Access to treatment associated with declining stigma in Botswana

Pour nourrir les réflexions sur la question posée dans Libération : comment dépister sans stigmatiser ? Réponse : en soignant !

- VIH/Sida - Conférences - AIDS 2006 à Toronto -

Theo Smart, Friday, August 18, 2006

Over the last few years, since the roll-out of antiretroviral therapy (ART), there has been a substantial decrease in HIV-related stigma in Botswana, according to a population-based study presented on Monday at the Sixteenth International AIDS Conference in Toronto.

Although there could be several possible explanations for this (including anti-stigma campaigns, the higher visibility of people living with HIV and AIDS and routine HIV testing), survey participants who knew that ART was accessible in Botswana were the least likely to stigmatise people with HIV.

"Our findings raise the possibility that universal access to ART may play a critical role in the reduction of HIV stigma in sub-Saharan Africa," said the study's presenter, Dr William Wolfe of the University of California, San Francisco.

HIV stigma "There is now broad consensus that HIV stigma is a critical barrier that must be addressed if we are going to make inroads in the global spread of HIV/AIDS," said Dr Wolfe. Stigma is common throughout the world and is associated with delays in HIV testing and treatment seeking behaviour.

Most stigma reduction efforts have focused on educational initiatives and media campaigns. But according to Dr Wolfe, "more recently, there has been an emphasis on structural approaches to stigma reduction based on the hypothesis that lack of access to treatment is a critical factor contributing to HIV stigma."

In fact, one of the cases offered by the World Health Organization in support of the 3 by 5 Initiative was that access to antiretroviral therapy would rapidly reduce denial, stigma and discrimination. However, there has been little quantitative data to date to show that access to treatment really does reduce stigma.

Background on Botswana Botswana has the one of the highest rates of HIV infection worldwide (24% of adults aged 15-49). The country also has progressive leadership on the issue of HIV, and launched an antiretroviral treatment programme in 2002.

Stigma was widespread in Botswana before the ART programme began. According to the Botswana AIDS Impact Survey (BAIS I) conducted in 2001, 75% of the population endorse stigmatising attitudes, and PLWA survey in 2000, found that stigma was contributing to delays in access HIV testing services the failure to disclose status in those who tested positive (Wolfe W et al. AIDS Care, 2006 in press).

Survey design Dr Wolfe and colleagues conducted another survey to assess whether access to ART was having an impact on HIV stigma in Botswana. In this study, they also evaluated an alternative measure "anticipated HIV stigma" in which survey individuals were not required to indicate whether they endorsed stigmatising attitudes but rather whether they thought that they would be subjected to similar stigma were they to test HIV-positive. Finally, the survey evaluated the association of perceived access to ART with either stigmatising attitudes or anticipated stigma.

The survey, conducted in November and December 2004 involved 1,268 adults drawn from five districts in Botswana with the highest HIV prevalence. Measures of stigmatising attitudes were adapted from the UNAIDS General Population Survey. The same questions had successfully been used in the BAIS I survey in 2001. Additional questions regarding anticipated discrimination were developed and constituted a 9-item scale of "projected stigma."

Demographic information gathered on the participants included sex (52% were women), residence (44% urban, 30% peri-urban, and 27% rural), education beyond high school (54%), income over 1000 Pula (55%), poor health status (29%), correct HIV knowledge (85%), inconsistent condom use (35%) and frequency of visits to the doctor (22% less than once a year, 45% one to two times a year and 33% three or more times per year).

Results 484 (38%) of the respondents held at least one stigmatising attitudes. For example, 27% said that they would be unwilling to share a meal with an HIV-positive person, although only 4% said that people with HIV should not have equal rights and only 2% thought that HIV-positive students should be removed from school.

There were several factors significantly correlated to having at least one stigmatising attitude. Participants who use condoms inconsistently were much more likely to have stigmatising attitudes (1.56 adjusted odds ratio (AOR)). Conversely, those with more education, who visit the doctor more than three times a year, and those who live in a rural residence were less likely to hold stigmatising attitudes. But perceived access to ART was factor most associated with not endorsing stigmatising attitudes (0.42 AOR).

Although more than 60% of the participants said that they did not hold stigmatising attitudes, more felt that if they were to test HIV positive and disclose their status, they would probably face significant stigma. For example, 54% said that they would be treated as an outcast by their community ; 31% anticipated bad treatment at work or school ; 30% said that they thought that it would break up their marriage or relationship ; 12% said that it could lead to physical abuse by their spouse or partner ; 12% also thought that they might lose their job or receive bad treatment from health professionals ; 5% said that they would be disowned by their family.

Again, inconsistent condom use was most highly correlated with anticipated stigma (1.82 AOR). Although education beyond high school had been associated with not endorsing stigmatising attitudes, it was not significantly associated with the lack of anticipated stigma (AOR 0.94). But once again, those with perceived access to ART were least likely to anticipate stigma (AOR 0.09).

The prevalence of stigmatising attitudes was significantly lower after the rollout of ART compared to the earlier BAIS I survey. For example, in BAIS I, 58% said that they would not buy vegetables from an HIV-positive shopkeeper compared to 23% in 2004 ; 88% of respondents previously said that they would care for a relative with AIDS compared to 95% in 2004 ; and 41% stated stated that a teacher with HIV should not be allowed to teach in 2001 compared to only 3% in 2004.

Dr Wolfe noted that there could be several factors, aside from universal treatment access, contributing to the reduction in stigma, including Botswana's routine testing policy (which has led to a large increase in the number of people who know their status since it was introduced in 2004). However, it is unlikely that the routine testing policy could have had much of an impact on this survey, this it had not been in place long when this survey took place. Botswana has also initiated educational campaigns, activism and increased visibility of people with HIV in the country (including the annual Miss HIV beauty pageants). Finally, the leader of Botswana, President Festus Mogae, publicly announced that he had been tested (he was HIV-negative).

Although it is impossible to assign causality on the basis on this cross-sectional data, given the strength of the "perceived access to treatment" as a protective factor in the survey, the ART rollout was probably the most significant stigma reducing factor in Botswana. In fact, 63% of the respondents in the survey agreed that access to ART has led to decreased discrimination towards PLWA.

"All of these factors have likely played a role, and demonstrate the importance of a multimodal strategy against HIV stigma - a strategy which we feel must include access to treatment as a part of it," concluded Dr Wolfe.

References Wolfe W et al. Impact of universal access to antiretroviral therapy on HIV stigma in Botswana et al. Sixteenth International AIDS Conference, Toronto, abstract MOAX0301, 2006.