Stigma as a barrier for testing Overwiew of research

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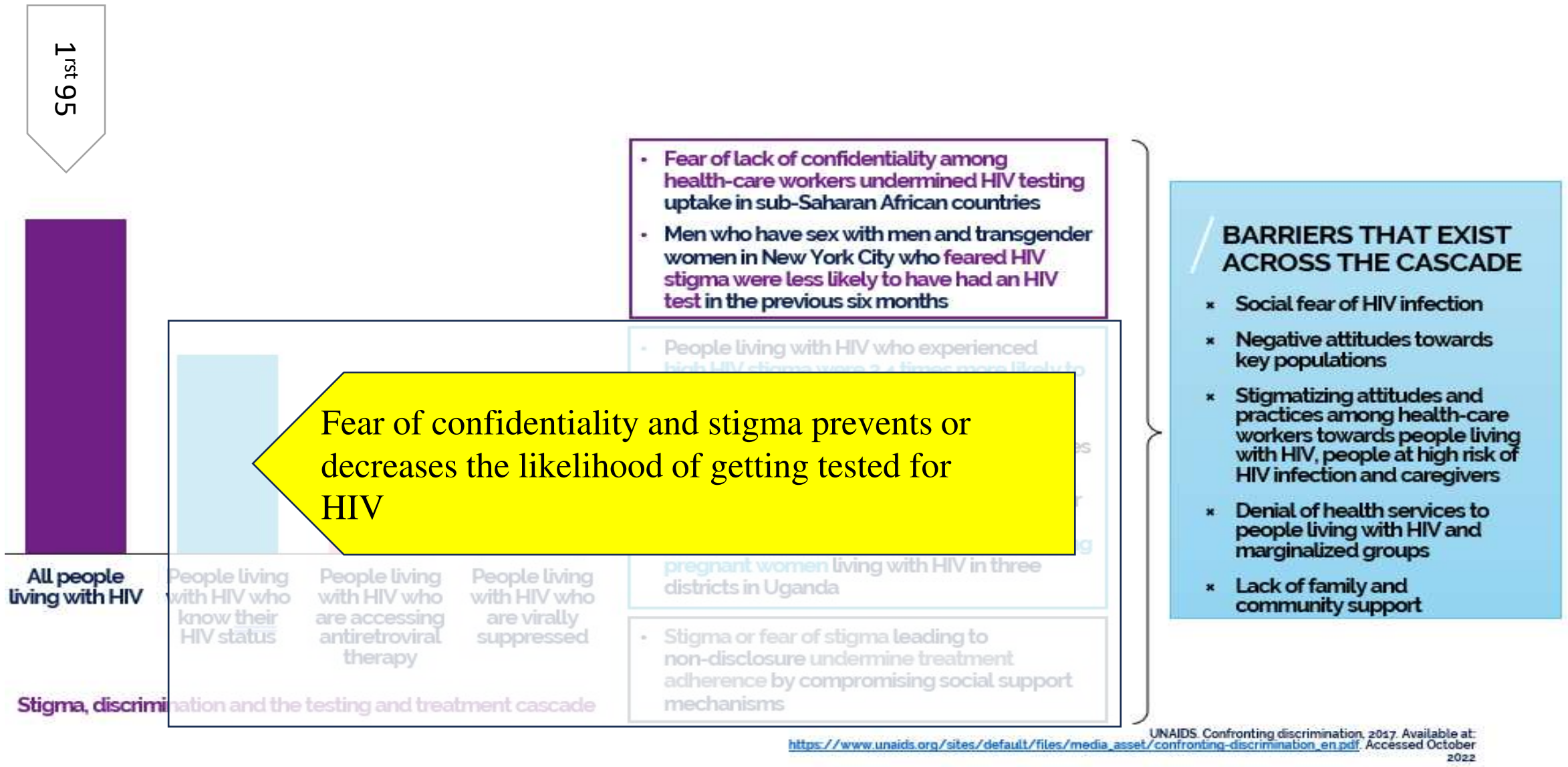
STIGMA PREVENTS THE ACHIEVEMENT OF THE UNAIDS TARGETS



UNAIDS. Confronting discrimination. 2017. Available at: https://www.unaids.org/sites/default/files/media_asset/confronting-discrimination_en.pdf. Accessed October 2022

BARRIERS TO HIV TESTING

HEALTH SYSTEM LEVEL

PATIENT LEVEL

- LOW RISK PERCEPTION
- FEAR OF DISEASE
- FEAR OF DISCLOSURE
- ACCESSIBILITY OF HEALTH SERVICES

INSTITUTIONAL/POLICY LEVEL

Deblonde et al. (2010). Barriers to HIV testing in Europe: A systematic review. *European Journal of Public Health*, *20*(4),

BARRIERS TO HIV TESTING

HEALTH SYSTEM LEVEL

MISSED DIAGNOSTIC OPPORTUNITIES

- ✓ 59% of new diagnoses believed they could have been tested sooner if someone had told them about the risk (n = 247)
- ✓ 40% people: the main reason for HIV testing was the primary physician's recommendation (n = 247)
- ✓ 81% of the Spanish population (n = 1044) reported not having been ever tested because their physician has not recommended it.
- ✓ Primary care physicians had not offered the test to 82.4% Africans diagnosed with HIV+ (n= 176)

A large proportion of the population has not been tested for HIV because no healthcare professional (HCP)has offered it to them and that those who have been tested or would be tested have been positively influenced by medical advice.

Why HCP do not offer HIV testing more often?

Burns et al. (2007) Why the(y) wait? Key informant understandings of factors contributing to late presentation and poor utilization of HIV health and social care services by African migrants in Britain. *AIDS Care*, *19*(1), 102–108.
Fuster-RuizdeApodaca et al. (2017). Psychosocial determinants of HIV testing across stages of change in Spanish population: a cross-sectional national survey. BMC Public Health, 17(1),

BARRIERS TO HIV TESTING

HEALTH SYSTEM LEVEL

STIGMA-RELATED BARRIERS

- **ANXIETY: INHIBITION/AVOIDANCE**
- **MISATTRIBUTED VULNERABILITY (STEREOTYPES)**

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BARRIERS TO HIV TESTING

HEALTH SYSTEM LEVEL

STIGMA-RELATED BARRIERS

ANXIETY: INHIBITION/AVOIDANCE

Some physicians are inhibited when talking about HIV with their patients or even avoid it and prefer to refer to other services in case they have to address this issue.

This inhibition or avoidance also occurs in patients who report feeling embarrassed or uncomfortable talking to their doctor about their sex life, among other personal and sensitive issues.

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Burns et al. (2007). Why the(y) wait? Key informant understandings of factors contributing to late presentation and poor utilization of HIV health and social care services by African migrants in Britain. *AIDS Care*, *19*(1), 102–108.
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BARRIERS TO HIV TESTING

HEALTH SYSTEM LEVEL

STIGMA-RELATED BARRIERS

MISATTRIBUTED VULNERABILITY (STEREOTYPES)

It was found that people who do not "fit traditional risk profiles" are not asked to test. It could be that some physicians continue to have a stereotypical view of the infection, which interferes with the opportunity to diagnose early.

Deblonde et al. (2010). Barriers to HIV testing in Europe: A systematic review. *European Journal of Public Health*, *20*(4),
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CLINICAL CASE EXAMPLE

"I spent four years going to doctors. In the mornings, I couldn't walk well. In the emergency room, they thought it was from the back. They did magnetic resonance (MR) and told me that I had hernias ..., they gave me anti-inflammatories ..., then I could not walk .., and also my arms .., they did MR of the head .., the doctor told me that I had a brain tumor and that I was going to live 6 months.. They sent me to the neurologist and told me I had to operate... They did a very big surgery. They removed the tumour.. Later in the hospital, the doctor came to me and said: we have the result of the analysis of the tumour. It is a toxoplasma. He immediately tested me for HIV."

Married woman and nurse: profile that does not fit traditional stereotypes

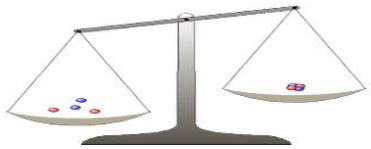
Fuster-RuizdeApodaca et al. Determinants of late diagnosis of HIV infection in Spain. Psychosoc Interv. 2014;23(3):177–85

BARRIERS TO HIV TESTING

HEALTH SYSTEM LEVEL

PREDICTORS OF STIGMA IN HEALTHCARE WORKERS

Personal perspective



Professional perspective

- Gender, political ideology, conservative values, education.
- Perceived severity of HIV,
- Misbeliefs about HIV transmission
- Attributions of blame towards PHIV
- Degree of proximity to PHIV

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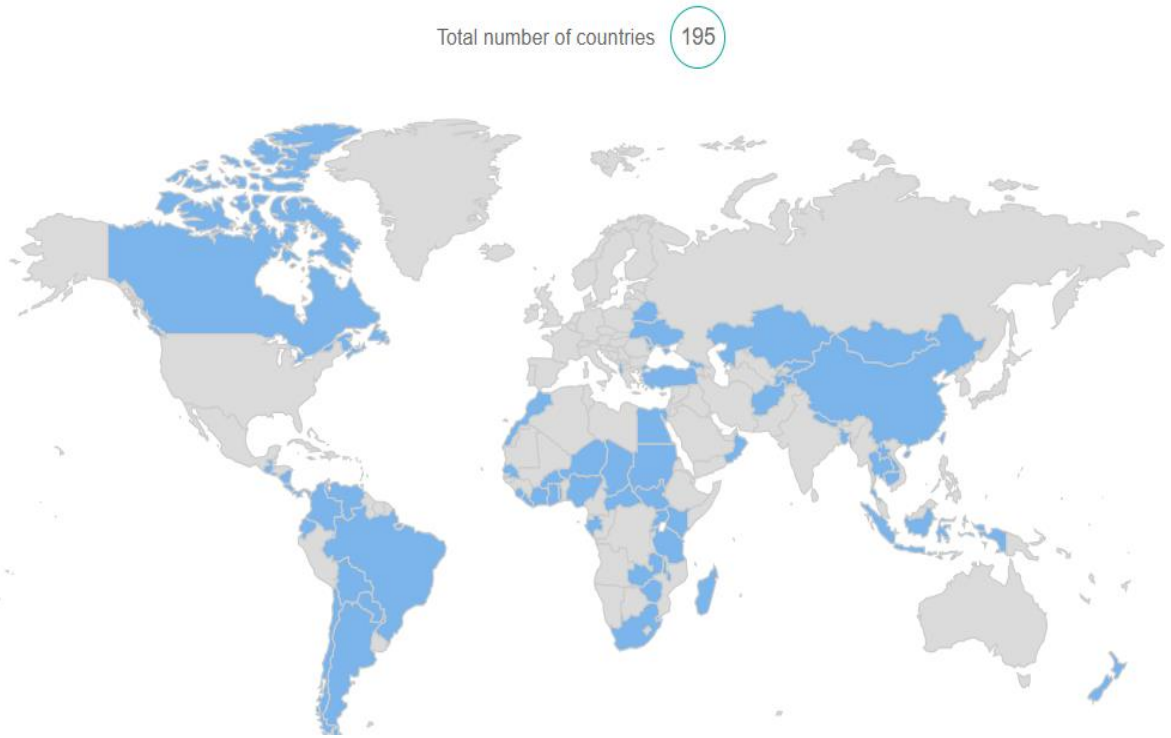
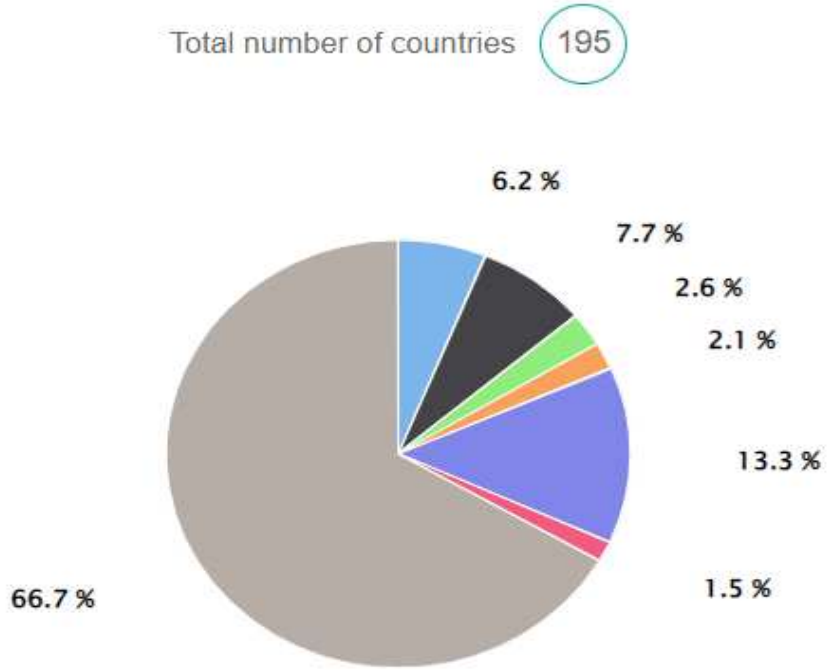
- Professional experience in HIV
- HIV knowledge
- Self-confidence and self-efficacy in caring for PHIV
- Concerns about occupational infection (perceived risk)

Fuster-RuizdeApodaca et al. (2013). Healthcare proffesionals' attitudes towards PHIV in Spain. XVI SEISIDA National Conference and XI AIDS Impact international conference. https://www.seisida.net/wp-content/uploads/2019/12/Presentacion-estudio-estigma-ambito-sanitario_Fuster-et-al_seisida13.pdf

Delivery of training programs on HIV-related human rights and non-discrimination for healthcare workers (2022)





Despite the awareness of the existence of stigma and the factors that facilitate it, data from UNAIDS last year showed a limited percentage of countries delivering stigma-related programs. 2/3 of countries did not report data. In Europe, only a few Eastern European countries reported data. This data reveals that they deliver such programs as a recurrent part of on-the-job training at the national level

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STIGMA-RELATED BARRIERS

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Negatively associated with testing

- ✓ 70% of newly diagnosed Africans did not perceive themselves to be at risk (UK, n =256)
- ✓ 43% of MSM had never been tested due to a lack of risk perception even though they had risky sexual practices (Netherlands, n = 1627)
- ✓ 91% of the Spanish general population did not perceive risk of acquiring HIV and 41% expressed because only certain groups of people have HIV (n = 1499)

Deblonde et al. (2010). Barriers to HIV testing in Europe: A systematic review. *European Journal of Public Health*, *20*(4),
Fuster-RuizdeApodaca et al. (2017). Psychosocial determinants of HIV testing across stages of change in Spanish population: a cross-sectional national survey. BMC Public Health, 17(1),

BARRIERS TO HIV TESTING

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PATIENT LEVEL

- LOW-RISK PERCEPTION
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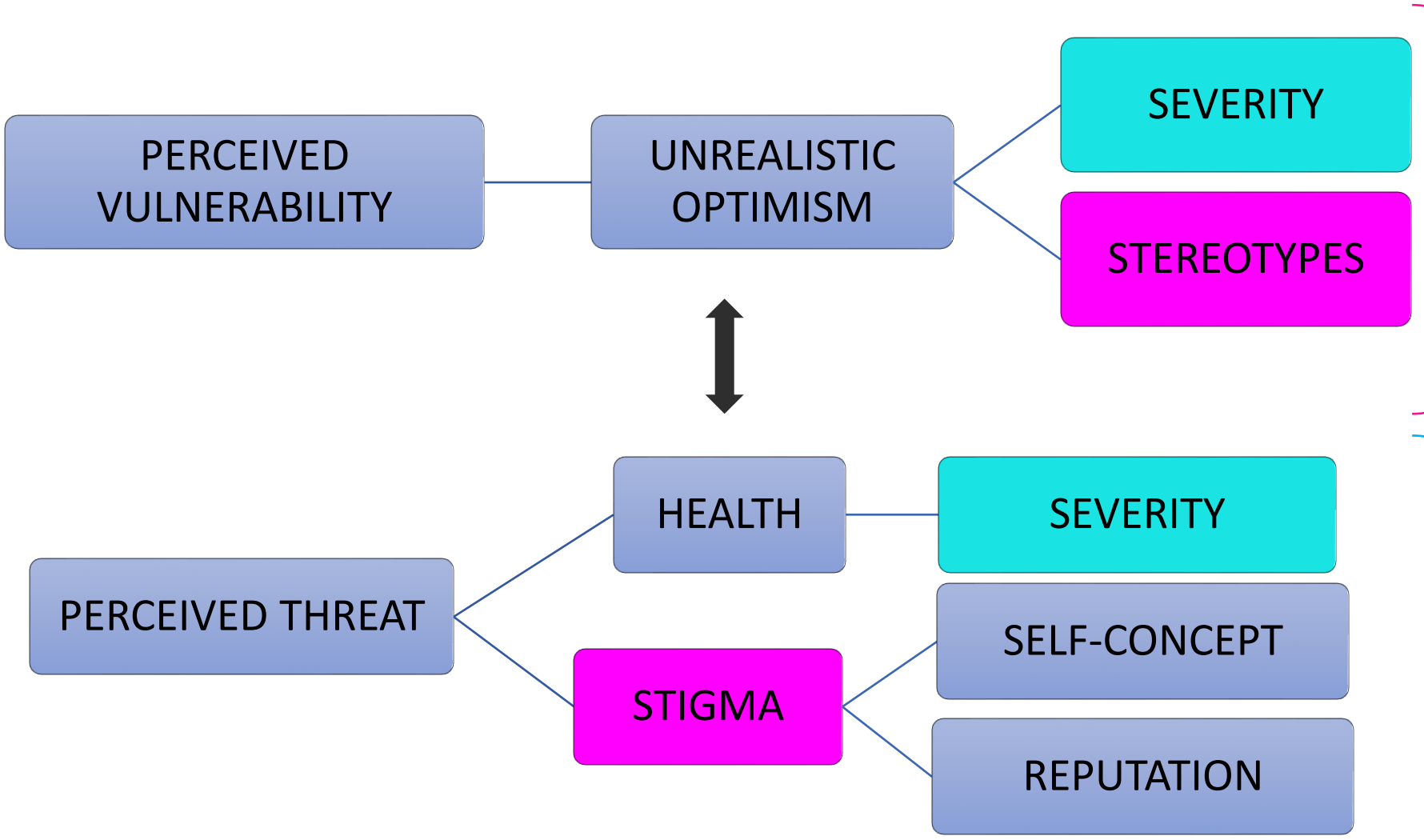
- ✓ Fear of the possibility of encountering someone at the test site and of blaming and anticipated discrimination (UK)
- ✓ Fear lack of confidentiality: 2nd most frequent barrier to testing (The Balkans)
- ✓ 43% concerned about rejection of loved ones (Spain)

Deblonde et al. (2010). Barriers to HIV testing in Europe: A systematic review. *European Journal of Public Health*, *20*(4), .
Fuster-RuizdeApodaca et al. (2017). Psychosocial determinants of HIV testing across stages of change in Spanish population: a cross-sectional national survey. BMC Public Health, 17(1),

VARIABLES INFLUENCING BARRIERS AT PATIENT LEVEL

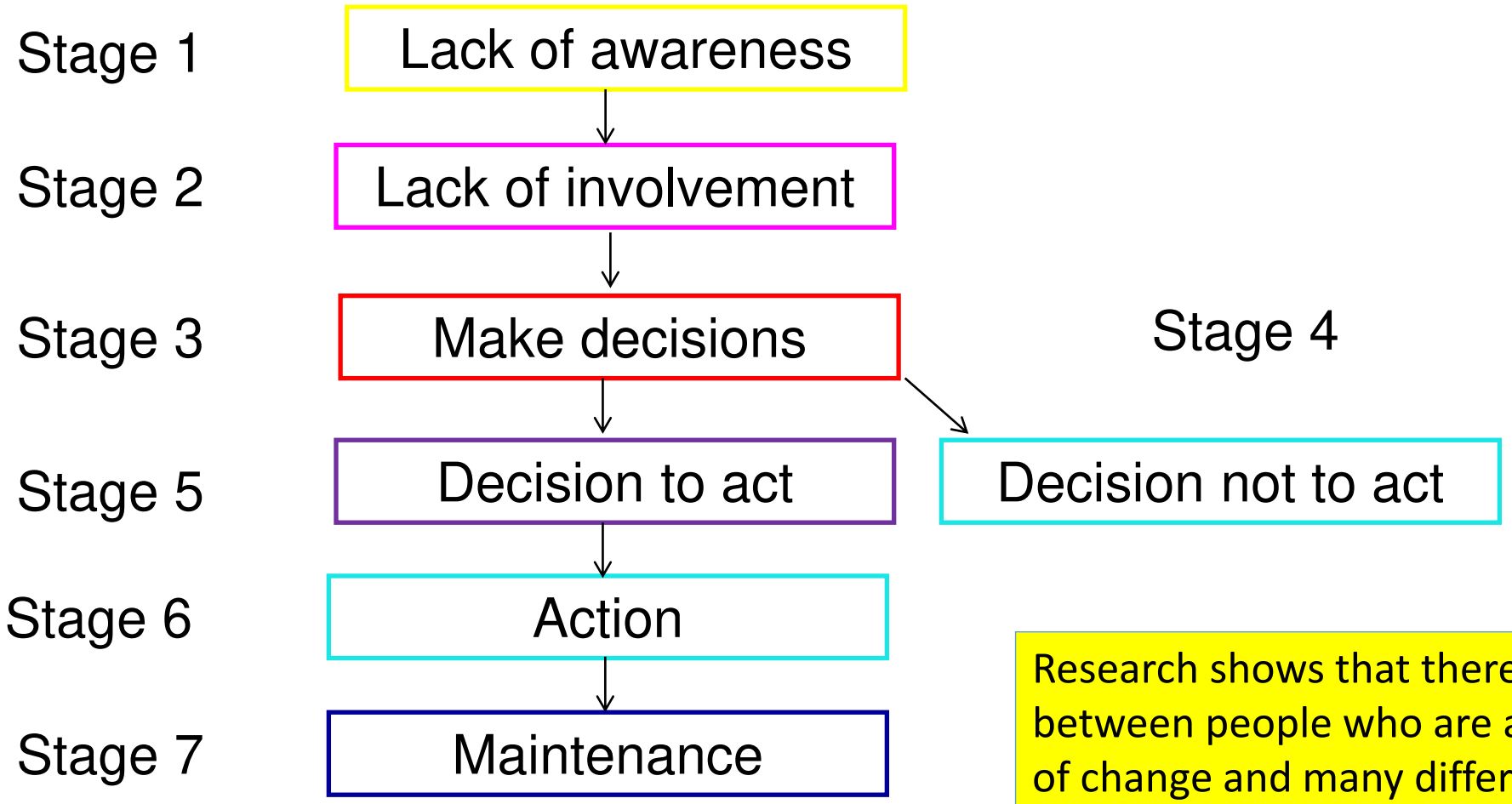


People generally think that negative things, including illness, are less likely than average to happen to us. This unrealistic optimism is more likely when the illness is severe, and there are stereotypes about it.

The threat to health from the perception of severity and the threat of stigma makes the problem of getting tested for HIV that much significant, as it is something that "marks or segregates": getting tested can be a threat to self-concept (avoidance).

Weinstein ND. Unrealistic optimism about susceptibility to health problems. J Behav Med. 1982;5(4):441–60.
Fuster-RuizdeApodaca et al. Determinants of late diagnosis of HIV infection in Spain. Psychosoc Interv. 2014;23(3):177–85

STAGES IN ADOPTING HEALTH BEHAVIOURS



Research shows that there are few differences between people who are at a particular stage of change and many differences between those who are at different stages.

Weinstein ND, Sandman PM. A model of the precaution adoption process: Evidence from home radon testing. Heal Psychol. 1992;11(3):170–80

STAGES IN ADOPTING HEALTH BEHAVIOURS

Stage 1 — Lack of awareness

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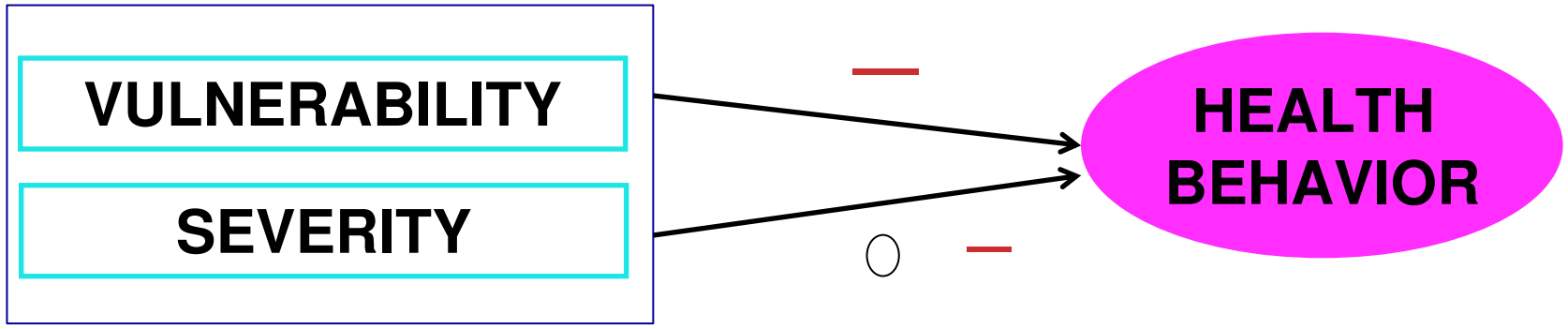
Stage 2 — Lack of involvement

In the early stages, before the decision-making, perceived threat (vulnerability or severity), either has a negative influence or no influence on adopting health behaviours. Threat leads to anxiety, avoidance, lack of vulnerability or self-efficacy.



- ✓ Anxiety: Avoidance/Inhibition
- ✓ Misattributions of vulnerability
- ✓ Lack of self-efficacy

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CLINICAL CASE EXAMPLE

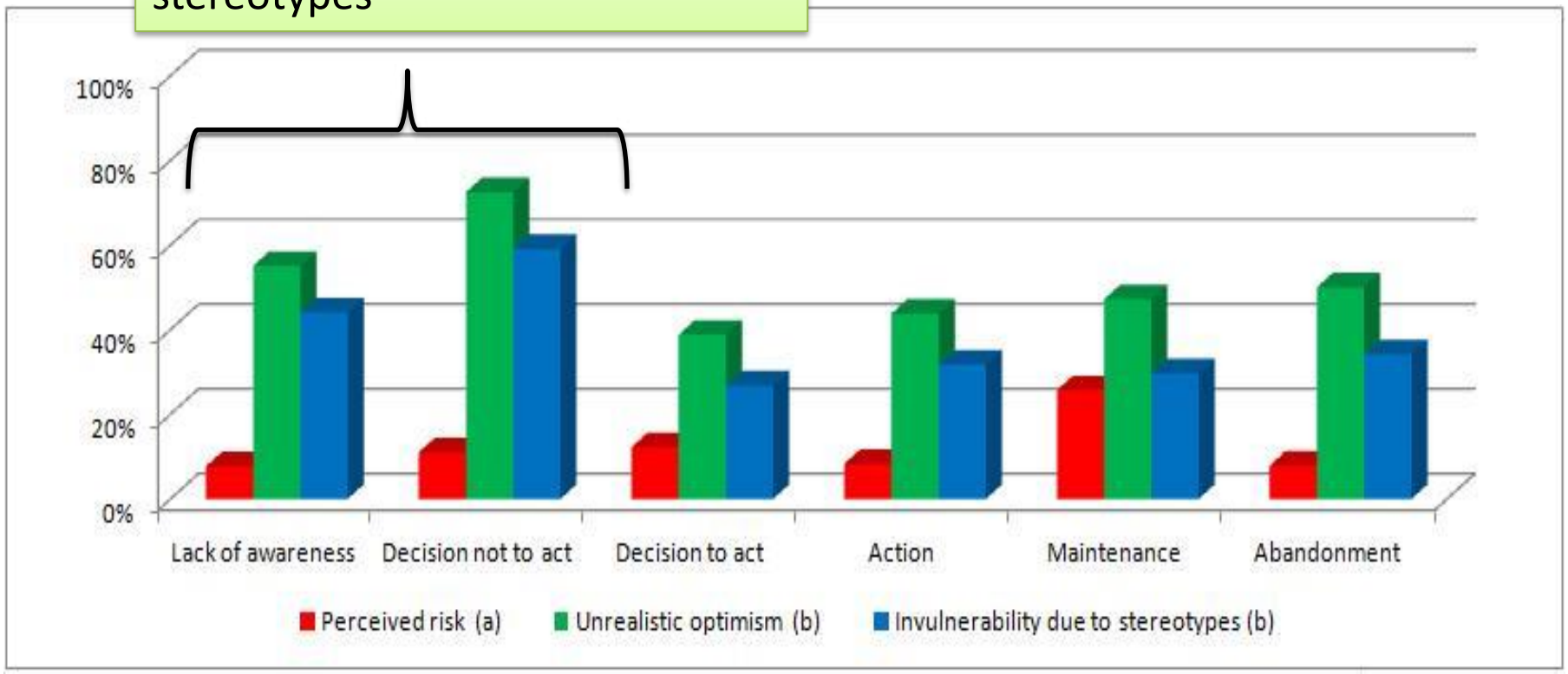
"I started to feel bad, I started losing strength, my legs were shaking. I had been a junkie and always felt that it could be that (HIV). In the past I had thought about getting tested, but I never did it out of fear... I went to the doctor.., four times to the emergency room... I told the doctors my symptoms and that I was being treated for hepatitis C. They did normal tests and nothing ever came out. I never told the doctor to test me for HIV for fear that I would.

Heterosexual male, previous history of drug use, hepatitis C

Fuster-RuizdeApodaca et al. Determinants of late diagnosis of HIV infection in Spain. Psychosoc Interv. 2014;23(3):177–85

STIGMA AND LATE DIAGNOSIS ACROSS STAGES OF CHANGE

Greater unrealistic optimism and less vulnerability associated with stereotypes



Fuster-RuizdeApodaca et al. Psychosocial determinants of HIV testing across stages of cange in the Spanish population: a cross-sectional national survey. BMC Public Health.; 2017; 17(1):234

STAGES IN ADOPTING HEALTH BEHAVIOURS

Stage 1 — Lack of awareness

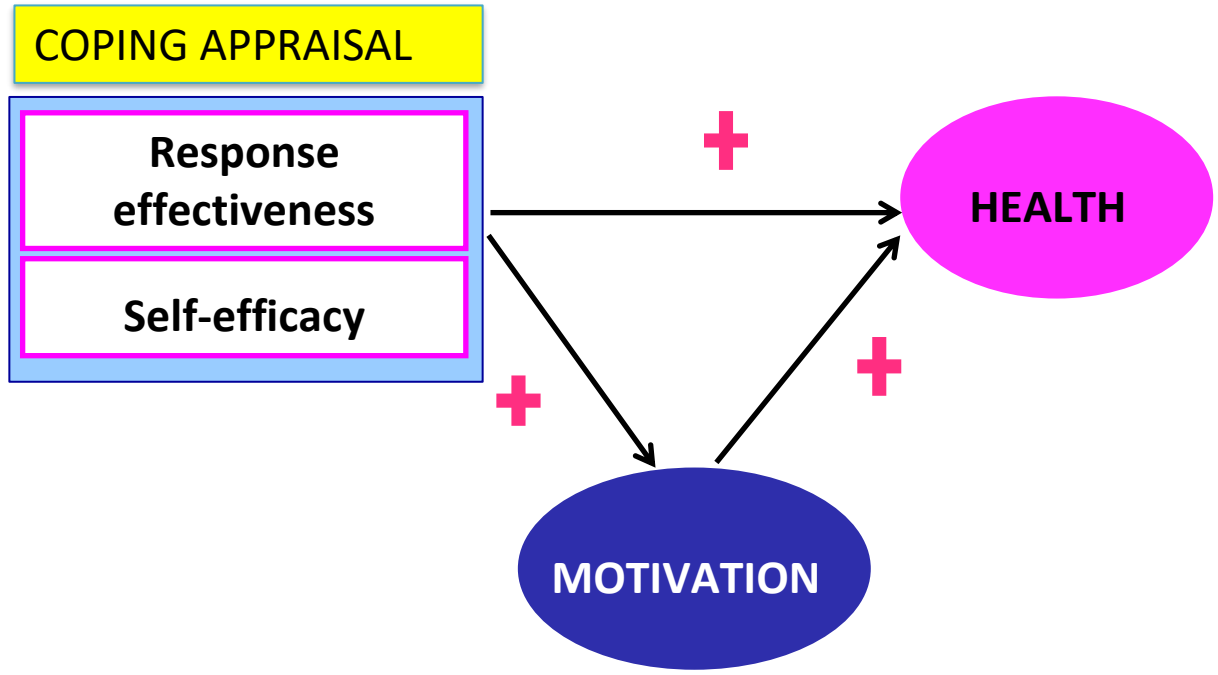
Stage 2 — Lack of involvement

Stage 3 — Make decisions

Stage 5 — Decision to act

Stage 6 — Action

Stage 7 — Maintenance



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BARRIERS TO HIV TESTING

PUNITIVE LAWS PREVENT HIV TESTING

- ✓ Criminalisation of HIV transmission
- ✓ Discriminatory treatment and unlawful of same-sex sexual relationships
- ✓ Penalty of sex work
- ✓ Lack of access HIV testing for undocumented migrants

INSTITUTIONAL/POLICY LEVEL

Deblonde et al. (2010). Barriers to HIV testing in Europe: A systematic review. *European Journal of Public Health*, *20*(4)
UN Political Declaration on HIV and AIDS: Ending inequalities and getting on track to end AIDS by 2030

CONCLUSIONS

- HIV stigma contributes to the failure to achieve all the AIDS Global goals, particularly the first 95.
- Prejudice, stereotypes, and discrimination against people with HIV create a social context in which personal concerns for safety, a sense of shame, social exclusion and other adverse social conditions accompany the fact of receiving a positive HIV test.
- People who endorse prejudicial attitudes towards people with HIV are themselves less likely to accept HIV testing.
- Anticipating future stigma is linked to lower testing uptake rates in multiple populations.
- Punitive laws, such as criminalizing HIV and sexual behaviours, can also undermine efforts to increase HIV testing.
- Stigma-related barriers to HIV testing occur at different levels, and the response must be multilevel and multi-component.

Sullivan et al. Falling Short of the First 90: HIV Stigma and HIV Testing Research in the 90–90–90 Era. AIDS Behav. 2020;24(2):357–62.

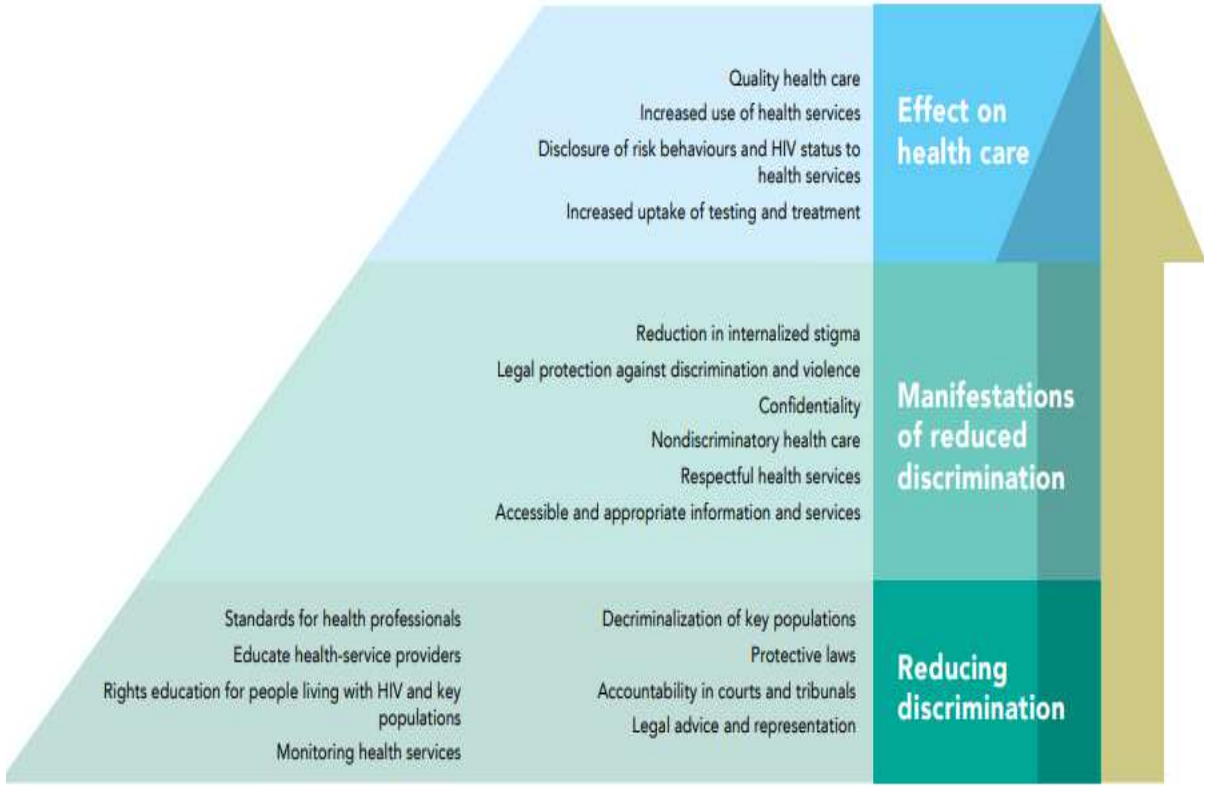
ACTIONS

HepHIV 2023
13-15 NOVEMBER·MADRID

UNAIDS 2017 | REFERENCE

Confronting discrimination

Overcoming HIV-related stigma and discrimination in health-care settings and beyond



INTERVENTIONS

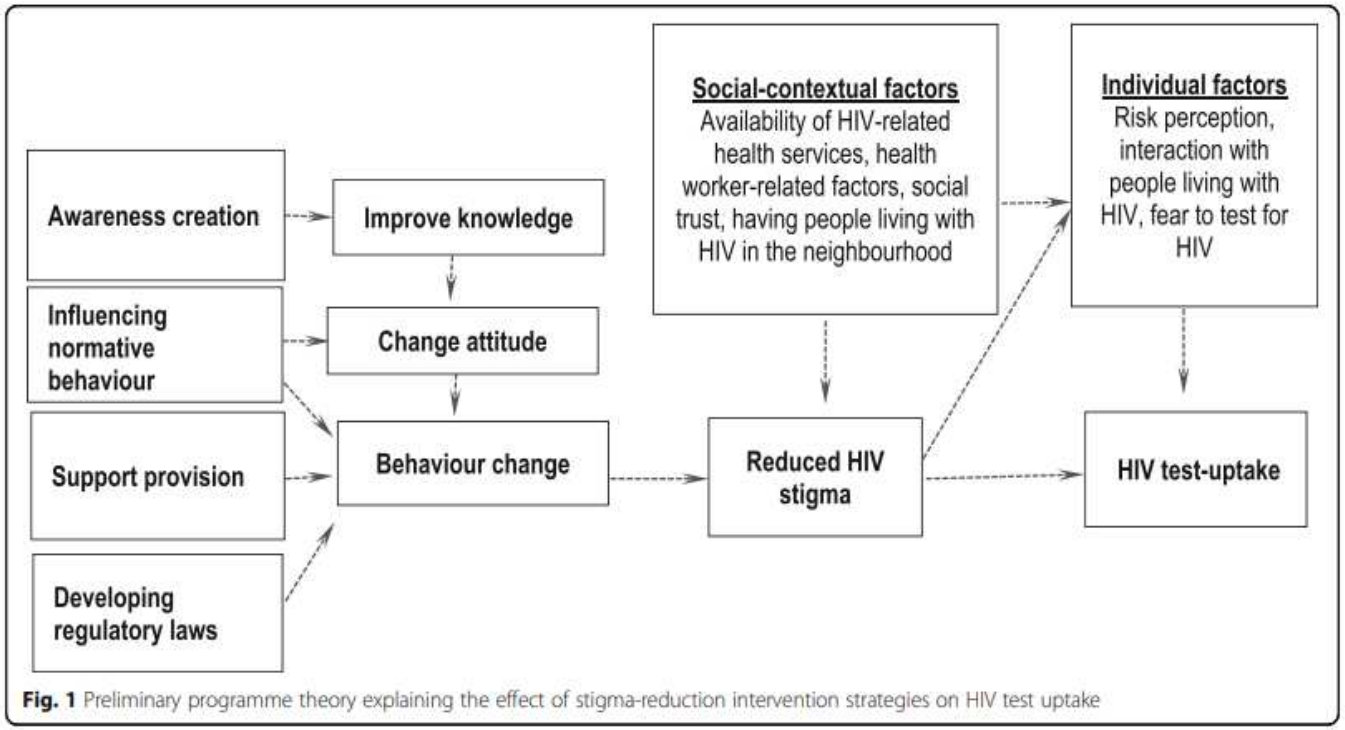


Fig. 1 Preliminary programme theory explaining the effect of stigma-reduction intervention strategies on HIV test uptake

A systematic review of 34 articles about stigma-reduction interventions strategies on HIV test uptake

Interventions produced an effect through two pathways:

(a) Knowledge leads to changes in stigmatizing attitudes

(b) knowledge and attitudes lead to changes in stigmatizing behaviours and HIV test uptake.

The identified pathways were found to be influenced by some structural factors (e.g., anti-homosexuality laws, country-specific HIV testing programmes and policies), community factors (e.g., traditional beliefs and practices, sexual taboos and prevalence of intimate partner violence) and target-population characteristics (e.g., age, income and urban-rural residence)

Thapa et al. Stigma reduction in relation to HIV test uptake in low- and middle-income countries: A realist review. BMC Public Health. 2018;18(1):1–21.

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