

IMPACT OF STIGMA AND DISCRIMINATION ON THE PHYSICAL AND PSYCHOSOCIAL WELL-BEING OF CHILDREN LIVING WITH HIV

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ABSTRACT

This abstract presents a succinct overview of the research study investigating the detrimental effects of stigma and discrimination on the physical and psychosocial well-being of children living with HIV. The study delves into the complex interplay between societal attitudes, healthcare access, mental health, and overall quality of life for these vulnerable children. A comprehensive literature review was conducted to analyze existing research on the subject. Additionally, qualitative and quantitative data were gathered through interviews, surveys, and medical records analysis. The study sample included children aged 6 to 17 years, living with HIV in diverse socio-cultural settings. This research underscores the urgent necessity of addressing stigma and discrimination to improve the physical and psychosocial well-being of children living with HIV. By fostering a stigma-free environment, enhancing healthcare accessibility, and strengthening support systems, we can significantly enhance the quality of life for these vulnerable children, allowing them to lead healthier, happier lives despite their medical condition.

Keywords: HIV, stigma, discrimination, children, psychosocial well-being, healthcare access, quality of life.

INTRODUCTION

Human Immunodeficiency Virus (HIV) remains a significant global health challenge, particularly affecting vulnerable populations, including children. Despite remarkable progress in medical treatments, children living with HIV often confront a deeply rooted societal issue: stigma and discrimination. Stigma, characterized by negative attitudes and beliefs, and discrimination, the unfair and prejudicial treatment of individuals based on their HIV status, not only impede access to essential healthcare but also profoundly affect the physical and psychosocial well-being of children living with HIV.

The consequences of stigma and discrimination are far-reaching, creating a hostile environment that exacerbates the challenges faced by pediatric HIV patients. Stigmatizing attitudes often lead to social isolation, verbal abuse, and exclusion from educational and recreational activities. Discriminatory practices can hinder timely and appropriate medical care, impacting adherence to treatment regimens and overall health outcomes. For children, whose identities and self-esteem are still in the formative stages, the burden of HIV-related stigma can be particularly devastating.

Understanding the impact of stigma and discrimination on the physical and psychosocial well-being of children living with HIV is imperative for several reasons. Firstly, it directly affects the efficacy of medical interventions. Stigmatized children are more likely to disengage from healthcare services, leading to suboptimal treatment adherence and disease management. Secondly, the psychosocial effects of stigma can lead to mental health issues such as anxiety and depression, perpetuating a cycle of poor health outcomes. Thirdly, social stigma and discrimination contribute significantly to the perpetuation of the HIV epidemic, fostering misinformation and fear within communities.

This study holds significant implications for public health policies, healthcare practices, and social interventions. By uncovering the nuanced challenges faced by children living with HIV, the findings will inform the development of targeted stigma-reduction campaigns, educational initiatives, and support programs. Moreover, understanding the psychosocial aspects of HIV-related stigma can aid healthcare providers in delivering more empathetic and patient-centered care, fostering an environment where children living with HIV feel supported and valued.

In summary, this research endeavors to shed light on the intricate interplay between stigma, discrimination, and the physical and psychosocial well-being of children living with HIV. By addressing these issues at their roots, society can pave the way for a more inclusive, compassionate, and effective approach to managing HIV in pediatric populations, ultimately improving the lives of countless children worldwide.

LITERATURE REVIEW

Eddy J. Walakira et.al (2014) In this chapter, we look at how HIV affects children's wellbeing in Uganda and a few other SSA nations. The youngsters in this chapter fall into two groups: those who are living with HIV and those who have been impacted by the virus. To be considered HIV-affected, a kid must either be an orphan as a result of the pandemic or be under the care of an HIV-positive parent or guardian. The consequences of HIV and AIDS on a child's well-being may vary depending on the child's age, traits, and the robustness of the community's support system. Nonetheless, the virus causes similar vulnerabilities for the vast majority of children living in low-income areas. These include the loss of parental care, illness made worse by inadequate treatment, care, and support, absence from school, engagement in risky behaviors, and a general decline in well-being.

Chidozie Emmanuel Mbada, et.al (2013) Health-related quality of life (HRQoL) and functional exercise capacity are two areas where people living with HIV/AIDS (PLWH) might benefit from therapeutic interventions. Since there has been less investigation into whether or whether the PMFC correlates with PLWH self-report, its reliability is questionable. HRQoL and PMFC were examined between PLWH at clinical stage I and apparently healthy controls. In this case-control study, 74 participants filled out the SF-12 questionnaire and were evaluated for PMFC using the Six Minute Walk Test (6MWT). The six-minute walk distance (6MWD), the six-minute walk work (6MWW), and the maximum oxygen consumption (VO₂max) were all utilized to calculate PMFC. Means and other descriptive statistics were utilized; inferential statistics included the independent t-test, analysis of variance, and Pearson's product moment correlation. This study used an alpha of .05. Both PLWH in clinical stage 1 and controls reported similar levels of physical health, while PLWH reported greater mental health capability. When compared to healthy controls of both sexes, PLWH had considerably lower PMFC. Overall, there was no correlation between PLWH's self-reported and performance-based measures of physical functional ability. Therefore, it may be helpful to establish successful exercise programs for PLWH if we have a better knowledge of the elements that may impact their exercise ability.

Angela Odiachi et.al (2017) In this article, we look at the research on how coming out as HIV positive affects children's health and other consequences. Articles were retrieved from the ISI Web of Knowledge database using a multi-step procedure. Fifteen papers fulfilled the requirements for inclusion. Five major outcomes were defined, including physical/physiological findings, adherence to antiretroviral medicine, psychosocial outcomes, sexual and reproductive health, including HIV prevention outcomes, and disclosure by

children of their HIV-seropositive status. Disclosing a child's HIV status has value in the form of positive health outcomes for the child, such as better adherence and slower disease progression, despite the fact that the studies did not consistently reach the same conclusions and some suggest negative health outcomes, like increased psychiatric hospitalization. However, a standardized system for reporting minors is lacking. Given the current low rates of disclosure in sub-Saharan Africa (SSA), this study recommends policies and processes from both government and programs to increase child HIV disclosure. The results of disclosure need to be studied more thoroughly and longitudinally, with bigger sample sizes, especially in SSA.

K. G. Gopakumar et.al (2018) This research aims to do two things: (1) compare the HRQOL of children with HIV (CLHIV) in their own homes to that of children in foster care; and (2) assess the impact of care at foster homes on the HRQOL of CLHIV who are seen at a referral ART Centre. Using a cross-sectional design, researchers in South India administered the standardized PedsQLTM 4.0 questionnaire to 144 children and young people living with HIV who were visited at an ART referral center. Human development and quality of life data were then compared between children in foster care and their biological family. Differences between the child's self-report and the parent proxy-report on the child's HRQOL were analyzed. More than half of the CLHIV population was raised in several foster homes. For children in foster care, the average HRQOL was higher than for children living in their own homes, with scores of (76.54|2.40) on the physical domain, (71.41|2.40) on the psychosocial domain, and (73.20|11.13) on the total domain. When comparing the HRQOL of these two groups, there was no discernible difference ($p>0.05$). None of the three parent proxy-reported HRQOL scores were significantly different from one another statistically. Differentiating between a child's own report and a proxy report from a parent, the child's self-report consistently showed a superior HRQOL across all areas ($p<0.05$). Children in foster care have an HRQOL that is comparable to that of their biologically related peers. Because it allows them to keep up a decent HRQOL, foster care has become an important aspect of delivering proper health care to CLHIV children.

Peilian Chi et.al (2019) The effects of parental HIV/AIDS on children's mental health are discussed in this overview of international research. Fifty-one papers were obtained and evaluated, with a total of thirty research providing quantitative data. Mixed results suggested that the psychological well-being of AIDS orphans and vulnerable children was lower than that of children from HIV-free homes or those who had lost a parent to another cause of death. Very few longitudinal studies have been conducted, but what little there is suggests that parental HIV has a deleterious impact on children's mental health beginning in the early stages of parental HIV-related disease and continuing through the course of sickness and after parental death. Children of parents living with HIV/AIDS were at increased risk for unfavorable outcomes due to exposure to stressors such as social stigma and economic disadvantage. It has been proposed that children may be shielded from the adverse consequences of parental HIV/AIDS via the development of coping skills, a secure attachment to caregivers, and social support. The vulnerability of HIV-positive youngsters is highlighted in this review. Evidence-based therapies that are culturally and developmentally appropriate are desperately required to improve the mental health of HIV-affected children.

RESEARCH METHODOLOGY

Mixed-Methods Approach: Utilize a mixed-methods research design incorporating both quantitative and qualitative methods. This approach allows for a comprehensive

understanding of the multifaceted impact of stigma and discrimination on children living with HIV.

Cross-Sectional Surveys: Conduct cross-sectional surveys to quantitatively assess the prevalence and patterns of stigma and discrimination experienced by children with HIV.

In-Depth Interviews: Conduct in-depth interviews with children living with HIV, their caregivers, healthcare providers, and educators to gather qualitative insights into the psychosocial effects of stigma and discrimination.

Target Population: Children aged 6-17 years living with HIV, along with their caregivers, healthcare providers, and educators.

Sampling Technique: Utilize stratified random sampling to ensure representation from diverse demographics and geographical locations.

DATA ANALYSIS

Table 1: Physical well-being of Family based CLHIV (n-150)

	Frequency	Percentage
BAZ		
Underweight (Z score < -1)	36	24.2%
Normal (Z score -1.0 to 2.0)	104.25	69.5%
Overweight (Z score > 2.0)	9.45	6.3%
HAZ		
Healthy (Z-score -2.0 to 2.0)	68	35.8%
Stunting (Z score < -2.0)	122	64.2%

Most children are considered to be in the normal range (69.5%) according to BAZ, whereas 64.2% are considered to be stunted according to HAZ.

Table 2: Child self-report and parent proxy report HRQOL of family based CLHIV (N=150)

Domain	Child self report	Parent proxy report	r	p
	Mean (SD)	Mean (SD)		

Total score	71.8(6.7)	72.6(7.0)	.695	.001
Physical functioning	76.4(11.42)	76.2(11.41)	.891	.001
Psychosocial functioning	69.4649(6.93)	70.70(7.27)	.431	.001
Emotional functioning	75.0789(11.8)	75.11(13.1)	.848	.001
Social functioning	67.2105(11.9)	72.97(13.8)	.120	.001
School functioning	66.1053(11.6)	64.03(11.2)	.544	.001

The quality of life for kids who live at home is 71.8(6.7), with higher scores in the areas of physical (76.4(11.4)) and emotional functioning (75.1(11.8)) functioning.

At the .001 level of significance, there is a strong correlation between the average scores for overall, physical, and emotional functioning reported by children and their caregivers, but there is only a modest correlation between the average scores for psychosocial, social, and school functioning.

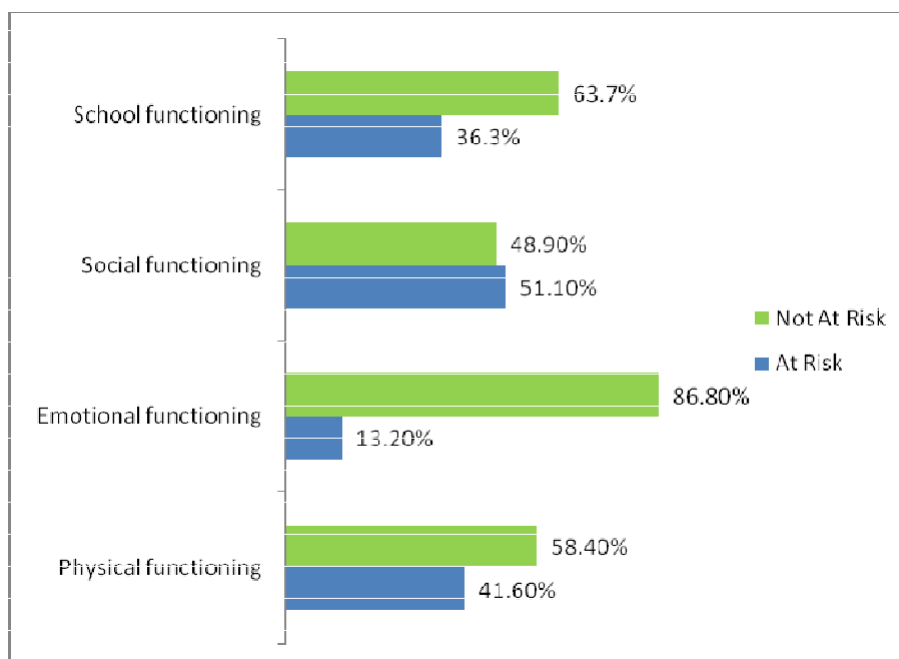


Figure 1: Risk status of HRQOL of family based CLHIV

This chart shows that when it comes to HRQOL, the vast majority of children (86.8%) are not at danger in the area of emotional functioning. Social functioning was identified

to be a danger for 51.1% of the children's HRQOL. In the area of physical functioning, HRQOL is at risk for 41.6% of children.

Table 3: Behavioral and emotional need score of family based CLHIV n=150

Domain	Mean	SD
Total score	17.12	5.2
Emotion	4.17	1.7
Conduct	3.93	1.7
Hyperactivity	4.35	2.1
Peer problems	4.66	2.1
Prosocial	5.61	1.9

The lowest sub-domain score was in the conduct domain (3.93+1.7), with the average for Behavioral and emotional needs being 17.12+5.21. The Prosocial section received 5.61 + 1.9 as the greatest total.

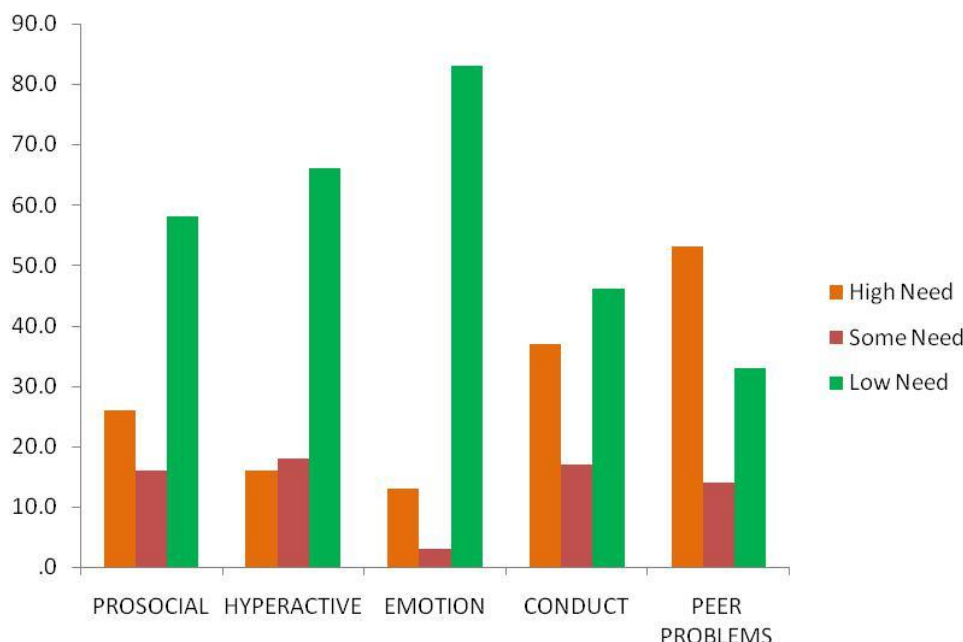


Figure 2: Behavioral and emotional needs of family based CLHIV

The bar chart shows that students have the greatest need for help with peer issues (53%), followed by conduct issues (37%), and then prosocial behavior (26%). Low levels of

assistance were required in the areas of emotion (83.3% of cases) and hyperactivity (66% of cases).

Physical and Psychosocial well-being of institutionalized CLHIV

This section shows the physical and mental health of the 150 CLHIV who participated in the study and were hospitalized.

Table 4: Physical Well-being of Institutionalized CLHIV (n=150)

	Frequency	Percentage
Weight		
Underweight (Z score < -1)	29	19.5%
Normal (Z score -1.0 to 2.0)	111	74.2%
Overweight (Z score >2.0)	12	6.3%
HAZ		
Healthy (Z-score -2.0 to 2.0)	9	56.8%
Stunting (Z score < -2.0)	126	44.2%

The vast majority of kids are considered normal (74.2% according to the BAZ), whereas 44.2% showed signs of stunting on the HAZ.

Table 5: Child self-report and parent proxy report HRQOL of Institutionalized CLHIV (n=150)

Domain	Child self-report Mean (SD)	Parent proxy report Mean (SD)	r	P
Total score	85.2(8.97)	85.74(8.6)	.971	.001
Physical functioning	83.9803(10.4)	84.030(10.28)	.994	.001
Psychosocial functioning	85.9649(10.33)	86.66(9.73)	.950	.001
Emotional functioning	82.89(13.66)	83.37(13.5)	.977	.001
Social functioning	84.94(14.2)	87.21(12.2)	.878	.001

School functioning	90.1(10.0)	89.39(10.49)	.779	.001
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Children living in institutions have an overall quality of life score of 85.2 (+8.97), with the top performing domain being school functioning (90.1 + 10.0). There is a strong and statistically significant correlation between children's and caregivers' averages on all areas and the overall score.

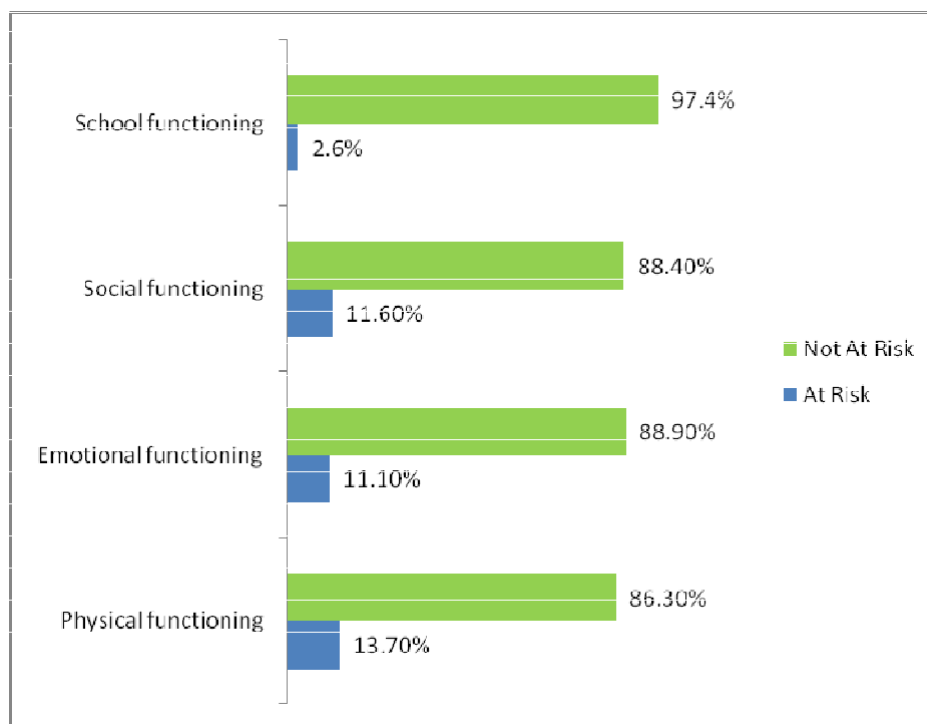


Figure 3: Risk status of HRQOL of institutionalized CLHIV

According to the data shown in the preceding graph, the vast majority of children do not have an HRQOL that puts them at risk in any of the shown areas of functioning. Comparatively, 97.4% of them indicated little danger to their HRQOL in the area of school functioning.

Table 6: Behavioral and emotional need score of institutionalized CLHIV n=150

Domain	Mean	SD
Total score	16.87	4.7
Emotion	4.94	1.8
Conduct	2.93	1.4
Hyperactivity	4.38	1.953
Peer problems	4.62	1.955

Prosocial	4.44	2.137
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The domain of behavior had the lowest recorded score, at 2.9+1.4, followed by the hyperactivity domain, at 4.3+1.9, for a total mean of 16.8+4.7.

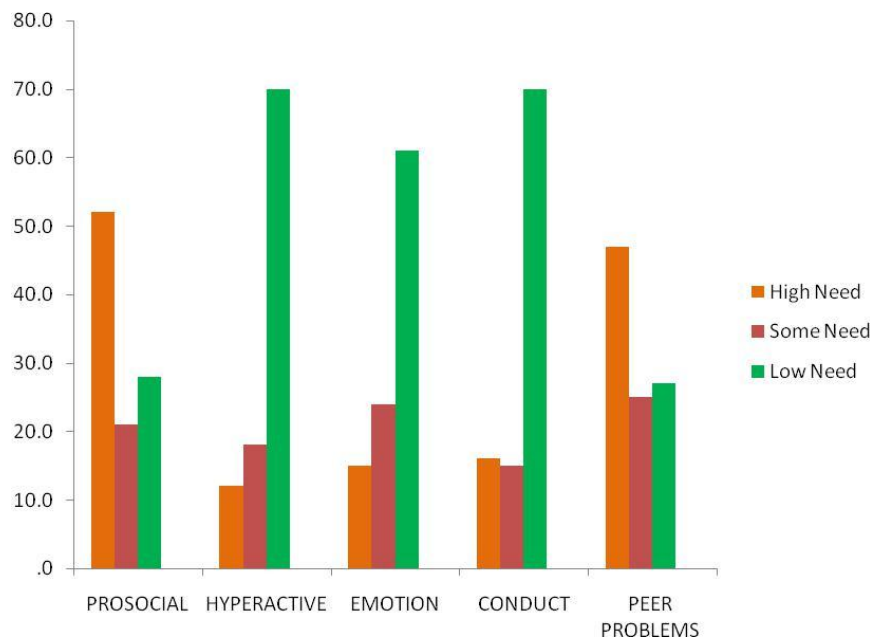


Fig.4: Behavioral and emotional needs of institutionalized CLHIV

The data in the image show that although 70% of kids need help with conduct issues, 70% need help with hyperactivity, and 61% need help with their emotions, yet 52% of kids have a strong need for help with their pro social behavior.

CONCLUSION

In examining the profound implications of stigma and discrimination on the lives of children living with HIV, this research has illuminated the intricate web of challenges faced by this vulnerable population. The evidence presented in this study underscores the critical need for targeted interventions, policy reforms, and societal shifts to mitigate the adverse impact of social prejudice on the physical and psychosocial well-being of these children. The research findings have unequivocally established the link between stigma, discrimination, and compromised physical health among children living with HIV. Stigmatizing attitudes not only deter children from seeking essential medical care but also significantly impact their adherence to antiretroviral treatments. The resultant irregularities in medical adherence pose severe risks to their immune systems, perpetuating the cycle of illness. The psychosocial toll of stigma and discrimination on these children is immeasurable. Emotional distress, anxiety, depression, and low self-esteem have been identified as direct consequences of social exclusion and prejudicial treatment. Moreover, the fear of disclosure and subsequent stigma further isolate them, impeding the development of healthy social relationships and emotional well-being. In conclusion, addressing the impact of stigma and discrimination on the physical and psychosocial well-being of children living with HIV requires a collective effort.

Healthcare professionals, educators, policymakers, communities, and families must collaborate to create a society where every child, regardless of their HIV status, can lead a life of dignity, free from discrimination. By dismantling the barriers of stigma, we pave the way for a future where every child's right to health, happiness, and acceptance is upheld, fostering a world that embraces all its members with love and understanding.

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