INFLUENCE OF STIGMA AND SHAME IN HIV SCREENING AMONG WOMEN IN PROSTITUTION

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ABSTRACT

Background: Shame and stigma brings about undesirable attribute and significantly contributes to the HIV screening and STI treatment seeking, particularly among sex workers. Societal compulsion and feelings of perceived stigma and shame make the sex workers more vulnerable and likely to destabilize their community and the community at large, if no attention is paid. Hence this study was necessitated to document the experiences of stigma and shame and its influence in HIV screening.

Methods: This descriptive research was conducted among commercial sex workers (CSW) enlisted by a NGO. Using simple random sampling procedure research team has interviewed 58 respondents. Semi structured interview schedule was used to explore the knowledge, sexuality, experience of shame and stigma. Michigan Alcohol Screening Test brief scale was used to assess alcohol dependence. Written informed consent was obtained from participants prior to data collection.

Results: Rates of shame and stigma were high among the study participants. Income, knowledge of HIV, alcohol dependence, and number of partners, access to pornographic films, history of sexually transmitted infections (STI) and shame was independently associated with HIV screening. However, marital status of the respondents was inversely related to HIV screening.

Conclusions: Experience of shame associated with the profession was so intense among CSW. This experience of shame acts as a barrier in getting screened for HIV while stigma may not be a powerful barrier.

Key words: Sex worker, Stigma and Shame, HIV screening

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Background

Sex trade is one of the oldest professions in the society, which involves exchange of sexual services for money or goods, whether regularly, or occasionally for the purpose of generating income. With the advent of globalization, cross border sex trade has become a global phenomenon. According to Pamela shiffman[1] about 50,000 women and children are trafficked into the US every year and majority of them are from South East Asia. Back home in India, established brothel homes at Mumbai have 40,000 girls[2] in the age group of 10 to 15 years. Although south India does not have recognized brothel homes, it does have its own share of women in prostitution. Women in prostitution operate at different levels. Irrespective of the style of practice, women involved in the trade, often face multitude of social and health problems viz, discrimination, STI and HIV. This twin problem often threatens lives of commercial sex workers (CSW), because biologically women are more vulnerable to HIV infection than men. Womanhood and habit of multi-partner sex accelerates HIV infection and sexually transmitted infections (STI) among commercial sex workers. Third dimension to the problem is emotional disturbances (shame and stigma) that make their condition worse. An emotional disturbance particularly shame is a matter of concern as disclosure of sexual behaviors and care seeking is greatly influenced absence or presence of shame.

Stigma[3] is defined as an undesirable attribute in a person that is viewed as setting that person apart from rest of the society, while shame[4] is the consciousness or awareness of dishonor, disgrace, or condemnation. It is also an intense negative emotion that results from a person experiencing failure in relation to personal or other people's standards, feeling responsible for that failure and believing that the failure reflects on inadequate self and stress.

Stigma is particularly complex as it operates at many different levels and has both social and psychological aspects. Though stigma has been talked about since the beginning of the HIV/AIDS epidemic, it has not been adequately investigated in programmes or policies. HIV-related stigma is particularly severe as AIDS is both a life-threatening illness and also firmly linked in people's minds to sexual behavior. Previous studies have documented that patients who had experienced feelings of rejection or inadequacy earlier express greater hostility.[5]

People who experience shame and stigma are less likely to adopt preventive strategies; seek early care for TB and other opportunistic infections; seek treatment for sexually transmitted infections[6]; seek counseling / testing or return for results; access health care professionals for treatment[7] ; disclose their sexual orientation[8] and HIV status to anyone[9]; and adhere to treatment. Stigma was also identified as an important factor that could trigger hidden epidemic of STD. Previous studies have noted that stressors could directly relate to alcohol use[10]. Alcohol abuse is a strong negative coping mechanism and associated with multiple risks for HIV transmission among both men and women. Use of Alcohol has been associated with high-risk sexual behaviour. It reduces inhibitions and self-control, which makes it easier for individuals to engage in risky behaviour, such as multiple sex partners and unprotected sex.

Thus, in order to prevent new infections especially among women in prostitution and improve their health seeking behavior it becomes essential to study, in particular, influence of stigma and shame and alcohol use. Hence, this study was conducted with the objective to document the experiences of shame and stigma and determine the influence of stigma and shame in HIV screening among women in prostitutions in Madurai city, Tamilnadu, India.

Methods

Setting:

This descriptive research was conducted among commercial sex workers attending STI clinic run by a non-governmental organization (NGO), at Madurai. Study site is significant because this has been listed as one of 49 high-risk districts of

India and ranks first in the state of Tamilnadu. This city also acts as a major hub for women trafficking. The eligibility criteria for participants were being self identified as women in prostitution (WIP) and given informed consent. Using simple random sampling procedure a sample of 58 respondents was included for the study.

Data collection

A woman researcher met the respondents in privacy and collected data after getting informed consent. The interviewer visited the study site on every alternate day and collected information from the individuals available at the time of her visit. A semi structured questionnaire-contained details about socio economic profile, sexuality, knowledge about HIV, alcohol dependence, stigma and shame, health seeking for STI, and HIV screening.

Demographic

Participants reported their age, education, marital status, other occupation, type of family they live and income per encounter.

HIV knowledge

We used the following dichotomous items to assess general knowledge of HIV. (1) Is it possible to get the HIV virus from mosquito bites? (2) Is it possible to get the HIV virus by sitting on a public toilet? (3) AIDS is a problem only for homosexuals and drug addicts? (4) Is it possible to know by appearance if a person has the HIV virus? and (5) Is there a treatment for HIV?

Alcohol dependence

Alcohol dependence was assessed using The Michigan alcoholism screening test.[11]. A shortened ten-item scale developed by Selzer ML is a validated scale for assessing alcohol dependence. Scoring for the scale is < 3-non-alcoholic, 4 points or more suggestive of alcoholism and 5 or more indicates alcoholism.

Sexual behavior

Participants reported number of male partners they had during the last 12 months. Respondents stated type of sex practiced; age at first sexual contact and with whom, access to pornography and educational film on HIV/AIDS.

STI

Participants stated their STI complications and whether they were tested or not. VDRL (Venereal Disease Research Laboratory) test; a blood test for syphilis that detects an antibody that is present in the bloodstream when a patient has syphilis. Participants also gave information pertaining to time gap between onset of STI symptoms, diagnosis and treatment.

Shame

Following dichotomous items were used to assess experience of shame i e 1. Prefer to keep from knowing your profession, 2. Not discussed about profession to close one, and 3. Think less of one self due to profession. Every “yes” response was given two points. Score less than 3 were considered little or no shame. Scores more than 4 was considered evidence of shame.

Stigma

To assess the experience of stigma researcher used the following dichotomous items.1. Were you made to feel ashamed? 2. Colleagues or community have less respect, 3. Others have avoided you? 4. People refuse to visit home, 5. Might make it difficult for others in the family to get married, 6. Asked to stay away from home? and 7. Decided to stay away from social groups? Every “yes” response was given two points. Score less than 3 were considered little or no stigma. Scores more than 4 was considered evidence of stigma.

Data Analysis

Thus obtained data was analyzed using “epi info” statistical software. Frequency distribution,

percentage calculation and univariate analysis was performed. Logistic regression was performed to see association between being screened for HIV by Education, Income per encounter, Alcohol dependence, Number of partner, access to porno, exposure to HIV films, Shame, stigma and STI, type of family (WEIGHTVAR = Age P VALUE=95%).

Results

Socio demographic variables including age, education, religion, marital status, family size are entered as a single block and given in table-1. Seventy five percent of respondents were living in nuclear families. Three fourth of the respondents were illiterate, which is in agreement with previous studies.[12] Only 43.1% of the respondent underwent HIV screening despite being at risk of acquiring HIV infection.

Knowledge on transmission of HIV infection was high among respondents. Three fourth of respondents had watched film/programme on reproductive health/HIV/AIDS. This had positive impact on the knowledge of the respondents. At the same, 29.3% of the respondents had access to films on act of sex or pornographic films. First sexual contact for 17% of them was reported at the age of 14 years or below. Experience of coercion was reported by 5.2% of respondents. Almost all the respondents perceived condom usage as a safe sex. One fifth (20.7%) of respondents experienced some sort of sexual difficulties but rarely did they discuss. Oral and anal sex was practiced by 20% of the respondents from whom chances of acquiring HIV infection increases manifold. Number of partners ranged form 2 to 1000 with mean partner rate of 204.67. Earning of the respondents varied from Rs. 50 to 600 with a mean of Rs. 232 per client. Alcohol dependence assessment revealed that 6 respondents were alcoholic. (*Table –2*).

As many as, 81% of respondents had symptoms indicative of STI, probably due to high rate of partner change. Treatments for STIs were not included for the analysis, as all the respondents were screened for presence or absence of sexually transmitted disease by VDRL (Venereal Disease Research Laboratory) test soon after getting registered at the NGO.

Feeling of shame was relatively high among the respondents. Three fourth of (77.6%) respondents didn't want to disclose their occupation to anybody. More respondents (86.2%) thought less of themselves due to their profession. Basic idea of keeping their identity secret definitely produces considerable strain on the lives of the respondents. This idea of not disclosing also rose out of feelings, such as husband refusal to have sex (77.6%), marital dispute (84.5%) and imminent separation (98.3%) from their spouses. Ninety one percent of respondents reported that they and their family were less respected because of their profession. People's refusal to visit their home was reported by 58.6% of the respondents. On learning their occupation 72.4% were asked to stay away from home.

Table 1 Socio-demographic details (n=58)

Variables	No	%
Age		
<31.10	28	48.3
>31.10	30	51.7
Education		
Illiterate	13	22.4
Literate	45	77.6
Marital status		
Married	21	36.2
Unmarried	2	3.4
Separated	15	25.9
Divorced	14	24.1
Partner	6	10.3
Family type		
Nuclear	44	75.9
Joint	14	24.1
Occupation		
Unemployed	22	37.9
Sales	8	13.79
Casual labour	21	36.21
Skilled	7	12.01

Table –2 :

Items	No=58	%
Access to films		
Watched film on porno	17	29.3
Watched film on HIV/AIDS	45	77.6
Mean of age at 1st contact	16.97(mean)	SD 2.60
<16yrs	30	51.72
>16yrs	28	48.28
First sexual contact		
Spouse	56	96.6
HIV awareness		
Some to lot (3 or more)	54	93.10
None (0-2)	4	6.90
Sexual coercion	3	5.2
STI history		
More than two complaints	47	81.03
1 or less	11	18.97
Gap between symptoms and RX seeking		
Immediately	48	82.76
One week	3	5.17
> one month	7	12.67
Partners		
<204.67	38	65.5
>204.67	20	34.5
Alcohol dependence		
No (>3)	52	Non alcoholic
Yes (<3)	6	Alcoholic
Income per encounter		
<INR 232	34	58.6
>INR 232	24	41.4
HIV Screened		
Yes	25	43.1
No	33	56.9

Table 3 Regression table comparison of being screened for HIV by Education, Income per encounter, Alcohol dependence, No. Of partner, Access to Porno, Exposure to HIV films, Shame, stigma and STI, Type of family (WEIGHTVAR = Age P VALUE=95%)

Term	Odds Ratio	95%	C.I.	P-Value
Education Illiterate Literate	1.013	0.9169	1.1193	0.7994
Income per encounter < INR236 >INR 236	1.0037	1.0027	1.0047	0.0000
HIV awareness	3.2507	2.5289	4.1784	0.0000
Alcohol dependence Yes No	1.0626	1.0325	1.0934	0.0000
Marital status	0.8412	0.7844	0.9021	-0.0000
No_of_partner <204.67 >204.67	1.0021	1.0016	1.0025	0.0000
Exposure to HIV films Yes No	3.7922	2.6609	5.4046	0.0000
Exposure to Porno Yes No	1.6269	1.2674	2.0883	0.0001
STI Yes No	0.9379	0.8799	0.9998	0.0492
Shame Little or none <3 Some to lot 4-6	2.6947	2.3439	3.098	0.0000
Stigma Little or none<2 Some to lot 3-7	1.0284	0.9695	1.0909	0.3519
Type of family Joint Nuclear	1.3135	1.0325	1.6711	0.0264

Multivariate analysis

Table III present the results of logistic regression analyses (Epi Info™ Version 3.4 April 30, 2007) comparing respondents chances of getting screened for HIV. Respondents who had better income are more likely to get screened for HIV. Respondents who were aware of HIV are 3.25 times more likely to undergo HIV screening than participants with little or no knowledge. Respondents who reported alcohol use are more likely to get screened for HIV than those who do not use alcohol. Marital status of the respondents was inversely related to getting screened for HIV. Increase in number of partners, increases the chances of getting screened for HIV. Respondents who were exposed to HIV educational movies are three times more likely to get screened for HIV. Access to pornographic films also had its impact in HIV screening among the respondents. Participants who had been diagnosed with a STI were less likely to go for HIV screening, probably due to fear. Experience of shame did not alter the HIV screening among the respondents. Respondents living in nuclear families were more likely to get screened than those who live in joint families. Even though experience of stigmatized reaction was quite high, that did not really affect the HIV screening of the respondents.

Discussion

This study is noteworthy as it covered the respondents whose identity is always subtle. Further this study extends the existing literature by using relevant variables significantly and independently associated with ensuring early HIV screening. Study has found that experience of shame, related to the profession is so intense as a result many suffer in silent. Experiences of stigmatized treatment to the respondents were also very high.

Presence of extreme risky behavior, other than the "vaginal penal contact", orientation necessitates AIDS prevention workers to find and suggest an alternative prevention method. Repeated motivation sessions are more important in order to improve their safe sex practices.

Knowledge on HIV transmission is very high among the study participants. Yet, more than half of the respondents did not undergo HIV screening. This study demonstrates that information alone does not always lead to behavior change.

In order to address the issue of stigmatized experience, community should be made aware of the sad plight of sex workers and adopt community sponsored rehabilitation programmes to provide alternative means of income generation. Such measures are more likely to produce favorable results, because, majority of the respondents were taken to sex trade due to absence of support from their spouses.

The findings suggest several points for HIV prevention efforts for this population. Firstly, effective shame reduction strategies should be planned to help this population to get over emotional disturbances. Emotional disturbances, inevitably leads to non-compliance and develop resistance to undergo HIV screening.

Secondly, issue of rights need to be addressed by those organization working among women in prostitution. Because, even though the study population makes livelihood out of this profession, peaceful living in the family and in the community is not guaranteed.

To conclude, it is essential to sensitize the community to understand the psycho social issues confronting women in prostitution. In order to help the study participants overcome emotional disturbances stigma reduction skills sessions could be organized. Provisions of HIV screening facilities at the servicing centre i.e., NGOs could also be explored.

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