

HIV/AIDS Stereotypes: Exploring its existence through the eyes of the community

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Abstract : This research explores the stereotypes that exist against the HIV/AIDS community, how they behaviorally manifest in the general population and how the infected community responds to it. The ground reality in Indian society concerning HIV is one that is hostile and stigmatized, stemming from a lack of awareness of the disease and what it entails. While considering adolescents with HIV/AIDS risk taking behavior is observed more often. To that end, a qualitative method was employed so as to better understand the impact of these psycho-social factors on the level of an individual's subjective experiences. Through thematic analysis it emerged that societal reactions and realities about HIV/AIDS manifest into stigmatizing behaviors which the community has learnt to cope with in several ways, primarily the presence of sheltered rehabilitation care. The discussion highlights the various manifesting impact of the stereotypes at the individual level.

Key Words: HIV/AIDS Adolescents, Qualitative, Lived experiences, Cultural Perception, Stereotypes, Rehabilitation, Well-Being.

I. INTRODUCTION

This paper considers the stereotypes regarding HIV in India and their manifestations as seen in various parts of the country. To this end, this study explores effects of stereotypes and cultural perceptions held by the general i.e non HIV population on the HIV infected or HIV+ individuals. Also considered is the lived subjective experiences of the HIV infected who have routinely experienced these stereotypes and the manifesting discriminatory behaviour.

There are 23, 95,442 People Living with HIV/AIDS (PLHA), and there are 1, 04,450 Children Living with HIV/AIDS (CLHA) and an estimated 1, 72,668 AIDS related deaths in India (State Fact Sheet, 2007-2012). However, despite having such a large prevalence in our country, the overall situation for the HIV infected population continues to be precarious. HIV continues to be a stigmatized disease, despite significant advances in care and concerned efforts to reduce discrimination, stereotypes and prejudice (Thomas, et al., 2005; Steward, et al., 2008; Sivaram, et al., 2009). Being infected and living with HIV is associated with a variety of overlapping and intersecting experiences which can, in and of themselves, be stigmatized. Often the stigmatizing individual is a health care provider, which can influence access to and quality of healthcare and medical facilities (Wagner et al., 2017).

Prejudice, refers to negative emotional responses based on group membership. *Discrimination* can be said to be differential (usually negative) behaviors directed towards members of different social groups. Although sometimes overt, both prejudice and discrimination can be blatant or relatively subtle (Barreto & Ellemers, 2005). With regard to HIV infected population, there exists to some extent, forms of prejudice which inevitably gets manifested in discriminatory behavior. This is then manifested into *stereotypes*, which are beliefs about social groups (in this case HIV infected group) in terms of the traits and characteristics that they are believed to share (Baron, 2015, pp. 178-179). Stereotypes often lead to stigma, something which is highly common in the population chosen. All over the world, people display their best and worst when confronted with the epidemics of HIV and AIDS. At its worst, people are stigmatized, ostracized by their loved ones and their communities, discriminated against individually and institutionally (Daniel & Parker, 1993; Altman 1994). Studies have been published describing the forms, contexts and consequences of AIDS-related stigma (UN, 2001).

Various researches have explored the interconnected relationship between stigma and discrimination association with HIV/AIDS. HIV/AIDS-related stigma and discrimination are closely tied to other inequalities and ultimately create and reinforce each other. The role of stigma in society is described as a constant process of devaluation. Stigma builds on and reinforces earlier prejudice such as engagement in illicit sex with sex workers, having been "promiscuous", "woman's disease", junkies or as a "gay plague" (Maluwa, Aggleton & Parker, 2002). AIDS exploits people's three primitive anxieties: fear of germs and disease, fear of death, and deep-seated worries about sex and sexuality (Patton, 1986). There are three phases in the AIDS epidemic in any society: the first being the epidemic of HIV infection, the second is the epidemic of AIDS, and the third epidemic is a combined reaction of stigma, discrimination, blame, and collective denial (Mann, 1987). The resultant discrimination associated with HIV and AIDS stigma frequently leads to the violation of the rights of people living with HIV/AIDS, as well as the rights of their families, originating from various sources, from governments, private organizations, and institutions, as well as from communities, families, and individuals.

The objective of this paper is to find out the realities of the existence of said stereotypes through the eyes of the affected community. Through the examination of realities, this study also aims to explore the experiences and perception of the HIV/AIDS community towards stereotypes that exist against them. The rationale of the present study arises from the fact that only few

studies have focused on the experiences of adolescents perinatally infected with HIV. Overall there exists a dearth of literature that highlights the experiences and the realities of the HIV infected adolescents in the without parents or family.

Furthermore, the use of the qualitative method allows better understanding of the lived subjective experiences of the HIV infected population regarding stereotypes and discriminatory behaviour faced by them. The emphasis on the lived experiences will facilitate greater effectiveness in the design and execution of intervention programs for this selected special population. To this end, it will also enable health care professionals and social scientists to establish and consider various alternatives to improve the quality of life of these individuals.

Research Questions

The research questions mooted in the present study,

- What are the life experiences of individuals infected with HIV in the Indian context?
- What is the nature of the stereotypes that exist against the HIV/AIDS community?
- How does the HIV/AIDS community view the stereotypes against them?

II. METHOD

Sample

With regard to the focus group discussion (FGD), purposive sampling was used. It is a non-probability sample that is selected based on characteristics of a population and the objective of the study. A sample of two boys and two girls of ages 16-18 were selected. The adolescents are current residents of Snehagram Vocational and Rehabilitation Centre, and do on occasion go to urban areas in pursuit of employment in society.

Inclusion criteria.

- Adolescents infected with perinatal HIV.
- Individuals currently residing in Snehagram Rehabilitation Center.

Exclusion criteria.

- Individuals had not acquired HIV through other sources than a parent to child transmission.
- HIV+ adolescents with mental or physiological disabilities.

Tools used for the study

Focus Group Discussion (FGD). Focus groups constitute of researcher/moderator-led group discussions designed to extract opinions about a topic (Krueger, 1988). The FGD as conducted in this research comprised of questions designed by the researcher, ratified by experts in the field. The FGD had a dual-moderator, semi-structured design in order to facilitate greater discussion, keeping in mind the objective which was to generate narrations regarding the lived experiences of the HIV infected individuals, in rural and semi-rural areas, centered on individuals from a low socio-economic status.

Research Design

The design of the research broadly follows a qualitative approach of data collection. The researcher conducted an in-depth focus group discussion (FGD) with selected HIV infected individuals, in order to secure a subjective evaluation of their life experiences with stereotypes and discrimination that is real, perceived or imagined.

The design follows an interpretivist paradigm and exploratory meaning making of the data was the main objective, so as to secure the lives subjective experience of HIV infected individuals with regard to stereotypes and discriminatory behaviour. Hence, the FGD was done to capture these views. Following this, transcription was done, and a thematic analysis was carried out to analyse and explore the themes that emerged and trends observed. Bracketing was done by researcher to keep analysis as bias-free as possible.

Data Collection Method

The study used the qualitative methodology design. Dual moderator focus group was selected in which one moderator ensured all topics were covered while the second moderator (the researcher) ensured smooth discussion. Participants were chosen from Snehagram Vocational and Rehabilitation Center for HIV+ children. During the FGD in order to facilitate greater discussion on the topic, the researcher provided certain questions and statements which provoked experience sharing, which was predominantly focused on the domains of experiencing stereotyping, reality of societal reactions to HIV status, subjective experience of the infected population to said stereotypes as well as the perception of the non-HIV infected held by the HIV infected individuals.

Data Analysis

Qualitative data collected from the conducted FGD was analyzed by employing thematic analysis technique. It emphasizes pinpointing, examining, and recording patterns (or "themes") within data (Braun & Clarke, 2006). Themes are patterns across data sets that are important to the description of a phenomenon and are associated to a specific research question (Daly, 1997). This method of analysis was chosen since it is considered to be an unobtrusive or non-reactive method of social research. Verbatim

transcription of the data collected from FGD was undertaken, following which coding and analysis was carried out to explore emerging trends. This researcher undertook specific safeguards to reduce chances of errors of omission and/or errors of misinterpretation in the transcription and analysis process.

Ethical Considerations

The ethical considerations that were kept in mind for this study were in line with the American Psychological Association (2010) code of ethics for psychologists. The study was approved by the Department of Psychology, CHRIST (Deemed to be University), Bengaluru. In this study, the participants of the FGD were explicitly asked for verbal consent which ensured their participation in the research. Furthermore, participants were assured that they could withdraw from the study at any point they wished to. Strict measures were taken throughout the research process to ensure that the researcher's own views and opinions did not influence any step of the study.

III. RESULTS

This section aims to present and discuss the various findings of the study based on the qualitative data gathered from tools used. The data collected from four HIV infected adolescents with the help of focus group discussion (FGD), were analyzed using thematic analysis. The data to be analyzed consisted of the transcripts and notes during the process of data collection. The Attride-Stirling model (Attride-Stirling, 2001) of thematic networks was used to organize the data and themes into thematic web-like networks that made the conceptualization and presentation of themes more visual and succinctly summarized. The said networks gave an overview of the themes that emerged as a result of the thematic analysis carried out on the data collected. The various themes that emerged as a result of this analysis were then organized into first order themes, whose clusters formed the second order themes that encompassed the essence and core of the data collected and analyzed.

Sample characteristics

The demographics looked into for the purpose of the study included the age, sex, and HIV infected or HIV+ status. The sample consisted of four individuals who are HIV infected and are currently residing in Snehagram Vocational Rehabilitation Center. The sample consisted of two males and two females. Their ages ranged between 16 and 18 years. Table 1 displays a summary of the demographic details of the participants considered for the study.

Table 1
The demographic details of the participants

Participant	Age	Gender	Medical Health Status
SK	16	Male	HIV+
ML	18	Female	HIV+
MP	17	Female	HIV+
YW	17	Female	HIV+

Organization of results

The FGD conducted during the process of data collection was audio recorded and transcribed. Thematic analysis was subsequently conducted on the transcribed FGD followed the Attride-Stirling model of thematic network analysis (Attride-Stirling, 2001). The employed technique allowed for the reduction of the vast data into meaningful and relevant themes that encapsulated the core essence of the data collected, while keeping the broad objective in mind. The objective was to explore the subjective experiences of the community in response to said discrimination and stereotypes. With this objective in mind, data was analyzed and coded to extract relevant themes. The resultant twenty one basic themes that is, first order themes were subsequently clustered to form five organizing themes that is second order themes. There was no over-arching global theme which captured the nature of the data collected and its relation to the broad objective. The said themes are not hierarchical in nature since the Attride-Stirling model (Attride-Stirling, 2001), views thematic networks as web-like structures where each of the multiple themes interrelate and interact with each other dynamically but are also distinct enough to represent different views and ideas.

The organizing themes that emerged from the data have been presented in Fig. 1 along with its underlying basic themes to facilitate clarity. Transcripts and direct verbatim quotes from the interviews conducted have been used to validate and elaborate on each first order themes proposed. This presentation of data is aimed at giving a clear perspective on how the data was organized, analyzed and conceived by the researcher keeping in mind the objective of the study.

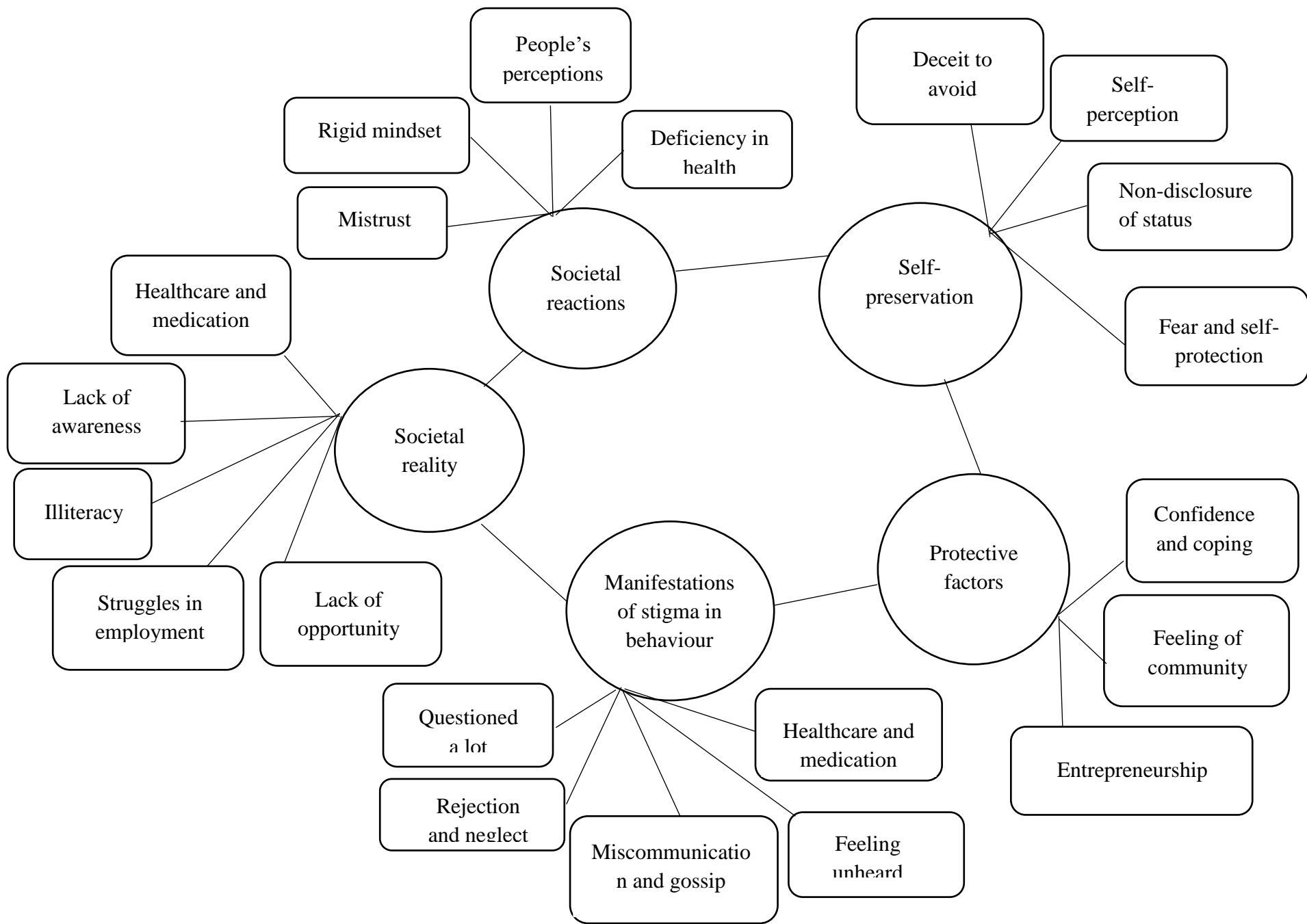


Figure 1. Thematic network depicting the first order themes of HIV/AIDS stereotypes that emerged along with the second order themes based on the Attride-Stirling model.

The following are the second order themes that were clustered on the basis of double hermeneutical analysis of transcription data.

Societal reactions. The participants of the FGD primarily reached a base consensus regarding the fact that stereotypes are a reality in society which is most often transformed into stigmatizing and discriminatory behavior. “People think that HIV+ children cannot work, they are unhealthy.” (Participant YW, 17 December, 2017, Focus Group Discussion), capturing how reactions are often manifested in a variety of dimensions. The infected individuals have to deal with such reactions which they state are a daily and major hindrance to them in their functioning when outside Snehegram.

Rigid mindsets. Participants were almost adamant that the stereotypes regarding HIV originate from the minds of people, which according to them exist as a result of socialization processes owing to the fear associated with it during its initial years of discovery. As encapsulated here, “It is like cement in their minds”. (Participant ML, 17 December, 2017, Focus Group Discussion)

People’s perceptions. The distorted perceptions of individuals residing in general society are the primary cause for the existence and persistence of the many stereotypes regarding HIV/AIDS. Participants noted how there is an almost universal negative perception regarding HIV which influences the reactions of the non-infected individuals with an almost fear-response to the news that one is infected with HIV. As one participant puts it, “They say we are bad and will not even try to understand.” (Participant ML, 17 December, 2017, Focus Group Discussion)

Mistrust. The participants believed that when they tried explaining their condition to people, even after multiple attempts there was a general feeling of mistrust experienced. They claim that people did not put in much effort to try and understand their position and there was a clear and indicative lack of trust in their status.

Deficiency in health. The non-infected population often reacts to the infected by regarding them as not physiologically or psychologically healthy. There exists a thought process that persists which labels said individuals as unfit for hard labor and in general, to be sub-average to a non-infected human being just because of their condition despite the reality being starkly different. For instance, “They are unhealthy” (Participant YW, 17 December, 2017, Focus Group Discussion). This permeates into various forms of specific negative attitudes and stigmatization directed towards the infected.

Societal reality. With regard to the realities of society, the general trends that emerged were regarding the ground environmental realities as faced by HIV infected individuals. They face numerous multi-faceted difficulties ranging from their personal and professional lives. As remarked in the course of discussion, “face such behavior not because he was a bad worker but only because he had HIV.” (Participant ML, 17 December, 2017, Focus Group Discussion)

Struggles in employment. Employment is an essential component for the survival of HIV+ individuals, since ensuring income ensures nutrition and medication. Owing to various stereotypes that exist in the mindset there is often a huge problem for the infected population to secure employment. Usually, such discriminatory behaviors are overtly displayed which costs the infected individuals dearly, as seen in, “He face such behavior not because he was a bad worker but only because he had HIV.” (Participant ML, 17 December, 2017, Focus Group Discussion).

Healthcare and medication. Healthcare and medication, or more specifically the lack thereof, was also a general grievance as to how the society does not support the infected population. Specialized treatment and medication that is required to survive with HIV is absent in most parts of the country, especially in rural areas and even when available is expensive. It was very interesting to see one participant stating that, “there is a lack of awareness by doctors as well” (Participant ML, 17 December, 2017, Focus Group Discussion).

Lack of opportunities. Owing only to their condition HIV+ individuals do regularly get discriminated and do not get the chance to secure the same opportunities and chances that many others of their age would. As one participant sadly remarks, “If we tell our status, then we do not get chances or opportunity. (Participant ML, 17 December, 2017, Focus Group Discussion).

Illiteracy and lack of awareness. According to the participants, a lack of knowledge about the condition is one of the major facets contributing to the problem, as stated, “I think it is because of a lack of awareness”, (Participant SK, 17 December, 2017, Focus Group Discussion).

Manifestations of stigma in behavior. “They treat us differently“, as succinctly summarized by participant ML, and elaborated on this theme. Infected individuals are faced with situational stimuli that illustrate how the stigma leads to attitudes and discriminatory behaviors associated with said stigma.

Questioned a lot. Once their HIV status is revealed, participants state how, “they will keep on questioning and asking us sensitive things” (Participant ML, 17 December, 2017, Focus Group Discussion). Even when infected individuals trust others with their medical condition, the general population does not reciprocate and in turn almost interrogates them and keeps on asking details

about them at the same time refusing to accept anything that is said. Furthermore, their privacy is hardly ever respected and non-infected individuals actively disregard personal boundaries of infected individuals in process of their questioning.

Miscommunication and gossip. The rural society which most of the participants are a part of is usually a close knit community, a factor which adds on to the institution of gossip which is prevalent. Miscommunication is also another aspect which is deliberately done by the general population with regard to HIV+ status, as a form of discrimination and stigmatization. As seen in the FGD, “Even if they somehow find the truth or guess it, they will add up so many masalas in that, and exaggerate” (Participant ML, 17 December, 2017, Focus Group Discussion).

Feeling unheard. Often the most important aspect of an infected individual’s life is to be heard and acknowledged by others especially with regard to narrations of their situation. The participants of the FGD repeatedly stated how the general population and policy makers do actively disregard their subjective and lived narrative.

Rejection and Neglect. Rejection is something infected individuals face on a daily basis outside the sheltered environment of Snehagram from a variety of sources which in most cases include their family members and relatives. Thus, said rejection often translates into neglect, as summarized in this quote, “talk about how to get rid of those persons.” (Participant SK, 17 December, 2017, Focus Group Discussion).

Self-preservation. Most participants showed a great level of self-preservation and self-care with regard to oneself. They actively engage in behaviors that support them in preservation and protection.

We are afraid to say that we are HIV infected, especially in workplace because then we get rejected only due to our status, and the status of our medical condition, if we tell it to people then we do not get chances and opportunity (Participant ML, 17 December, 2017, Focus Group Discussion).

Deceit to avoid questioning. One of the recurring incidents in the FGD was the insistence of the participants that lying was a fundamental essentiality in order to avoid questioning and therefore, avoid stress. As was remarked, “When we grew up we learned not to tell and keep this as a secret to protect ourselves,” (Participant YW, 17 December, 2017, Focus Group Discussion).

Non-Disclosure of status. Since the HIV/AIDS community has to deal with stigma and discrimination on a daily basis, one of the ways that infected individuals cope and engage in self-care is to choose not to reveal their HIV status. To quote from the FGD, “We do not give information that we are HIV+”, (Participant ML, 17 December, 2017, Focus Group Discussion).

Fear and Self-protection. It is common nature for HIV infected individuals, especially those living outside of a sheltered rehabilitation center to actively engage in various forms of self-protective behaviors which are a result of the fear they possess due to the maltreatment they have received from the society. Preservation thus becomes a top priority, as they state, “We are afraid... people behave differently and discriminate.” (Participant ML, 17 December, 2017, Focus Group Discussion). Therefore, this fear is very real and an experiential part of their daily lives.

Self-perception. How an individual views oneself can play a major role in their ability to manage difficult situations. The participants in the study portrayed positive self-perceptions which they believe help them in dealing with the negative societal environment they are a part of. With the aim of protecting oneself, the positive self-perceptions that HIV+ individuals hold about themselves act as a self-preservation technique.

Protective factors. While viewing themselves in the context of the sheltered rehabilitation center, participants display empowerment and actively state the importance of the community ‘we feeling’. They note how emotional expression whether positive or negative is greatly facilitated by the environment in Snehagram. “This does not make us feel that we are alone and marginalized but also give us strength that we can beat it”. (Participant ML, 17 December, 2017, Focus Group Discussion).

Feeling of community. Snehagram promotes and propagates a ‘we’ feeling and community ownership within its institutional framework. This according to the participants comprises of an important aspect of their lives since it enables them to possess a shared subjective experience of the situation owing to the fact that all of them face similar issues.

Confidence and Coping. According to the participants, “Confidence has increased because of acceptance”, (Participant ML, 17 December, 2017, Focus Group Discussion). Within the context of community rehabilitation, participants report that their confidence has improved greatly despite the realities of their conditions. They also report that the center which not only provides them with education, and a community lifestyle but also life-skill training has significantly enhanced their capacity for coping with the stress cause by their condition.

Entrepreneurship. Owing to the lack of job opportunities available to HIV infected individuals and the discrimination they face at the workplace, self-sufficiency is a way in which these individuals attempt to sustain themselves. The participants in the study have developed an entrepreneurial mindset due to the support and knowledge available at the sheltered rehabilitation center they reside in. They believe that it is a more viable option to create jobs for themselves rather than to rely on others.

IV. DISCUSSION

This section of the paper aims at discussing the various themes that emerged when analysis of the results based on the thematic network analysis model of Attride-Stirling (Attride-Stirling, 2001). Through a thorough analysis of the interview transcripts, there emerged twenty-one first order themes and five second order themes. The responses provided by the participants were sufficient in the aim of achieving the broad objective of the research and said themes will be discussed hereby in relation to their relevance to research questions. The findings show that overall there is a very real presence of stereotypes regarding HIV/AIDS which in turn establishes a negative experience for the infected population.

Experience of HIV infected individuals in India

From the findings of the study, the most salient aspect that has emerged is the experiences of the infected individuals in the external context, outside the sheltered rehabilitation center. In such a context, as seen from the data, the societal reactions and realities of the situation often translate into the experience of a variety of stigma and discriminatory behaviors towards them, culminating in a negative experience. The impacts of said negative experiences of the participants of the study were in line with the findings of Richter (2009), which focused on long-term psychological effects of deprivation, which include distress, exploitation, and discrimination among others. The results of the present study following analysis are in line with the findings of Richter (2009), where participants said that they feel afraid to disclose their status due to the invariable discrimination associated with it. Furthermore, the study conducted by Hossain and Susan (2010), illustrates the importance of introducing appropriate intervention programs to reduce stigma. In the current study the importance of Snehagram as a sheltered rehabilitation center providing specialized intervention modules was evidenced in the psychological and coping impacts on the infected individuals. Thus, corroborating with existing research in the area.

Nature of stereotypes against HIV/AIDS community

There exists a large body of literature that states with evidence how there is a great variance in the nature and manifestations of HIV/AIDS stereotypes. Studies done among infected communities in Maharashtra report how stereotypes get manifested in stigma and avoidance behavior. Furthermore, the study reported that the overall awareness of HIV related stigma is higher in the rural community than the tribal community (Vlassoff, 2012). On similar lines, the findings in the current study further corroborate this fact, since some participants from a semi-tribal ground reported that tribal communities have less or no awareness with regard to HIV related stigma and behavior. Another domain with regard to manifestations of stereotype is in the medical healthcare setting, which as seen from *Figure 1*, is one of the first order themes illustrated from the data. This finding is in line with another study conducted in Bangladesh, which reported that there is a high level of HIV related discrimination in the healthcare setting among health-care workers, towards HIV infected individuals (Hossain & Susan, 2010).

Perception of HIV/AIDS stereotypes by infected individuals

In the current study conducted, there were repeated referrals from the participants which stated how fear is a primary driver when it comes to the existence and persistence of HIV/AIDS stereotypes. According to all participants of the study, the initial death rate associated with HIV was what prompted this fear which over time has become an inherent part of the stigmatization process. In addition, there further exists a substantial presence of other studies which also present results in line with current research. For instance in a study conducted by Patton (Patton, 1986), it was explicitly stated how AIDS stereotypes were predominantly driven by three fears, primary of which included fear response to the condition, perpetuated by the non-infected population. Also explored through the participants responses in the current research was their preoccupation with the literacy levels or the lack of thereof which according to them influences in a major way the magnitude of stereotypes as well as of discriminatory attitudes and behaviors. This finding was in harmony with the findings of Hossain and Susan (2010) which encapsulated how higher levels of schooling and accurate knowledge of the condition leads to a subsequent decline in the exhibition of stereotypes, discrimination and stigmatization.

Additionally, the negative subjective experiences of the community with regard to the stereotypes amongst the perinatally HIV infected is also attributable to their lack of primary social support systems such as parents. As is widely reported, orphans are more vulnerable and predisposed to developing a variety of psychological and physical risks (Sengendo & Nambi, 1997). As reported by Cluver, Gardner and Operario (2008), HIV infected orphans reported higher levels of stigma, and fewer positive identification. This also appears to be the case here, as negative stereotyping and stigma-response behavior that was inflicted upon the participants were further made deprecatory due to their lack of parental protection and emotional support.

Contributions and Limitations

Perhaps the most distinct contribution of this study is the qualitative and thematic oriented examination of the subjective experiences of those infected with HIV. The chosen method of qualitative study does add significantly more of the human experience but it does so at the expense of a larger sample size, due to time and budget constraints. This further attributes to the inadequacy of a theoretical saturation of this study which could not be holistically achieved. It should be noted that the population chosen is also not fully representative, and extraneous influences on these individuals must be accounted for due to a wide range of psycho-social exposure. The lack of member checks of the findings puts the thematic networks proposed into question in terms of their relevance and applicability in the larger scheme.

Conclusion and Future Recommendations

This study is representative of a preliminary effort to employ the qualitative method so as to successfully explore and interpret the stereotypes that exist against the HIV/AIDS community in India as seen by the community themselves. A major facet of the study was its fundamental focus on the nature of the stereotypes as manifested by the general population, as well as how the HIV/AIDS community responds to these stereotypes. From the findings there emerged two distinct first and second order themes. Also materialising is an interconnected web of various aspects that constitute the phenomena that is the HIV/AIDS stereotypes. Participants speak about how societal reality and reactions such as lack of awareness, mistrust, rigid mindsets and illiteracy all contribute to the stereotypes that exist against them. These are then viewed as manifesting in behaviours such as rejection and neglect, gossip and feeling unheard. Future research should focus on the tailoring of rehabilitation programs that fit the needs of who have to be classified as a special population. Thus, automatically the relevance and importance in subjectively understanding the interactions between the infected and the general population from the eyes of the community becomes all the more valid.

It was also seen how, in order to cope with these stigmatising experiences and behaviours, HIV infected adolescents have developed various self-preservation strategies and protective factors. These came out in the form of behaviours such as not disclosing one's status, and deceit when questioned about their condition. The presence of sheltered rehabilitation emerged as a protective factor for them in terms of providing confidence and a feeling of community. It should however, be noted that a larger and more representative sample of HIV infected adolescents would facilitate more generalizable results. Moreover, using a more intricate and detailed methodology of Interpretive Phenomenological Analysis may provide a more in-depth understanding and glimpse into the actual lived experiences of the HIV infected population.

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Conflicts of interest

There exists no conflict of interest with regard to any and all aspects of this research.

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