Bel-Air College of Nursing in India promotes nondiscriminatory care of persons living with HIV throughout its programs, albeit with no specific intervention. We examined whether nursing students’ stigmatizing attitudes were related to number of years at Bel-Air. At the start of the 2015 and 2016 academic years, 310 Bachelor’s (BScN; 4-year program) and 119 Auxiliary Nurse Midwife (ANM; 2-year program) students completed the Zelaya and colleagues (2008) Stigma Scale (24 Likert-type items). Three subscales (Fear, Blame, Personal Discrimination) measured Overall Personal Stigma. The fourth subscale measured Perceived Community Discrimination. BScN students’ mean Overall Personal Stigma and subscales scores declined and Perceived Community Discrimination scores increased from Year 1 to 4. For ANM students, Overall Personal Stigma, Fear, and Personal Discrimination scores were lower for Year 2 than Year 1 students. Bel-Air emphasizes effective and nondiscriminatory care throughout the entire curriculum, providing a model for reducing student nurses’ stigmatizing attitudes.

To end the HIV epidemic by 2030, the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2015) has set a bold global agenda calling for the “three Zeros” of no new infections, no HIV-related deaths, and no HIV-related stigma and discrimination. Stigma and discrimination in health care settings is not only a moral issue, it is also a major barrier to early testing, treatment, and adherence (UNAIDS, 2017). Care for persons living with HIV (PLWH) is nonstigmatizing and nondiscriminatory when caregivers express respect through verbal and nonverbal communications, offer appropriate care, and do not make PLWH wait longer for care, use universal
precautions for all patients, do not subject PLWH to unnecessary precautions or isolation, and fully maintain confidentiality (UNAIDS, 2017). In the most overt cases, stigma is seen in the denial of treatment for PLWH (UNAIDS, 2017). Unfortunately, many health workers share the stigmatizing attitudes of their larger societies (UNAIDS, 2017). High levels of stigma and overt discrimination during care remain widespread in health care settings, and reducing stigma and discrimination by health workers is a key component of ending stigma (UNAIDS, 2017).

Reducing HIV stigma among health workers is very important in India, which has the world’s third largest HIV epidemic (Avert, 2017). Although prevalence is relatively low (0.3%), India’s large population means that there are 2.1 million PLWH and 86,000 new infections each year (Avert, 2017). Controlling this large epidemic requires the development of a stigma-free and nondiscriminatory health care environment that encourages early testing and treatment, and maximizes the benefits of treatment as prevention.

In India, as is true in most countries, nurses provide the majority of patient care in both urban and rural areas and in hospital and community settings (Squires, White & Sermeus, 2015). Thus, reducing stigma and discrimination by nurses is an important component of controlling the epidemic. There is no better time to develop nonstigmatizing attitudes and nondiscriminatory care practices than during initial nursing education when nursing students are learning how to practice. It is important that nursing education teach positive attitudes along with treatments, so that students learn to provide safe, nonstigmatized, and nondiscriminatory care. In this paper, we examine nursing students’ levels of stigma at a unique college of nursing that offers a model of nondiscriminatory HIV care. We expect that stigmatizing attitudes will differ by the number of years students have been in this college’s program.

Background

HIV-Related Stigma in India

Stigma can be defined as “an attribute that is deeply discrediting” and “reduces the bearer from a whole and usual person to a tainted, discounted one” (Goffman, 1964, p. 3). In addition to HIV itself, PLWH often have multiple stigmatized identities (e.g., drug user, homosexual, multiple sex partners, female gender). Stigmatization and discrimination associated with these identities are linked to the broader culture, socioeconomic status, race/ethnicity, and spirituality/religion (Bradley-Springer, 2016).

Although the construct of stigma is similar across settings, the form stigma takes is dependent on the sociocultural context (Van Brakel, 2006). Indian cultural factors contributing to stigma have been examined in two recent studies. The first study, conducted by Nudelman (2013), examined India and four other countries (Congo, Ethiopia, Nigeria, and Uganda) where the HIV epidemic has imposed a high health and socioeconomic burden. In all five countries, cultural factors both determined and legitimized stigma and discrimination. Strong gender inequality meant that women were more affected by stigma and discrimination than men. Socioeconomic factors also affected stigma through their impact on the power and financial resources available to deal with stigma and discrimination. In India specifically, the study also found that lack of confidentiality in health facilities was widespread and contributed to stigma (Nudelman, 2013).

The second study examining the interaction between HIV-related stigma and Indian culture found a significant knowledge gap and, specifically, Indian cultural elements that increased stigmatization (Duff, 2013). Taboos surrounding social discourse about sex lead to negative feelings, embarrassment, and silence. Communities generally responded to PLWH with rejection and isolation; rejection was rationalized by blaming the PLWH for behaviors that led to infection, fear of transmission, and the belief that PLWH would deliberately infect others, further legitimatizing isolation for PLWH.

Rationales for stigmatization identified in India were consistent with the three main domains of HIV-related stigma identified in prior research: (a) fear of the disease and its transmission, (b) blaming a PLWH because s/he is seen as responsible for having HIV, and (c) support for discriminatory acts or policies (Zelaya et al., 2008). Examining each of these components separately is important because the factors that lead to each differ. Fear is related
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