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Psycho-Social Impact of Stigmatization against Pregnant Women with HIV

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ABSTRACT

***Background*: Stigmatization, discrimination, and poor social support are challenges faced by people living with HIV, and the stigmatization of pregnant women with HIV is still very frequent, which can have a profound negative impact on patient's health. This can have a psychosocial impact on the sufferer.**

***Objective*: To study and determine the psychosocial impact of discriminatory behavior towards pregnant patients with HIV.**

***Methods*: This is a case report of two cases of pregnant women with HIV at the Voluntary Counseling and Testing (VCT) Polyclinic of RSUP Prof. Dr. I.G.N.G. Go to Denpasar. In-depth interviews were conducted with them regarding their views on openness to their families and communities about their condition.**

***Results and Discussion*: It was reported that two cases of pregnant women with HIV who were carrying out antenatal care in the Obstetrics and Gynecology Polyclinic Room, Prof. dr. I.G.N.G Ngoerah Central General Hospital Denpasar. In both cases, discriminatory treatment and stigma still strongly haunt the sufferers even though the form and source are slightly different. In the first case, the patient was afraid of getting discriminatory treatment and stigmatization that came from the family environment and the wider environment. Meanwhile, in the second case, it shows that the discriminatory treatment that causes stigma does not only come from far away but also comes from the people themselves. Both have a psychosocial impact that creates a sense of social discomfort, even though the race is slowly diminishing with the assistance of a counselor. There is a need for a wide range of active education by health workers to the patient's family and the community in reducing the stigma and discrimination against pregnant women with HIV.**

***Conclusion*: Women with HIV, especially those who are pregnant, are still full of negative judgments, and discriminatory behavior towards them. This can cause psychosocial impacts on patients. The disparity between knowledge about unknown patterns of HIV transmission on the one hand and risky sexual behavior, on the other hand, can be one of the risk factors for contracting HIV. This also contributes to stigma and discrimination against pregnant women with HIV.**

Keywords: HIV, Pregnant Women, Psychosocial, Stigma.

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I. Introduction

Zero discrimination has long been echoed by the World Health Organization (WHO), but discrimination against people with Human Immunodeficiency Virus (HIV) continues to this day. HIV infection remains an important global public health problem. Despite its still high incidence, HIV infection has claimed 40 million lives so far. Human Immunodeficiency virus (HIV) is a virus that is transmitted through blood, usually from sexual intercourse, sharing needles, and vertical transmission during birth or through breast milk. More than 70% of all HIV infections are the result of sexual intercourse. Women in developing countries have a higher risk of becoming infected with HIV than their male partners for several reasons, both biological and sociological. It is estimated that 1.3 million women and girls living with HIV become pregnant each year globally [1].

World Health Organization (WHO) states that "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." An important implication of this definition is that mental health is more than the absence of mental disorders or disabilities [2]. Psychosocial health is a term that encompasses four components of well-being: mental, emotional, social, and spiritual health. This balance and reciprocity help a person live a healthier life [3].

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Families are the main source of support for patients with HIV, especially pregnant women. However, to get more positive results, it is necessary to have support from friends and professionals such as health care, which are very helpful. A number of studies suggest that inadequate interpersonal resources may lead to stigma and discrimination related to HIV [4]. Social support from family is less suspected as an important psychosocial problem that can contribute to the mental health and well-being of pregnant women living with HIV. In this case report, two pregnant women with HIV were interviewed at the Obstetrics and Gynecology Polyclinic/Voluntary Counseling and Testing (VCT) clinic, Prof. Dr. I.G.N.G. Ngoerah Central General Hospital Denpasar related to psychosocial support obtained from the surrounding environment, especially family.

II. Case Report

A. Case I

The first case is a 36-year-old woman, in her third pregnancy with 36 weeks of gestation. She has history of HIV since 2013 that was transmitted from her ex-husband. Her first married is in 2009, and the first child of the first husband has died at the age of one year due to a lung infection. The first marriage was over because she was pregnant. The second child and current pregnancy is from her second marriage. The patient found out that she had HIV in 2013 because at that time her husband was seriously ill and just found that he had HIV, so the patient was also examined. The patient had never had sexual intercourse before other than with her first husband.

The patient remarried and their second child was born in 2016. The status of the second husband was HIV non-reactive and knew the patient had HIV before marriage. The patient and her husband underwent a program for a second pregnancy and delivered a healthy baby by cesarean section with non-reactive HIV. The planned caesarean section in the third pregnancy will be carried out in two weeks.

The patient said that she hid the fact of suffering from HIV from his parents and siblings because he was afraid of possible rejection from his family. Only the patient and her husband know about her HIV status and current condition. The patient also has no plans to reveal her condition to her family in the future, wanting to keep this a secret until she dies because of fear of that the children and herself being stigmatized.

B. Case II

The second case was a 33-year-old woman with a gestational age of 22 weeks. The patient only found out that she had HIV three weeks ago because of the intermittent fever she had felt for the past few months. Currently the patient is in her fourth pregnancy with a history of miscarriage in her first pregnancy. The patient has been living with her current husband since 2015 and just got married in 2019. The patient does not know where she got HIV from because her husband's status is non-reactive. The patient said it might be from his ex-boyfriend who died of illness, but it is not known what the illness was at that time.

The patient had previously had sexual relations with other ex-boyfriends other than the deceased. There are several tattoos on the patient's body, so it is not known for sure whether HIV transmission is through sexual intercourse or from tattoo needles. The patient said she was sad because his husband judged that she must have had sex with another man because she had been married for 7 years but his husband was not HIV-reactive. Both children have been tested and the results are non-reactive for HIV. The patient said she was afraid to tell her family about her condition because of fear that her children and herself would be ostracized and become the subject of gossip. She plans to tell her mother when she gives birth.

III. Discussion

In the first case, the partner already knows the status of the patient with HIV and can accept it well. However, fear and worry still haunt the patient because she is very afraid of being known by her family and environment. Thus, the patient is still trying to save it, not telling parents or other families. The patient still tries to hide his HIV status from her parents and siblings because of fear of rejection that might occur from his family. Only the patient and her husband know about her HIV status and current condition. The patient also has no plans to reveal his condition to her family in the future, wanting to keep this a secret until she dies because of fear of the children and herself being exposed to stigma and other discriminatory treatment. In contrast, in the second case the patient did not know her status from the start. Known to be HIV positive after married for the second time and during pregnancy as a part of the examination during antenatal care. Her husband did not accept her condition and questioned when the transmission occurred and from whom.

It turned out to be true, both cases showed that discriminatory treatment and stigma still haunted the sufferers even though the forms and sources were slightly different. In the first case, the patient was afraid of getting discriminatory treatment and stigmatization that came from the family environment and the wider environment. Meanwhile, in the second case, it shows that discriminatory treatment that causes stigma does not only come from far away, but also comes from her own husband.

Many studies report high rates of stigma and discrimination against pregnant women with HIV. Social challenges in the form of discriminatory behavior that cause stigma do not only come from more distant communities, but also come from families, workplaces and even health workers who care for them [5].

Stigma is a sign that separates individuals from one another on the basis of socially assigned judgments and causes some people or groups to be considered tainted or “less than” others [6]. Stigma against people with HIV is negative attitudes and beliefs about people with HIV, prejudice that comes with labeling individuals as part of a group that is believed to be socially unacceptable. Stigma is a major concern for many people living with HIV and has a major impact on the health of patients and family members. The consequences of stigma can be devastating, can lead to family discord, social rejection, social isolation, inequality in health care, poorer health outcomes, and is a form of human rights violation [7], [8].

Women have a high risk of being infected with HIV because they have biological, psychological vulnerabilities and low socioeconomic status. In addition, male sexual practices are dominant, and epidemiological factors also contribute. Women bear three dangers because of being infected with HIV: the dangers of being an HIV-infected person, the dangers of being the mother of a child, and the dangers of being a caregiver for her partner. Not infrequently their children die so that they become parents with HIV without children or leave orphans with HIV. Women living with HIV are at very high risk of living a painful and humiliating life because of ostracism. Women are often more vulnerable to stigma associated with HIV and are often referred to as 'vectors', 'diseases' and 'sluts'. Discrimination against women can discourage them from seeking the medical and psychological care they need during their illness. HIV stigma in women is associated with rejection from friends and family, society, feelings of uncertainty and loss, low self-esteem, fear, anxiety, depression, and even suicidal ideation [9]. [10].

Stigma against HIV poses a significant barrier to prevention, treatment, and care for people infected with HIV. Disclosure of HIV status to families can help patients get support and comfort from their families [11]. Patients who receive family acceptance have good levels of self-esteem and health status, while those who experience family rejection have poor health, suicidal tendencies, high levels of depression, and risky sexual behavior [12]. The cases mentioned above show the patient's concern about the stigma that may be obtained from the family and society which results in discrimination and exclusion of patients and their children.

Pregnancy may be a vulnerable time for mental health problems for women with HIV given the increasing rates of partner violence and the impact of HIV-related stigma on pregnancy. Pregnancy and HIV are two medically independent complex phenomena, which when coupled with mental health problems can create significant challenges for mothers, children and families [13]. Couple's HIV testing and counseling is an opportunity for couples to learn about their HIV status together. After laboratory testing and joint disclosure, couples could discuss prevention and treatment options with a counselor. Couple's testing and counseling promotes safer sexual behavior, improves communication between partners, and decreases HIV transmission [14]. In both cases above patients were offered counseling services with their families if they needed assistance in explaining their HIV-related conditions.

IV. Conclusion

Women with HIV, especially those who are pregnant, are still full of negative, discriminatory, and stigmatized judgments that can have psychosocial impacts. Existing research suggests that stigma against people living with HIV has a negative impact on patients' psychosocial well-being. Lack of knowledge about how HIV is transmitted and prevented as well as the fear of contracting HIV through physical and social contact can be a factor in the occurrence of stigma and discrimination against pregnant women with HIV, especially the burden of stigma is greater on women than men because of various factors and stigma aimed at children who are born from mothers with HIV. This encourages the importance of a wide range of active education by health workers.

Conflict of Interest

Authors declare that they do not have any conflict of interest.

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