Public Health @ UM
Creating the future of Public Health

The multidisciplinary approaches in addressing internal stigma on Patient Living with HIV (PLHIV) to improve the adherence of Antiretroviral Treatment (ART)

By:
Mohd Tarmizi bin Che Ali (s2113547)
Master of Public Health,
Department of Social & Preventive Medicine
Universiti Malaya

INTRODUCTION

During the past decade, the country has seen a steady shift in the HIV epidemic landscape, which has shifted from a predominance of People Who Injecting Drug (PWID) to a greater prevalence of sexual transmission, including Man Sex Man (MSM, Female Sex Worker (FSW) and Transgender (TG). It is estimated that more than 90 per cent of HIV infections are transmitted through sexual contact in 2019. According to the National Strategic Plan Ending AIDS, Malaysia aims to achieve 90-90-90 by 2020. It is involved PLHIV, who know their HIV status, PLHIV, who are on Anti Retrovirus Treatment (ART) and PLHIV, who are virally suppressed. However, from the data of HIV Testing and Treatment Cascade, Malaysia, 2019, only 89% PLHIV knows their HIV status, 57% PLHIV on ART and 85% PLHIV who are virally suppressed (1). The statistic shows that the percentage of PLHIV seeking ART treatment is still far from the NSPEA's target. Only half of the PLHIV goes to health facilities to get ART treatment.

Internal stigma or self-stigma refers to a result of HIV status that includes negative self-perception

This issue occurred not just in Malaysia but also globally. A qualitative investigation in Sub-Saharan Africa found that only two-thirds of eligible PLHIV started ART (2). In Gujarat, India, just 12% of PLHIV started ART (3).

CURRENT ISSUES:

Antiretroviral therapy (ART) and combination regimens, or highly active antiretroviral therapy (HAART), have significantly improved HIV-infected individuals' survival. However, these treatment regimens are complicated. Due to the critical nature of adherence to ART, reliable compliance assessment is critical for successful and efficient therapy and regimen review (2). There are several critical difficulties in the research of ART adherence, one of which is the need for a reliable assessment of adherence (3). Adherence is often measured using Paterson's pioneering study, which determined that up to 95% adherence is required for efficient HIV viral suppression (2). This is often accomplished by constructing a continuous or categorical variable from patient-reported adherence that distinguishes "optimal" from "sub-optimal" adherence using the 95 per cent threshold (4).

Many factors have been discovered as barriers for PLHIV to adherence with ART treatment. One of the most common

factors is Internalized stigma or self-stigma among PLHIV. Internal stigma or self-stigma refers to a result of HIV status that includes negative self-perception. PLHIV who have internal stigma mostly feels self-blaming, fear judgement, and the person feels not deserve to live, shame because having the disease, worthless and feeling guilty causing trouble to family and feeling no longer as human(5).

Internalised HIV stigma may strongly correlate with affective and behavioural health and well-being indices in PLHIV (paths A and B in Fig. 1).

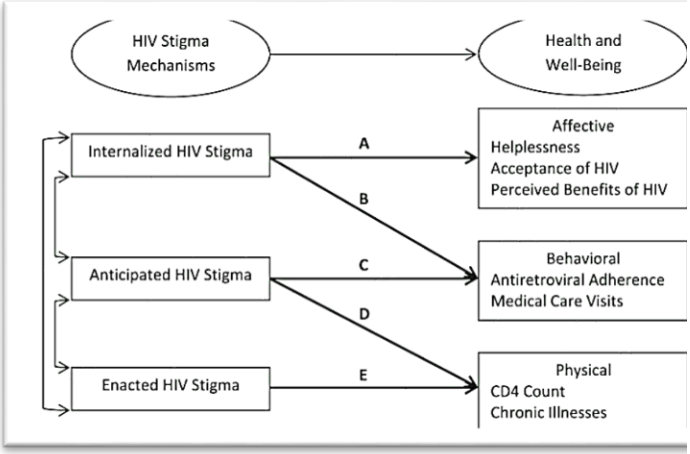

Figure 1Hypothesised associations between HIV stigma mechanisms and health and well-being among PLHIV (6)

.

Anticipated HIV stigma may have a pronounced effect on behavioural and physical indices of health and well-being in PLHIV (paths C and D in Fig. 1). PLHIV can anticipate substandard health care, social rejection, job loss, physical assault, and other forms of inequitable treatment regardless of whether they have already encountered these issues. In each situation, PLHIV who anticipate HIV stigma may avoid interactions in which they anticipate being treated negatively due to their HIV status. PLHIV is scared to go to the health care facilities for their treatment because they are afraid it may reveal their disease to others.

Earnshaw et al. conducted a study on the HIV-Stigma Framework and discovered that internalised HIV stigma had the strongest relationships with affective health and well-being measures. Internal HIV stigma was also uniquely associated with poorer behavioural health and well-being measures, such as longer days between medical appointments and a higher risk of ART non-adherence (1).

Depressive symptoms may also modulate the connection between internalised stigma and visit adherence in men. Depressed feelings are more common in guys than women in terms of internalising negative attitudes about their HIV status, leading to lower visit adherence. The new research implies that internalised stigma influences other HIV care continuum outcomes, notably ART adherence, via depressive symptoms. Another important conclusion is that attending HIV care visits reduces the impact of internalised stigma on ART adherence (9). Specifically, evidence shows that internalised stigma reduces visit attendance, which reduces adherence to ART.

Despite Malaysia's high non-adherence to ART, it is well below the aim set in our National Strategic Plan to End AIDS. It is a public health issue. Adherence to antiretroviral medication (ART) in PLHIV is critically important for public health. Multidisciplinary techniques should be employed to reduce internal stigma among HIV positive Malaysians.

MULTIPLE APPROACHES TO REDUCE THE INTERNAL STIGMA AMONG PLHIV IN ADHERENCE TO TREATMENT

Studies have shown that a combination of approaches has a better impact on improving adherence to ART

treatment and helps reduce the internal stigma among PLHIV. Through this strategy, the PLHIV will be taught coping skills and those who need counselling services should be assisted accordingly. The Education, Community involvement, Contacts with affected and infected groups, and Continuous counselling, named ECCC approach.

1. **Education on Stigma causes, effects, and reduction activities.**

An education strategy should be developed through seminars and public awareness campaigns. Angula and Ncama have created two training manuals based on existing content (7). A single manual can educate HIV-positive people on reducing stigma. These methods can teach community leaders or other groups like young people or staff from nonprofits. Lesson plans for health professionals on stigma reduction can be found here. Stigma and its influence on persons afflicted or impacted can be taught using certain curriculum units.

Reducing Stigma Education Will Address

- HIV/AIDS in general, including how HIV is transmitted and not transmitted, reduces the risk of non-sexual casual contact.
- Educate others about stigma, its causes, and its effects on stigmatised people, and how to reduce it.
- Stigma education should address common issues like verbal abuse, social isolation, and low self-esteem.
- Benefits to the community and reduced stigma

How Can Education Be Used?

- Workshops on HIV/AIDS stigma reduction for qualified participants/trainees (preferable community and opinion leaders and PLHIV support groups).
- Empowering kids to act as change agents and peer educators in their communities to transform PLHIV attitudes and behaviours.
- Life skills teachers should educate students on stigma and HIV transmission mechanisms to reduce fear and stigma against other HIV positive students and learners. • Hold essay contests on HIV/AIDS stigma reduction and publish the winning essays in local media.
- Create a forum for questions and answers on local radio stations about HIV/AIDS and stigma.

2. **Community Involvement drove by community and opinion leaders**

Participation in the community is critical in every activity aiming at improving health. Personal communication amongst experts, opinion leaders, health care providers, and family and friends of HIV/AIDS patients is as crucial as using mainstream media to spread the word. It should be used to educate the public on stigma, its consequences on people stigmatised, and how to reduce it.

Consider the following options for implementation:

- Educate the community on the impact of HIV/AIDS stigma on new infections, ART adherence, disclosure, and stigmatised groups. Give examples of HIV-positive people being stigmatised.
- Use the media to help reduce stigma, especially radio, which most rural towns lack. • The media should avoid derogatory remarks about HIV/AIDS, such as "AIDS kills." Ads urging people to quit stigmatising

others. Use text messaging and social media to educate and mobilise the community against HIV/AIDS stigma. If feasible, let Parliament discuss HIV/AIDS stigma.

- Educate the community about PLHIV rights and PLHIV rights and duties. This will allow them to get help at school without compromising their privacy.

3. Contact Approach: Motivated PLHIV Living Positively

It is possible to share a room with an HIV positive individual, eat together, or talk with them without fear of stigma. Invite motivated PLHIV who are appropriately counselled and live positively to testify stigma to help people understand its importance, repercussions, and how it hinders HIV prevention and treatment. PLHIV should be taught to reduce stigma. People are more receptive to changing their views and behaviour if they hear firsthand accounts of stigma.

Recommendations for Using Contacts

- AIDS is no longer a taboo subject. That should help reduce stigma and increase HIV disclosures, but it does not compromise confidentiality.
- Use video to show how the community harms marginalised people. Other movies or images can be delivered to raise awareness.
- Encouraged APLHIV to offer community testimonials. Let them talk about stigma.
- Stigma reduction activities should include HIV-positive people's families.

4. Continuous counselling for PLHIV and families.

Counselling helps people sort out issues and make informed decisions. It involves explaining or improving someone's behaviour, values, or living circumstances. Because HIV/AIDS is connected to mental stress, those affected need counselling.

- Increasing community counselling programmes to help PLHIV overcome self-stigma and emotional difficulties.
- HIV positive people's families should be counselled when needed.

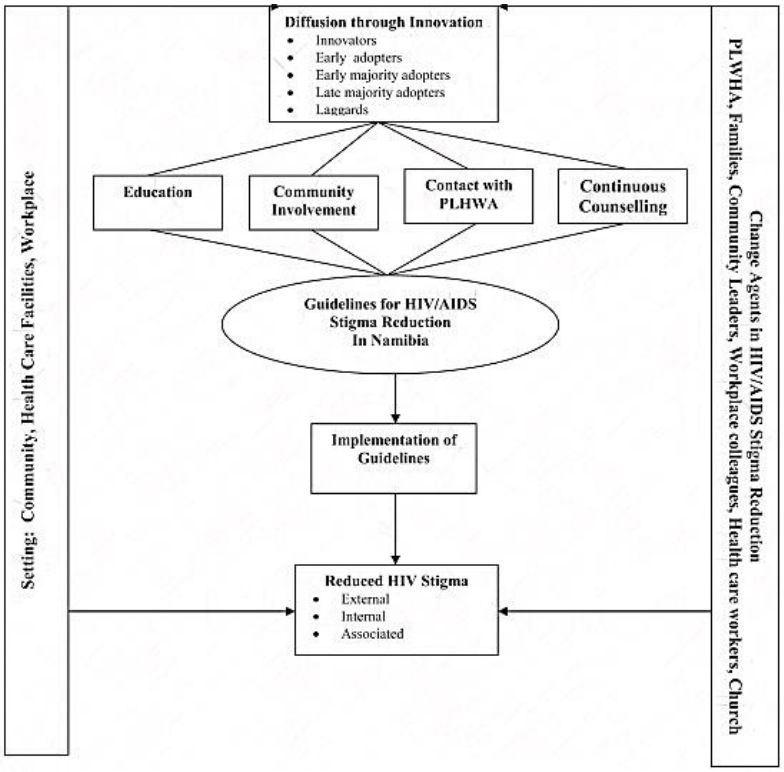

Figure 2Internal stigma or self-stigma refers to a result of HIV status that includes negative self-perception

REFERENCES

1. Ministry of Health Malaysia. MALAYSIA 2020, Country Progress Report to HIV/AIDS Epidemic. Malaysia HIV/AIDS Prog Rep [Internet]. 2020;1–25. Available from: https://www.unaids.org/sites/default/files/media_asset/global-aids-monitoring_en.pdf
2. Paterson DL, Swindells S, Mohr J, Brester M, Vergis EN, Squier C. Erratum: Adherence to protease inhibitor therapy and outcomes in patients with HIV infection (Annals of Internal Medicine (2000) 133 (21-30)). Ann Intern Med. 2002;136(3):253.
3. Malta M, Petersen ML, Clair S, Freitas F, Bastos FI. Adherence to antiretroviral therapy: a qualitative study with physicians from Rio de Janeiro, Brazil. Cad saúde pública / Ministério da Saúde, Fundação Oswaldo Cruz, Esc Nac Saúde Pública. 2005;21(5):1424–32.
4. Sabin LL, DeSilva MB, Hamer DH, Keyi X, Yue Y, Wen F, et al. Barriers to adherence to antiretroviral medications among patients living with HIV in southern China: A qualitative study. AIDS Care - Psychol Socio-Medical Asp AIDS/HIV. 2008;20(10):1242–50.
5. Naidoo JR, Uys LR, Greeff M, Holzemer WL, Makoae L, Diamini P, et al. Urban and rural difference in HIV/AIDS stigma in five African countries. African J AIDS Res. 2007;6(1):17–23.
6. Earnshaw VA, Smith LR, Chaudoir SR, Amico KR, Copenhaver MM. HIV stigma mechanisms and well-being among PLWH: A test of the HIV Stigma Framework. AIDS Behav. 2013;17(5):1785–95.
7. Angula P, Ncama BP. Guidelines for Community-Based HIV/AIDS Stigma Reduction Intervention in a Rural Community. World J AIDS. 2016;06(01):27–36.