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THE IMPACT OF SOCIAL STIGMAS ON SEXUAL HEALTH SEEKING BEHAVIOR: A REVIEW OF LITERATURE

Jason O. Talley
Dr. Jeffrey Schulz and Dr. Joan Cowdery, Mentors

ABSTRACT

Studies show a meaningful association between STI/HIV-related stigmas and low adherence to routine STI testing (Morris et al., 2014; Hull et al., 2017). These studies also show that healthcare workers help to facilitate a culture of stigmas among coworkers and patients. According to a national survey, only 16.6% of women and 6.1% of men who participated in the survey had been tested in the last 12 months (Cuffe et al., 2016). Low rates of STI testing contribute to the spread of chlamydia, gonorrhea, HIV, and syphilis (Big-Ideas-HIV-STIs.pdf, n.d.). The motivation for this literature review is to examine how STI and HIV-related stigmas influence sexual health seeking behaviors and sexual health outcomes for patients aged 18 to 24. This paper also examines how healthcare providers and clinicians perpetuate stigmas among patient populations and what kinds of sex education programming have been effective in improving sexual health behavior.

LITERATURE REVIEW

Introduction

The scope of this review. Continuous increases in Sexually Transmitted Infections (STI) and Human Immunodeficiency Virus (HIV) rates over the last five years are undeniable. In 2018, consolidated incidence cases of chlamydia, gonorrhea, and all stages of syphilis totaled 2,419,774 (Centers for Disease Control and Prevention [CDC], 2019d). The CDC estimated that in 2017 the costs related to congenital syphilis were over $12 million (National Academy of Public Administration, 2019). The widespread implementation of abstinence-only education has encouraged further stigmatization of sexual health (Kirby, 2008). Re-
search has confirmed that abstinence-only education produces no meaningful impact on participants’ understanding of STI/HIV transmission, and in some cases, has increased participants’ chances of being exposed to or transmitting an STI (Hogben et al., 2010; Santelli et al., 2017). The gap in STI/HIV knowledge created by abstinence-only education has increased stigmas among Adolescent Young Adults (AYAs). It is well documented that stigmas create significant barriers for individuals seeking sexual health treatment and related services. Studies have shown a link between a person’s knowledge of how STI/HIV are transmitted and levels of stigma. These studies found that as levels of STI/HIV knowledge wanes, stigmas increase (Kingori et al., 2017; Thornicroft et al., 2007; Yang et al., 2006). Data suggest that an increase in knowledge about STI/HIV transmission, disease and infection severity, and risk-reduction behaviors corresponds to declining levels of stigma.

Similar gaps in knowledge have been found among healthcare providers and medical students. Unless a student or clinician specializes in HIV prevention, treatment, and care, many healthcare workers (HCWs) do not receive STI/HIV training. Lacking training, many HCWs are unprepared to meet the needs of their patients (Stringer et al., 2016). Within healthcare facilities, STI/HIV stigmas negatively impact the quality of care, successful health outcomes, and accurate diagnoses and treatment (Nyblade et al., 2019). This review of literature examines possible causes of the STI and HIV epidemic, identifies sex education programs that have been successful in improving sexual health outcomes, and discusses the impact that STI/HIV-related stigmas have on sexual health-seeking behaviors and sexual health outcomes. This study also focuses on how healthcare providers and clinicians perpetuate stigmas about STI/HIV among patient populations. Gaining new insight on how these themes influence the health outcomes for STI/HIV-positive patients is important because it may assist program planners in developing more effective stigma-reduction interventions.

**Keywords:** STI, HIV, Stigma, Intervention, CDC, Sexual Health Education

**Databases:** Elsevier, ResearchGate, Social Sciences Citation Index, PsycINFO, CINAHL, CDC Community Health Improvement Navigator, PubMed Health, SEER, STD Communications Database.

**Factors Leading to STI Epidemic**

In 2017, infectious disease research showed that the ongoing STI epidemic in the U.S. has negatively impacted AYAs for the last three de-
cades. AYAs make up approximately 27% of sexually active Americans, but they represent an alarming 50% of annually combined reported cases of chlamydia, herpes, HPV, HIV, gonorrhea, and all types of syphilis (Youth-sti-infographic.pdf, 2013). According to a 2019 press release from the CDC, since 2014 there has been an increase in the national incidence rate over the last five years, including a 19% rise in the incidence of chlamydia, a 63% rise in the incidence of gonorrhea, a 71% rise in the incidence of primary and secondary syphilis, and a 185% rise in the incidence of congenital syphilis (CDC, 2019e). Despite the high prevalence of STIs among American populations, self-perceived susceptibility among women who have sex with men (WSM) aged 18 to 24 is low (Hickey & Cleland, 2013).

In 2017, Aurora Research & Consulting conducted an independent survey on behalf of Quest Diagnostics. The survey collected data from WSM aged 15 to 24 and their mothers to better understand the beliefs that young women have about sexual health. Of the 3,414 young women who participated in the survey, 56% reported that they were sexually active. Among those, only 39% said a condom was used during their most recent sexual encounter. Within the sampled population of young women (n = 3,414), less than one in four women had asked their clinician to administer an STI test. Sixty-two percent (62%) of respondents reported low levels of perceived susceptibility to STIs as a reason for not getting tested, despite high STI prevalence. Fifty-five percent (55%) reported they did not seek testing because they were asymptomatic, even though symptoms of STIs can be easily overlooked or are non-existent (Aurora Research & Consulting, 2017). Researchers identified two strengths of this study: first, the large sample size represented many different demographics; second, the survey was conducted by an outside company, which limited potential bias from Quest Diagnostic. Researchers also mentioned that the survey data was self-reported by the respondents. This is seen as a weakness because the survey asked sensitive questions regarding sexual behavior and health; respondents might have chosen answers that seemed more socially acceptable rather than responding truthfully.

**Sociological factors.** The causes of the STI epidemic are multifaceted and will require coordinated solutions. Major factors that contribute to this epidemic are sociological, biological, and cultural (Institute of Medicine (US) Committee on Prevention and Control of Sexually Transmitted Diseases, 1997). A possible sociological factor that could lead to the continuation of the STI/HIV epidemic is a shortage in STI/HIV prevention and treatment funding (CDC, 2017). State and local health departments play a vital role in providing prevention, screening, and testing...
services to a community. Many of these services receive funding through the Ryan White HIV/AIDS program. Funding is appropriated annually by Congress, and in 2019 the program received about $2.3 billion (Kaiser Family Foundation, 2019). The methods used to appropriate funds often miscalculate the true cost of providing HIV/AIDS services. That means that many public health organizations in underserved communities are unable to meet the healthcare needs of their patients. This leaves many people at risk of contracting or transmitting HIV to others in their community (Kaiser Family Foundation, 2019).

**Biological factors.** A common biological factor that contributes to high rates of infection is the asymptomatic characteristic of many STIs. STIs such as chlamydia, herpes, gonorrhea, syphilis, or human papillomavirus (HPV) often do not produce acute or noticeable symptoms. The most reliable strategy to confirm a person's sexual health status is to comply with sexual screening guidelines. Based on CDC guidelines for STI and HIV screening, it is recommended that people between the ages of 13 and 64 should be tested at least once in their life for HIV. Sexually-active women below the age of 25 should be tested for gonorrhea and chlamydia once every year, and sexually-active women older than 25 should be screened yearly for gonorrhea and chlamydia, based on individual risk factors. All men should receive testing for syphilis, gonorrhea, and chlamydia once a year, and based on individual risk factors, they should be tested every three to six months. If a person tests positive for an STI or HIV, immediate treatment is highly recommended to prevent further spread of infection (CDC, 2014b).

**Cultural factors.** Attitudes about sex and sexuality are important aspects of American culture. Sexual imagery and messaging are sensationalized through the lens of mass media and are easily accessible via the internet. However, Americans understand through their cultural conditioning that sexual behavior should remain private. The term *sexual secrecy* may be seen as the inherent difficulties of having open conversations about human sexuality, as well as political efforts to censor information about sexual health and sexuality (Institute of Medicine (US), 1997). Sexual secrecy negatively impacts STI prevention strategies by obstructing access to comprehensive sexual health education for AYAs, restricting funding for sexual-behavior research, discouraging sex partners to communicate openly, and stifling community-based activism regarding STIs. Secrecy has also impacted the way we train and educate primary healthcare professionals about sexual health. Poorly trained clinicians find it difficult and uncomfortable to initiate conversations about STI screening.
and treatment, which puts patients’ health at risk. The stigmatization of STIs has resulted in few patient-based constituent groups lobbying for STI-prevention programming.

The Current Epidemic of Sexually Transmitted Infections (STIs)

Prevalence rates of STIs within the United States are modestly estimated to be three times higher than in any other industrialized nation (St. Lawrence & Fortenberry, 2007). The burden of this epidemic is not evenly dispersed throughout the population. In 2018, reported chlamydia cases were highest among African Americans (CDC, 2019a). African American women between the ages of 20 and 24 reported chlamydia infection rates over 3.6 times the rate of white women in the same age group. Similar trends are represented in gonorrhea and syphilis surveillance data. African American women aged 15 to 19 reported rates of gonorrhea infection at over 2.3 times that of white women; African American women aged 20 to 24 years reported gonorrhea cases at almost twice the rate of white women (CDC, 2019b). Primary and secondary syphilis reporting rates for African American women between age 15 and 24 were over 6.4 times the reported rates for white women of the same age group (CDC, 2019c). Similar disparities in the incidence rates of chlamydia, gonorrhea, and syphilis were evident among African American males. 2018 Michigan surveillance data showed that combined, African Americans made up 38.9% of chlamydia cases, 55.5% of gonorrhea cases, and 54.8% for all strains of syphilis (Michigan Department of Health and Human Services [MDHHS], 2018).

This data is based on cases that were diagnosed, but not the actual prevalence of the disease. Rates of STI prevalence within these populations is likely much higher than reported. Data show that African American women utilize healthcare services less often than white women, and may delay treatment for more extended periods (Wright & Perry, 2010). Delaying the utilization of these resources could be a contributing factor to further disparities within this group.

Consequences of the Epidemic

Continuous increases in STI incidence and transmission rates due to poor infection-control practices have facilitated the overuse of antibiotics. The overuse of antibiotics has led to the emergence of multidrug-resistant pathogens (MDRP) (French, 2010) that evolve and spread quickly amongst human populations (Finley et al., 2013). Although gonorrhea, chlamydia, and syphilis have become multidrug-resistant, chlamydia and
syphilis are much less resistant than gonorrhea. Gonorrhea can be spread through unprotected sexual contact with an infected person's mouth, vagina, anus, ejaculate, vaginal fluid, or penis. The bacteria can also be spread prenatally, from mother to fetus in-utero. Without proper treatment, complications related to gonorrheal infection can cause damage to the fallopian tubes and uterus, increasing the likelihood of infertility, an ectopic pregnancy, and pelvic inflammatory disease (PID) (CDC, 2019f). Chlamydia can also be spread through unprotected sexual contact with the mouth, vagina, anus, penis, ejaculate, or vaginal fluid. Complications are similar to those caused by gonorrhea, but symptoms often go undetected unless a patient receives a full panel STI screening by a medical professional (CDC, 2014a).

The growing number of newly reported syphilis cases is another concern for public health professionals and maternal health specialists. The CDC reports that more than 115,000 new cases of syphilis were reported between 2017 and 2018. During this same period, the CDC found a 40% spike in new congenital syphilis cases (CDC, 2019d). The rapid rise in the rates of congenital syphilis has prompted STI prevention specialists to improve access to screening and treatment services for women and their partners. Maternal health clinics are advised to adhere to strict standards and policies that provide consistent and comprehensive prenatal care (Warren et al., 2018). Screening programs should put additional resources toward promoting routine screening for men who have sex with women (MSW) and are of reproductive age (Bowen et al., 2015).

Comparison of Sexual Health Education Programming

Program developers must recognize that AYAs differ in gender, sexual orientation, race, socioeconomic status (SES), developmental age, sexual experience, and cultural norms. The implementation of specially-tailored prevention programs that target populations based on the intersection of these differences is a helpful strategy to lower incidence rates within specific subpopulations. Programs that are most successful in decreasing high risk sexual behavior are culturally competent and inclusive (Sales & DiClemente, 2010).

Sisters Informing, Healing, Living, and Empowering. Sisters Informing, Healing, Living, and Empowering (SiHLE), a national, peer-led, community-based social skills training program, was developed to limit sexual risk-taking behaviors among sexually active African American females aged 14 to 18. The program was designed to include four 4-hour sessions conducted in a community setting outside school hours. Culturally
competent and gender-specific materials were used to keep participants interested throughout the sessions and to promote gender and ethnic pride. SiHLE provided group discussions and role-plays that were meant to teach the girls about reducing risky behavior (DiClemente, 2015).

Participants’ health behavior outcomes were assessed 12 months after the end of the program. Reports showed that participants increased condom application skills and consistent condom use. Outcomes also showed a reduction in the number of new sex partners, of unprotected sex, of STIs, and of self-reported pregnancy (Sisters Informing Healing Living and Empowering, [SiHLE], 2017). Core components that made SiHLE successful were their discussions about the triggers that made negotiating safer sex difficult, skill-building for assertive communication to negotiate abstinence and safer sex effectively, and program materials that were age, gender, and culturally appropriate (Wingood & DiClemente, 2006).

Health Improvement Project for Teens. Health Improvement Project for Teens (HIPTeens), a sexual risk reduction program, targeted non-pregnant, sexually active teenage girls. HIPTeens offered two 90-minute booster sessions at three and six months after program implementation. These sessions were designed to increase motivation to reduce sexual risk behavior, improve interpersonal and self-management skills, and to provide factual sexual health information. Outcomes among participants showed greater abstinence from vaginal sex at six months and fewer pregnancies (Morrison-Beedy, 2015). Essential program components were the emphasis on self-empowerment, value-setting and future goals, developing a personalized list of risk-reduction strategies, and practicing negotiation skills (Morrison-Beedy, 2015).

Reducing the Risk. A cognitive-behavioral skill-training program, Reducing the Risk, was developed to decrease sexual risk-taking behaviors among high school students. This program was implemented across a diverse demographic of students in California, Kentucky, and Ohio. Results from California showed an 18-month increase in the delay of sexual contact compared to the control group. This cohort also improved their knowledge of contraception, increased communication with their parents about abstinence, and ameliorated their prevention behavior (Kirby et al., 1991). Outcomes from Kentucky and Ohio showed increases in positive attitudes toward condom use, improved understanding of STI and pregnancy risk, and fewer sex partners, compared to control groups (Barbee et al., 2016; Zimmerman et al., 2008). Key points that made this program successful were addressing participants’ attitudes towards delaying sex, evaluating intentions to use protection, promoting personal goal-setting, practicing sexual refusal skills, and practicing condom negotiation.
Community Youth Service

The implementation of Community Youth Service (CYS) programs was another useful strategy to reduce adverse health outcomes associated with risky behavior. CYS programs were implemented in economically disadvantaged urban areas where a high prevalence of diseases disproportionately impacted minority communities. The Reach for Health CYS program addressed four primary health risks associated with adolescents living in the inner-city: drug and alcohol use, violence, sexual behaviors that increased the chance of being exposed to STI/HIV, and sexual behaviors that could lead to unintended pregnancy (O’Donnell et al., 1999). Reach for Health coupled community involvement opportunities with an in-class curriculum that focused on reducing health risks. Results from the program found an 8.2% increase in sexual activities among individuals in a control group, compared to a 3.4% increase in those who received CYS in-class curriculum programming, and 4.4% who received full CYS programming (O’Donnell et al., 1999). Rates of sex without a condom or birth control decreased among the CYS group by 27.7%, and the curriculum-only group by 30.8%, compared to increases seen in the control group (O’Donnell et al., 1999). Beneficial components from this program included educational material about gender roles, STD/HIV symptoms/treatment, skill practice, and a greater understanding of sexuality and relationship dynamics.

The Impact of STI and HIV-Related Stigma

Stigmas related to STIs and HIV create a significant barrier for at-risk populations who need treatment. Stigmas occur when “a person is set apart from others and linked to negative evaluations due to their real or imagined possession of a particular trait” (Cunningham et al., 2009, p. 226). Two types of stigma influence a person’s STI testing behaviors: perceived stigma, which includes an individual’s fear of societal attitudes, discrimination, or isolation based on a specific trait; and self-stigma, also referred to as shame or the internalized response to a stigma. Research shows that perceived stigmas play a part in the delaying of testing and treatment care (Malta et al., 2007), and self-stigmas are shown to impact a person’s willingness to get tested (Lynn et al., 2017). The barriers that stem from perceived stigmas could possibly increase the risk of transmission within a vulnerable population, and the risk of transmission goes up as the percentage of people being screened goes down.

Those who are unaware of their sexual health status, are sexually active, and do not comply with routine screening guidelines are at the
highest risk of transmission. Individuals diagnosed with an STI or HIV often feel a tremendous amount of fear, anger, guilt, anxiety, and shame. When these negative emotions surface, a person might turn to deceptive behaviors to control these feelings. These behaviors include passing, covering, blame, stigma deflection, and stigma transference (Nack, 2000). Below is a pyramid chart showing a framework of STI/HIV-related stigma (Figure 1) (Mahajan et al., 2008).

**Figure 1. Framework of STI/HIV-Related Stigma (Mahajan et al., 2008)**
Passing. Passing is a behavioral strategy used to protect oneself from a stigma and involves the denial of a stigmatized trait. When a person receives a positive STI or HIV diagnosis, knowledge of their new health status often does not fit into their self-narrative. To maintain a positive self-image, a newly-diagnosed person will conceal the truth about their health status. An infected person may go to great lengths to deny this truth about themselves (Nack, 2000).

Covering. This strategy is used when a person is no longer able to pass and resorts to deceitful behavior such as lying and misdirection when confronted with the truth. This person may use untrue stories to conceal stigmatized traits or behaviors to reduce the intense feelings of shame brought on by stigma (Nack, 2000).

Stigma deflection. Deflection occurs when a stigmatized person assigns blame to someone they know or have recently met. In the case of STI stigma, an infected person may label a past or present partner as contagious or potentially harmful to anyone they encounter. This allows the infected person to direct stigma away from themselves (Nack, 2000).

Stigma transference. When a stigmatized person experiences high levels of anxiety as a result of perceived stigma or self-stigma, feelings of fear and anger may arise. When a person becomes fearful of being discovered or angry because they believe someone suspects they are lying, the stigmatized individual may start to stigmatize others (Nack, 2000). Nack (2000) gives this example of stigma transference:

Kayla also transferred the stigma of sexual disease to an ex-partner, never confronting him about whether he had tested positive for STDs. The auxiliary trait of promiscuity colored her view of him: “I don’t know how sexually promiscuous he was, but I’m sure he had had a lot of partners.” Robin, a 21-year-old White undergraduate, went so far as to tell her ex-partner that he needed to see a doctor and “do something about it.” He doubted her ability to pinpoint contracting genital warts from him and called her a slut. Robin believed that he was the one with the reputation for promiscuity and decided to trash him by telling her two friends who hung out with him. Robin hoped to spoil his sexual reputation and scare off his future partners. In the transference of stigma, the women ascribed the same auxiliary traits onto others that others had previously ascribed to them. (pp. 107-108)

Blame. To relieve negative feelings associated with self-stigma, individuals may externalize their pain by turning their anger outwards.
Whether or not the target of blame is guilty or innocent matters little to the stigmatized person. What matters most is that they are no longer responsible for the outcome of their actions (Nack, 2000).

**How to Assess STI/HIV-Related Stigma**

To properly measure the impacts of STI/HIV stigmas on health outcomes and behaviors, reliable and valid instruments must be used. Quantitative instruments such as questionnaires, or measures employing a Likert Scale, are beneficial when trying to understand stigma trends over time within many different contexts. This is important because it allows program planners and stakeholders to develop more useful programs depending on the region, population, or social settings (Nyblade & MacQuarrie, 2006). Qualitative instruments, such as focus groups or in-depth interviews, are useful when evaluating the process of an STI/HIV stigma-reduction intervention. Quantitative analysis can allow researchers to explore nuances associated with how STI/HIV stigma is experienced within different contexts and among various populations. Throughout the articles reviewed, qualitative evaluation is preferred because it allows researchers to establish a more comprehensive scale of measure (Mahajan et al., 2008).

**Internalized Stigma and HIV Treatment**

A study showing the relationship between internalized stigma and inadequate adherence to antiretroviral treatment (ART) found that stigmas decreased participants’ adherence to ART over time. Those who have weak or fragmented social networks were shown to be less likely to adhere to ART, while those with robust and supportive social networks were protected from the negative impact of stigmas (Bogart et al., 2015; Katz et al., 2013). Bogart et al. (2015) developed a graph showing the relationship between adherence to ART and stigmas (Figure 2):

The y-axis shows the predicted probabilities (i.e., covariate-adjusted probability) of optimal adherence to medications (i.e., ≥85% of doses taken as prescribed) for four hypothetical populations of people: (1) those with no reported alter stigma and “low” change in social support capacity (i.e., one standard deviation below average); (2) those with no reported alter stigma and “high” change in social support capacity (i.e., one standard deviation above average); (3) those with any reported alter stigma and “low” change in social support capacity; and (4) those with any reported alter
stigma and “high” change in social support capacity…. The x-axis indicates the presence in the network of any alter expressing stigmatizing attributions. (p. 869)

Figure 2. Relationship Between Adherence to ART and Stigmas (Bogart et al., 2015)

For those who are HIV positive, adherence to ART is essential in preventing further spread of the virus. To effectively implement stigma-reduction interventions, it is crucial to understand the degree to which an HIV-positive individual experiences stigma. The HIV Stigma Scale (HSS) (Figure 3) is a 39-item questionnaire used to measure the psychosocial impact of HIV stigmas (Lindberg et al., 2014). The HSS questionnaire has been implemented across a variety of demographics and has proven to be a valid and reliable tool to identify levels of HIV stigma.

Stigmas Within the Context of Healthcare

Evidence shows that STI/HIV-related stigmas among healthcare workers (HCW) have been documented across a wide swath of health facilities. The majority of underlying HIV and STI-related stigmas that permeate many sectors of the U.S. healthcare system are a negative re-
sult of the HIV epidemic in the 1980s (CDC, 2019g). Some HCWs who were politically and socially aware during the time of the epidemic continue to harbor fears, biases, and moral beliefs that inform their views of HIV- and STI-positive patients, subverting the quality of care and impeding their ability to be successful providers (Nyblade et al., 2019).

### Figure 3. 39-Item Questionnaire HIV Stigma Scale

#### Personalised stigma
18. Some people who know I have HIV have grown more distant
24. I have been hurt by how people reacted to learning I have HIV
26. I regret having told some people that I have HIV
27. As a rule, telling others that I have HIV has been a mistake
28. Some people avoid touching me once they know I have HIV
29. People I care about stopped calling after learning I have HIV
30. People have told me that getting HIV is what I deserve for how I lived my life
31. Some people close to me are afraid others will reject them if it becomes known that I have HIV
32. People don’t want me around their children once they know I have HIV
33. People have physically backed away from me when they learn I have HIV
34. Some people act as though it’s my fault I have HIV
35. I have stopped socialising with some people because of their reactions to my having HIV
36. I have lost friends by telling them I have HIV
38. People who know I have HIV tend to ignore my good points
39. People seem afraid of me once they learn I have HIV
40. When people learn you have HIV, they look for flaws in your character

#### Disclosure concerns
1. In many areas of my life, no one knows that I have HIV
4. Telling someone I have HIV is risky
6. I work hard to keep my HIV a secret
17. I am very careful who I tell that I have HIV
21. I never feel the need to hide the fact that I have HIV (R)
22. I worry that people may judge me when they learn I have HIV
25. I worry that people who know I have HIV will tell others
37. I have told people close to me to keep the fact that I have HIV a secret

#### Negative self-image
2. I feel guilty because I have HIV
3. People’s attitudes about HIV make me feel worse about myself
7. I feel I am not as good a person as others because I have HIV
8. I never feel ashamed of having HIV (R)
12. Having HIV makes me feel unclean
13. Since learning I have HIV, I feel set apart and isolated from the rest of the world
15. Having HIV makes me feel that I’m a bad person
23. Having HIV in my body is disgusting to me

#### Concerns with public attitudes
5. People with HIV lose their jobs when their employers find out
9. People with HIV are treated like outcasts
10. Most people believe that a person who has HIV is dirty
14. Most people think that a person with HIV is disgusting
16. Most people with HIV are rejected when others find out
19. Since learning I have HIV, I worry about people discriminating against me
20. Most people are uncomfortable around someone with HIV
Professionals whose behavior is informed by stigmas have denied care to patients, physically and verbally abused patients, made patients wait longer during appointments, and provided poor-quality care to those who are stigmatized (Nyblade et al., 2017; Marshall et al., 2017; Varas-Diaz & Marzan-Rodriguez, 2007.) Nyblade et al. (2009) identified three causes of HIV-related stigmas among different national and international populations: little or no understanding of what stigma looks like and why it is harmful, a fear of being exposed due to incomplete knowledge about HIV transmission, and values and morals that demonize behaviors that lead to HIV exposure.

Reducing STI/HIV-related stigmas among providers is believed to have beneficial outcomes for STI/HIV-positive patients. Addressing the issue of STI/HIV stigmas using stigma-reduction programs has been shown to be effective among providers. Implementing HCW-centered stigma-reduction interventions could help to improve care and minimize the spread of STI/HIV (Geter et al., 2018). Despite the overwhelming evidence that STI/HIV-related stigmas have negative health outcomes for people impacted by STI/HIV, very few medical students and HCWs receive stigma-reduction training. Medical schools and physicians understand the importance of sex education, but the quality and frequency of sexual health education varies by institution (Shindel & Parish, 2013). There is little agreement among medical school programs as to what should be included in their sexual health curriculum, and some would prefer to eliminate sex education completely (Galletly et al., 2010).

There are many barriers that prevent comprehensive sex education curricula from being taught widely, such as shortages in qualified sex educators, lack of funding, and questions about the content of the pedagogical materials (Coleman et al., 2013). Not only do medical students advocate for more sexual health education throughout their training, but patients also prefer to interact with a competent medical professional. A study found that of 626 medical students, 42.4% felt they were inadequately trained to meet the sexual health needs of their patients. Researchers also found that 74.5% of patients who completed the survey felt most comfortable receiving sexual health information from providers who seemed comfortable and knowledgeable (Wittenberg & Gerber, 2009).

CONCLUSION AND ADDITIONAL QUESTIONS

Very few published peer-reviewed studies examine the efficacy of STI/HIV stigma-reduction interventions. This could be attributed to a
lack of interest among stakeholders to fund these kinds of interventions, the challenge of how to describe and assess levels of stigma, or other unknown causes. Of the small number of published studies, minimal evaluation has been conducted on the process, impact, or outcome of these programs. Many of the interventions designed to reduce STI/HIV-related stigmas are developed out of a social-cognitive or cognitive-behavioral framework. These types of programs are best used to address stigma at the individual level, but they do not adequately measure stigma at other social levels (Mahajan et al., 2008).

Because of the lack of evaluation and small number of studies, it is difficult to understand if interventions are most effective at the intrapersonal, interpersonal, community, institutional, or structural level. Table 1 shows possible strategies that can be used to address stigma at each level (Heijnders & Van Der Meij, 2006).

Table 1. Stigma Reduction Strategies (Heijnders & Van Der Meij, 2006)

<table>
<thead>
<tr>
<th>Level</th>
<th>Strategies</th>
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<tr>
<td>Intrapersonal level</td>
<td>Counseling</td>
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<td>Cognitive-behavioral therapy</td>
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<td>Self-help and support groups</td>
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<td>Treatment</td>
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<td>Empowerment</td>
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<td>Interpersonal level</td>
<td>Care and support</td>
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<td>Home care teams</td>
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<td>Community-based rehabilitation</td>
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<td>Community level</td>
<td>Education (social marketing, mass media)</td>
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<td></td>
<td>Contact with PLHAs</td>
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<tr>
<td>Institutional level</td>
<td>Training programs</td>
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<td>Government/structural level</td>
<td>Legal interventions</td>
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Successful prevention programs such as SiHLE, CYS, HIPTeens, and Reducing the Risk have been effective in reducing risk-taking behaviors among participants. Simbayi (2006) and Peretti-Watel (2007) have shown that STI/HIV stigmas and discrimination have an impact on risk-taking behaviors. The two studies found that within communities where STI/HIV stigmas are high, those who are stigmatized are less likely to divulge their health status to sexual partners. This puts potential partners at higher risk of exposure (Simbayi et al., 2006; Peretti-Watel et
al., 2007). Data collected from these studies show a link between stigma and risk behavior, such as unprotected sexual encounters, not disclosing health status to new partners, and infrequent STI/HIV testing. More research needs to be done to find out if joining curricula from successful risk-reduction programs with stigma-reduction interventions would be more effective in reducing risky behaviors among those who are STI/HIV positive.

More improvements must be made to help researchers define and identify STI/HIV stigma across a variety of socio-cultural settings. Measuring the overlapping effects of stigmas related to socioeconomic class, race, gender, sexual orientation and education, and understanding how they impact the way STI/HIV stigmas manifest within a community are important. STI/HIV stigmas manifest differently within various communities. Based on race, gender, or sexual orientation, stigmas may impact some individuals more than others. Having a tool that can measure how stigmas operate within different communities and providing proper education for caregivers could be major assets in developing successful interventions.

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