination as these laws are rarely enforced and have minimal cultural credibility. The study raises the possibility that patients with HIV/AIDS may not fully use health care services because they are denied access by HCPs who discriminate against them. There is a dire need to strengthen the information, education, and communication component of HIV/AIDS prevention efforts to dispel misconceptions that people tend to hold. To further the understanding of the root causes of discrimination and stigmatization of PLWHA, more in-depth qualitative research is needed to understand cognitive processes that lead one to discriminate. There is a need to investigate the extent to which researchers are able to measure what they purport to measure with the

current indicators of discrimination and stigmatization. The study concludes that all clinical staff should be educated about HIV/AIDS, modes of transmission of the virus, universal precautions, and the rights of PLWA. More sensible and pragmatic orientation needs to be arranged for medical staff to create the client-friendly health service mechanism. Last but not the least, religious activities, communities, and beliefs frame the daily behaviors and attitudes of many people living in countries with high rates of HIV/AIDS. Despite the public health community's widespread interest in understanding and addressing HIV-related issues like stigma and antiretroviral treatment (ART) adherence, relatively little is known about the influence that religion and religious communities have on people's attitudes and practices concerning HIV/AIDS.²⁸ Therefore, a lot more has to be done delve into the interplay between religion and stigma.

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References

- Goffman E. *Stigma: Notes on the Management of Spoiled Identity*. New York, NY: Simon and Shuster, Inc; 1963.
- Nyblade L, Carr D. *Towards a Stronger Response to HIV and AIDS: Challenging Stigma*. Washington, DC: International Center for Research on Women; 2008.
- Malcolm AP, Aggleton P, Bronfman M, Galvao J, Mane P, Verrall J. HIV-related stigmatization and discrimination: its forms and contexts. *Crit Publ Health*. 1998;8(4):347-370.
- Brookes HB, Govender L, Makhura T, Moalusi C, Varga C. Social and community factors affecting PMTCT program efficacy and implementation in Limpopo Province. Final study report submitted to UNICEF South Africa. Human Sciences Research Council, Durban; 2004.
- Castle S. Rural children's attitudes to people with HIV/AIDS in Mali: the causes of stigma. *Cult Health Sex*. 2004; 6(1):1-18.
- UNAIDS. 2006. Overview: Asia. Fact sheet. Geneva, Switzerland: UNAIDS; 2006.
- Habibullah C. The hidden truth about HIV/AIDS in Bangladesh. HIV/AIDS coordinator, Bangladesh Red Crescent Society; 2002.
- Ullah, AKMA, Rahman A. *The Horror: A Study on Commercial Sex and Risks of HIV/AIDS in Bangladesh*. Dhaka, Bangladesh: BRAC and ARDS; 2000.
- Letamo G. HIV/AIDS-related stigma and discrimination among adolescents in Botswana. *Afr Popul Stud*. 2004;19(2): 191-203.
- Yoddumnern-Attig B, Kanaungsukkasem U, Pluemcharoen S, Thongkrajai E, Suwanjandee J. *HIV Positive Voices in Thailand: Their Voices and Choices*. London, England: The International Community of Women Living with HIV/AIDS; 2004.
- UNAIDS. *2008 Report on the Global AIDS Epidemic*. Geneva, Switzerland: UNAIDS; 2008.
- Rai MA, Warraich HJ, Ali SH, Nerurkar VR. (2007). HIV/AIDS in Pakistan: the battle begins. *Retrovirology*. 2007;4(1):22.
- Letamo G. Prevalence of, and factors associated with, HIV/AIDS-related stigma and discriminatory attitudes in Botswana. *J Health Popul Nutr* 2003;21(4):347-356.
- WHO. *2.5 Million People in India Living With HIV, According to New Estimates. Report*. Geneva, Switzerland: WHO; 2007.
- Link BG, Phelan JC. Conceptualizing stigma. *Annu Rev Sociol*. 2001;27(1):363-385.
- Reuters. *Bangladesh: Stronger HIV policy needed*. Dhaka Office; 2008.
- Parker R. Alternative sexualities and genders in Brazil. Presentation made at the conference Stigma and Global Health: Developing a Research Agenda, Bethesda, MD; 2001.
- Herek G. AIDS and stigma. *Am Behav Sci*. 1999;42(7):1102-1112.
- Rushing WA. Moralizing and scapegoating. In: Rushing WA, ed. *The AIDS Epidemic: Social Dimensions of an Infectious Disease*. Boulder, CO: Westview Press; 1995:163-180.
- Sontag S. *Illness as Metaphor and AIDS and Its Metaphors*. 1st ed. New York, NY: Doubleday, Anchor Books; 1990.
- Jacoby A. Felt versus enacted stigma: a concept revisited. *Soc Sci Med*. 1994;38(2):269-274.
- Herek G, Capitano J. Symbolic prejudice or fear of infection? A functional analysis of AIDS-related stigma among heterosexual adults. *Basic Appl Soc Psych*. 1998;20(3):230-241.
- Alonzo AA, Reynolds NR. Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory. *Soc Sci Med*. 1995; 41(3):303-315.
- Mills J, Bonner A, Francis K. The development of constructivist grounded theory. *Int J Qual Methods*. 2006;5(1). http://www.ualberta.ca/~iiqm/backissues/5_1/html/mills.htm. Accessed November 2, 2009.
- Bharat S. *India: HIV and AIDS-Related Discrimination, Stigmatization, and Denial. Best Practice Collection*. Geneva, Switzerland: UNAIDS; 2001.
- Paxton S, Gonzales G, Uppakaew K, et al. AIDS-related discrimination in Asia. *AIDS Care*. 2005;17(4):413-424.
- Paul N. Discrimination against people living with HIV/AIDS in India: educated persons as perpetrators. *J Infect*. 2006;54(1): 103-104.
- Zou J, Yamanaka Y, John M, Watt M, Ostermann J, Thielman N. Religion and HIV in Tanzania: influence of religious beliefs on HIV stigma, disclosure, and treatment attitudes. *BMC Public Health*. 2009;9:75.
- Yang C, Boone L, Nguyen TX, et al. Defensin pseudogenes in HIV-1-exposed, persistently seronegative female sex-workers from Thailand. *Infect Genet Evol*. 2005;5(1):11-15.
- Sringernyuan L, Thaweessit S, Nakapiew S. A situational analysis of HIV/AIDS-related stigma in Bangkok, Thailand. *AIDS Care*. 2005;17(suppl 2):S165-S174.
- Ickovics JR, White K, Stasko E, Ghose T. HIV-related stigma and discrimination. In: UNDP, *Asia: A Review of Human Development Consequences*. Colombo, Sri Lanka: UNDP Regional Centre in Colombo; 2007.

32. Nahar L, Hakim M. Denial from health service providers in Bangladesh: is there any space left for PWHAs? International Conference on AIDS. July 7-12; 14: abstract no TuPeE5191. NGO Forum for DWSS, Dhaka, Bangladesh; 2002.
33. Songwathana P, Manderson L. Stigma and rejection: living with AIDS in villages in southern Thailand. *Med Anthropol*. 2001; 20(1):1-23.
34. Ainsworth M, Beyrer C, Soucat A. AIDS and public policy: the lessons and challenges of 'success' in Thailand. *Health Policy*. 2003;64(1):13-37.
35. Brown BM. *Measuring HIV/AIDS Stigma*. Cape Town, South Africa: Centre for Social Science Research; 2004.
36. Kalichman SC, Simbayi LC, Jooste S, et al. Development of a brief scale to measure AIDS-related stigma in South Africa. *AIDS Behav*. 2005;9(2):135-143.
37. Bond V, Chilikwela L, Clay S, Kafuma T, Nyblade L, Bettega N. *Kanayaka: The Light is On: Understanding HIV and AIDS related Stigma in Urban and Rural Zambia*. Lusaka, Zambia: Zambart Project and KCTT; 2003.
38. Manopaiboon C, Bunnell RE, Kilmarx PH, et al. Leaving sex work: barriers, facilitating factors and consequences for female sex workers in northern Thailand. *AIDS Care*. 2003;15(1):39-52.
39. Mitra D, Jacobsen MJ, O'Connor A, Pottie K, Tugwell P. Assessment of the decision support needs of women from HIV endemic countries regarding voluntary HIV testing in Canada. *Patient Educ Couns*. 2006;63(3):292-300.
40. Letamo G. (2005). Gender dimensions in misconceptions about HIV/AIDS prevention and transmission in Botswana. 25th International Union for the Scientific Study in Population Conference, July 18-23, Tours, France; 2005.
41. United Press International. *AIDS Spreads Panic in Bangladesh Villages*. August 12, 1991. http://www.upi.com/Health_News/2007/10/12/Sex-tourists-may-be-fueling-Caribbean-HIV/UPI-5526119221368/. Accessed August 24, 2009.
42. Kespichayawattana J, VanLandingham M. Effect of co-residence and caregiving on health of Thai parents of adult children with AIDS. *J Nurs Scholarsh*. 2003;35(3):217-224.
43. Human Rights Watch. *Locked Doors: The Human Rights of People Living with HIV/AIDS in China*. New York: H. R. Watch; 2003.
44. Safman RM. Assessing the impact of orphanhood on Thai children affected by AIDS and their caregivers. *AIDS Care*. 2004; 16(1):11-19.
45. UNDP. *Results: HIV/AIDS*. New York, NY: UNDP; 2003.
46. Reis C, Amowitz LL, Heisler M, et al. Discriminatory attitudes and practices by health workers toward patients with HIV/AIDS in Nigeria. *PLoS Med*. 2005;2(8):e246.
47. UNAIDS, 2002. World AIDS Campaign 2002 -2003: HIV/AIDS-related stigma and discrimination. Fact Sheet 2002. Geneva. UNAIDS.
48. amfAR. *AIDS Research Fact Sheet. Women and HIV/AIDS* (Fact Sheet#2). Washington, DC: Public Policy Office; 2008.
49. AOHC (Association of Ontario Health Centres). HIV/AIDS prevention, care, treatment and support best practices for community health centres, Canada; 2005.
50. Ogden J, Nyblade L. *Common at its Core: HIV-Related Stigma Across Contexts*. Washington, DC: International Center for Research on Women; 2005.
51. VanLandingham M, Im-Em W, Saengtienchai C. *Community Reaction to Persons with HIV/AIDS and Their Parents in Thailand*. Ann Arbor, MI: P. S. Center, University of Michigan Institute for Social Research; 2002.
52. Foley EE. HIV/AIDS and African immigrant women in Philadelphia: structural and cultural barriers to care, *AIDS Care*. 2005; 17(8):1030-1043.