Stigma and Quality of Life in African American Women Living with HIV Infection through the Lens of Intersectionality

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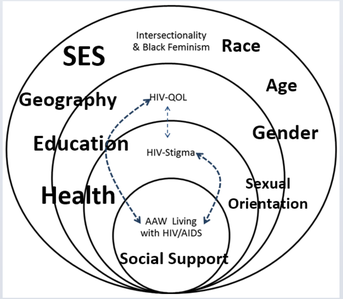
BACKGROUND

Background and Significance

- HIV/AIDS affect the health and social well-being of individuals, families, populations, communities, and nations around the world.
  - 1.2 million people live with HIV/AIDS in the US.
- African American women (AAW) bear a disproportionate burden of HIV infection (CDC, 2012).
  - Among women, AAW account for 64% (38.1 per 100,000) of new HIV infections as compared to White, non-Hispanic women (1.9 per 100,000) and Latina women (8.0 per 100,000).

Intersectionality Theory & Black Feminist Perspectives

- Intersectionality theory deals with relationships among multiple intersections that shape one's experiences and decisions because of being different (McCall, 2005). Black feminist thought is an application within the intersectionality paradigm that places AAW at the center of analysis (Collins, 1986, 2000).
  - AAW experience the trifecta of intersections: being Black, being female, and having HIV infection at a disproportionately higher rate (Collins et al, 2008).
  - Little is known about the intersection of race/ethnicity, gender, and HIV infection on the stigmatizing and quality of life (QOL) experiences of AAW.



Study Purposes

1. Describe HIV-stigma and HIV-QOL as perceived by AAW living with HIV infection.
2. Explore the association between AAW's perceptions of HIV-stigma and HIV-QOL.
3. Determine the influence of social (age, education, income, and partner status) and health (CD4 count, comorbidities, and emergency department [ED] admission) contextual factors on AAW's perceptions of HIV-stigma and HIV-QOL.

DESIGN & METHODS

Research Questions

1. What is the occurrence of HIV-stigma?
2. What is the occurrence of HIV-QOL?
3. Do HIV-stigma and HIV-QOL differ by social factors?
4. Do HIV-stigma and HIV-QOL differ by health factors?
5. What is the relationship between HIV-stigma and HIV-QOL?
6. Which social and health factors best explain the variance in HIV-stigma and HIV-QOL?

Study Design

- Secondary research
- Non-experimental, cross-sectional, descriptive, and correlational

Sample

- 169 AAW with at least one child living in household. Mean age: 46 years (20-69 age range), 86% partnered, 81% housed, 78% unemployed, and 37% did not complete high school. Median annual income $9,654.
- 95% public health insurance, 57% no ED visit within past year, 61% no AIDS diagnosis, 77% on highly active antiretroviral therapy (HAART), median CD4: 532 cells/mm^3, and mean comorbidities: 1.4 (0-5 range). Most prevalent comorbidities were cardiovascular, mental health, and hepatic related.

Setting

- Urban
- Cleveland, OH: *n* = 91 (53.8%)
- San Francisco Bay Area: *n* = 78 (46.2%)

Variables and Measures

HIV Stigma:

- 40-item HIV Stigma Scale (Berger et al., 2001)
- Response options: (1) strongly disagree, (2) disagree, (3) agree, or (4) strongly agree
- Subscales: personalized stigma, disclosure concerns, negative self-image, and public attitudes

HIV QOL:

- 42-item HIV/AIDS Targeted QOL Instrument (HAT-QoL) by Holmes & Shea (1997)\
- Response options: (1) all of the time, (2) lot of the time, (3) some of the time, (4) little of the time, or (5) none of the time
- Subscales: overall function, life satisfaction, health, financial, medication, HIV mastery, and disclosure

Social and Health Contextual Factors:

- Social: age, education, income, partner status
- Health: CD4 count, comorbidities, ED visit

RESULTS

Q1: Occurrence of HIV-stigma

Stigma Dimension (Scale Range)	*n*	*Range*	*M*	*SD*	α
Personalized Stigma (18-72)	78	12-68	37.53	12.90	.95
Disclosure Concerns (10-40)	78	10-40	25.22	7.36	.87
Negative Self-image (13-52)	78	14-45	28.41	8.45	.88
Public Attitudes (20-80)	78	20-79	44.82	13.63	.94
Total HIV-Stigma (40-160)	78	44-150	90.18	24.81	.96

Moderate levels of HIV-stigma for all dimensions. Includes only SF site. Higher mean score reflects greater perceived stigma.

Q2: Occurrence of HIV-QOL

QOL Dimension	*n*	*Range*	*M*	*SD*	*α*
Overall Function	168	4-100	56.50	25.49	.81
Life Satisfaction	169	0-100	74.20	27.91	.93
Health	168	0-100	61.27	33.75	.91
Financial	169	0-100	43.44	35.98	.90
[a]Medication	139	0-100	73.60	30.23	.92
HIV Mastery	167	0-100	57.56	37.02	.91
Disclosure	166	0-100	58.07	33.28	.87
Total HIV-QOL	169	13.99-100	60.02	23.52	.94

Moderate levels of HIV-QOL for all dimensions except for financial. Scale range: 0-100. Higher mean score reflects better HIV-QOL. [a]Includes only AAW who took HIV medications.

Q3 & Q4: HIV-stigma & HIV-QOL differ by social & health factors

- HIV-stigma does not differ by social or health factors.
- HIV-QOL differs significantly by partner status (social), education (social), and comorbidities (health)
- AAW who were partnered reported more life satisfaction (*M* = 90.63, *SD* = 15.09) as compared to AAW who were not partnered (*M* = 71.26, *SD* = 28.73).
- As compared to AAW who had a HS education or less, college-educated AAW reported better overall function (*M* = 53.13, *SD* = 25.56 vs. *M* = 66.28, *SD* = 22.87), health (*M* = 54.95 *SD* = 33.88 vs. *M* = 79.65, *SD* = 25.99), medication (*M* = 67.70, *SD* = 31.43 vs. *M* = 88.72, *SD* = 20.45), HIV mastery (*M* = 51.92, *SD* = 37.14 vs. *M* = 73.84, *SD* = 31.79), and total HIV-QOL (*M* = 55.73, *SD* = 22.83 vs. *M* = 72.56, *SD* = 21.12).
- AAW with less comorbidities reported more life satisfaction (*M* = 84.51, *SD* = 24.97) as compared to AAW who reported more comorbidities (*M* = 70.08, *SD* = 28.28).

RESULTS

Q5: Relationship between HIV-stigma and HIV-QOL

	QOL							
Stigma	Overall Fx	Life Satisf	Hlth	Fin	Med	HIV Mastery	Disclose	Total HIV-QOL
Personal Stigma	-.06	-.20	-.08	-.20	-.02	-.23*	-.34**	-.24*
Disclosure Concerns	.05	-.19	.17	.00	.32*	-.03	-.33**	-.02
Negative Self-image	-.13	-.23*	-.12	-.16	.12	-.24*	-.37**	-.25*
Public Attitudes	.02	-.19	.03	-.11	.18	-.13	-.28*	-.11
Total HIV-Stigma	-.02	-.21	.01	-.11	.16	-.17	-.36**	-.16

Note. Includes only SF site. Fx = Function. Satisf = Satisfaction. Hlth = Health. Fin= Financial. Med. = Medication. Disclose = Disclosure.
*p < .05. **p < .01.

- AAW who did not worry about disclosing their HIV status was associated with lower perceived total HIV-stigma, less personalized stigma, less disclosure concerns, less negative self-image, and less worries about public attitudes toward HIV.
- AAW who reported taking HIV medications was not a burden were associated with lower perceived personalized stigma and less negative self-image.
- AAW who reported high life satisfaction were significantly associated with less perceived negative self-image.

Q6: Predictors of HIV-stigma and HIV-QOL

HIV-STIGMA

- **Personalized stigma.** Social and health factors accounted for 26% of the variance (*F* = 2.373, *p* = .04). Number of comorbidities was the only individual predictor that contributed significantly (β = .33, *t* = 2.54, *p* =.01).
- **Public attitudes about HIV.** Social and health factors accounted for 25% of the variance (*F* = 2.286, *p* = .04). Number of comorbidities was the only individual predictor that contributed significantly (β = .27, *t* = 2.11, *p* =.04).

HIV-QOL

- **Total HIV-QOL.** Social & health factors accounted for 15% of the variance (*F* = 2.587, *p* = .02). Only the predictor, education, contributed significantly (β = .31, *t* = 3.32, *p* =.001).
- **Health.** Social & health factors accounted for 15% of the variance (*F* = 2.536, *p* = .02). Only the predictor, education, contributed significantly (β = .33, *t* = 3.56, *p* =.001).
- **Medication.** Social & health factors accounted for 14% of the variance (*F* = 2.382, *p* = .03). Only the predictor, education, contributed significantly (β = .29, *t* = 3.06, *p* =.003).

DISCUSSION

Discussion

- This sample of middle-aged AAW had multiple identities and roles (female, mother, AA, and HIV infection) that intersect and required the daily balancing of motherhood, caring for others, and managing HIV infection and comorbidities—often without personal social networks, without adequate financial support, and without assistance to navigate the public healthcare insurance system of care.
- Study findings indicate education might be the key to empowering AAW living with HIV infection to improve their QOL, which is bound inextricably to perceived stigmatization by themselves (internal) and others (external) because of their HIV status and social place in life.

Implications

- Care must be taken to not develop policies and interventions that fail to acknowledge cultural differences by insisting that White, middle-class values be adopted by AAW, resulting paradoxically, in racism and paternalism.

Further Research

- Using community-based participatory research, assess the linkage between HIV-stigma, HIV-QOL, and women's lives by focusing on macro- (e.g., human rights, public health policies and laws) and micro- (e.g., client-provider communication) level interactions.

Conclusions

- Social (being partnered and education) and health (comorbidities) factors can have negative and positive effects on how AAW living with HIV infection perceive stigma and QOL. Stigma can be a major obstacle for HIV/AIDS prevention and treatment.
- This study filled a gap in science by considering social and health characteristics for describing HIV-stigma and HIV-QOL as perceived by AAW within the intersectionality and Black feminism paradigm.

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