บทความวิจัย

ปัจจัยที่มีผลต่อการรับรู้ตราบาปในผู้หญิงไทยที่ติดเชื้อ เอชไอวี

Factors Related to Perceived Stigma Among Thai Women Infected with HIV

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บทคัดย่อ

การรับรู้ตราบาปในหญิงไทยที่ติดเชื้อเอชไอวีเป็นอุปสรรคในการเข้าถึงการรักษา ซึ่งจะส่งผลต่อความรุนแรงของโรค และคุณภาพชีวิต การวิจัยนี้ เป็นการศึกษาเชิงพรรณามีวัตถุประสงค์เพื่อศึกษาความสัมพันธ์ของปัจจัยที่เกี่ยวข้องกับการรับรู้การตีตราของหญิงไทยที่ติดเชื้อเอชไอวี โดยการหาความสัมพันธ์ระหว่าง ปัจจัยส่วนบุคคล ได้แก่ อายุ ระดับการศึกษา สถานภาพสมรส ระยะเวลาการติดเชื้อเอชไอวี การสนับสนุนทางสังคม และการรับรู้ตราบาป 4 ด้าน ในหญิงไทยที่ติดเชื้อเอชไอวี อายุระหว่าง 18-60 ปี ที่เข้ารับบริการสถานพยาบาลระดับตติยภูมิ เครื่องมือที่ใช้ในการวิจัยพัฒนาตามกรอบแนวคิดของ Berger et al. (2544) และแบบสอบถามการรับรู้ตราบาปของ สุวรรณพร มิตสุวรรณ (2550) วิเคราะห์ข้อมูลสถิติเชิงพรรณา วิเคราะห์ความสัมพันธ์โดยใช้สถิติ t-test และ chi-square

ผลการศึกษา พบว่า กลุ่มตัวอย่างรับรู้ตราบาประดับปานกลาง ซึ่งสัมพันธ์กับสถานภาพสมรส ($p=0.022$) อายุ ($p=0.01$) เมื่อวิเคราะห์การรับรู้ตราบาปรายด้าน สถานภาพสมรสมีความสัมพันธ์กับ personalized stigma aspect ($p=0.03$) ระยะเวลาได้รับวินิจฉัยติดเชื้อเอชไอวีสัมพันธ์กับ public attitudes aspect ($p=0.01$), negative self-image aspect ($p<0.01$) และการสนับสนุนทางสังคมสัมพันธ์กับ disclosure aspect ($p=0.002$) personalized stigma aspect ($p=0.05$) และ negative self-image aspect ($p<0.003$) การค้นพบนี้ชี้ให้เห็นว่าบุคลากรทางการแพทย์ควรจัดกิจกรรมและต้องเข้าใจการรับรู้ตราบาปของผู้ป่วยและปัจจัยที่เกี่ยวข้องเพื่อลดการตีตราผู้ติดเชื้อเอชไอวีในประเทศไทย

คำสำคัญ : ปัจจัยเกี่ยวข้อง, การรับรู้, ตราบาป, ผู้หญิงไทย, เชื้อเอชไอวี

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Abstract

Perceived stigma in Thai women infected with HIV could be a barrier between patients and healthcare services, which could cause inappropriate treatment and increase the severity of the disease. These problems may then affect their quality of life. This descriptive correlational study aimed to examine the relationship of factors related to the perceived stigma of Thai women infected with HIV and explore the relationship between personal factors: age, educational level, marital status, duration of diagnosis with HIV infection, social support, and perceived stigma of Thai women infected with HIV. The perceived stigma can be divided into four aspects, including the personalized stigma, disclosure, negative self-image, and public attitudes aspects.

The purposive sample included Thai women in the age range of 18-60 years old, which comprised eighty women infected with HIV recruited from tertiary hospitals in Thailand. The questionnaires were composed of a demographic data questionnaire, perceived stigma questionnaire of people infected with HIV, developed from the literature review by Berger et al. (2001), and social support questionnaires of people infected with HIV, modified from the concept of Weiss (1974) by Suwannaporn Mitsuwan (2007). The data were analyzed using descriptive statistics and inferential analyses, including t-test, Pearson correlation, and Chi-square.

It was shown that the sample group perceived stigma at a medium level. There were significant differences between marital status ($p=0.022$), age ($p=0.01$), and perceived stigma among Thai women infected with HIV. However, when analyzing the data of each aspect of perceived stigma, it was found that marital status had the significant influence upon the personalized stigma aspect ($p=0.03$) and duration of diagnosis with HIV infection had the significant influence upon the public attitudes aspect ($p=0.01$) and negative self-image aspect ($p<0.01$), while social support had the significant influence upon the disclosure aspect ($p=0.002$), personalized stigma aspect ($p=0.05$), and negative self-image aspect ($p<0.003$). These findings suggested that health care personnel should organize activities and need to understand the perceived stigma of patients and factors which had significant relationships with perceived stigma to support Thai women infected with HIV, leading to a reduction in perceived stigma

Keywords : Factors, Perceived, Stigma, Thai women, HIV

Introduction

From the global HIV statistics issued by The Joint United Nations Programme on HIV/AIDS (UNAIDS) in 2018, 77.3 million people have become infected with HIV since the start of the epidemic. There were 36.9 million people globally living with HIV in 2017; 21.7 million of those people had access to antiretroviral therapy. Around 1.8 million people have become

newly infected with HIV since then, while 940,000 people have died from AIDS-related illnesses. Approximately 35.4 million people have died from AIDS-related illnesses since the start of the epidemic (UNAIDS, 2018).

There are adult women infected with HIV all around the world. The most affected region is sub-Saharan Africa, where 59% of adult women are infected with HIV (UNAIDS, 2014). Those newly infected with HIV account for almost 1,000 young people per day. Infection rates among adolescent girls are twice those of younger men in sub-Saharan Africa (UNAIDS, 2014). Further, the rate of HIV infection in teenage girls is increasing. The worldwide infection rate for teenage girls is two times higher than for boys of the same age (UNAIDS, 2012).

From Thailand's records, there were 193,965 women who were HIV-infected in 2013 (UNAIDS, 2014). The statistical rates for newly-infected young women aged between 15-24 for all infections showed an increase of 0.43% from 2011 to 2013 (UNAIDS, 2014). Moreover, infection rates for Thai teenage girls represent 1.5 times those for boys (Bureau of Epidemiology, 2012). Nowadays, there are about 15,000 AIDS-related deaths (all ages). When accounting for age, AIDS-related deaths for those between 0-14 years old account for less than 100 people, while AIDS-related deaths for women aged 15+ years old are 5,500 people, while AIDS-related deaths for men 15+ years old are 9,100 people (UNAIDS, 2018).

HIV infection in Thai women is different from HIV infection in Thai men. It was found that HIV-infected women have suffered mental health problems significantly more than men (Bussayarin Srikum, 2003). Because Thai society has not quite achieved equality between men and women, Thailand's social norms can seemingly accept a man having sex with a prostitute, but a woman infected with HIV will be seen as being promiscuous and a disease transmitter (Srisamang Songrob, 2008). There were some studies in South Asia, including Thailand, showing HIV-infected women had been discriminated against, with social exclusion at 15%, which is higher than for HIV-infected men who were discriminated against with social exclusion at 2% (Poxton et al., 2005). It was also found that HIV-infected women in Thailand cannot make decisions about the economy, jobs, sex, condom use, or contraception. The role of Thai women is merely to act as a "wife" and "mother" responsible for the household's cooking, cleaning, and raising children (Srisamang Songrob, 2008). When women know they are infected with HIV, they typically do not disclose their infection to others, especially their partners, due to the fear of stigma and divorce.

Furthermore, they do not seek or get help from their partner due to fear of violence (Sagay et al., 2006). Also, 52% of HIV-infected women do not disclose their infection because of the fear of a negative reaction from their partner (Maman et al., 2003). Disclosure of HIV

infection to their partner remains low among women. Some of the women who have been infected with HIV experience violence, including forced sterilization and forced abortion as well as the denial of voluntary sterilization or safe abortion services. Involuntary and coerced sterilization and abortion among women who live with HIV occurs in many countries (UNAIDS, 2014).

Thailand has embraced its commitment to the 2011 United Nations General Assembly Special Session on HIV to prevent and control the AIDS epidemic as well as to pursue the strategy of 3 Zeroes: (1) Zero HIV new infections; (2) Zero AIDS deaths; and (3) Zero AIDS stigma and discrimination. The researcher reviewed the literature and found that the relationship of perceived stigma and factors could be used as a guide to support Thai women infected with HIV, thus enabling them to adapt appropriately (Joint United Nations Program on HIV/AIDS, 2011). The researcher determined the essential variables associated with the perceived stigma of Thai women infected with HIV, including the age at which different ages have different experiences in the face of adaptation and lifestyles. Education level is a variable which is shown to be a fundamental factor that can indicate different perceived stigma. Marital status is an important factor that helps Thai women infected with HIV get support. For receiving encouragement from a spouse to live with HIV infection, the duration of the diagnosis of HIV infection is a sign of stigma. Moreover, receiving social support is another important variable, as well as other variables associated with stigma awareness being accepted by the society of Thai women infected with HIV. For this reason, the researcher chose five important variables, as mentioned in the test. These variables can help determine the relationship for the perceived stigma of Thai women infected with HIV (Babita Subedi, Bishow Deep Timilsina, Neeta Tamrakar, 2019; UNAIDS, 2013).

According to the discussion, it has been shown that perceived stigma in Thai women infected with HIV could be a barrier between patients and healthcare services, which could cause inappropriate treatment and increase the severity of the disease. These problems may affect their quality of life. An extensive review of the literature has shown that previous studies in women infected with HIV were mostly conducted in other countries. However, the context of recognizing honor among women infected with HIV is different from that of women infected with HIV in Thailand. Therefore, the researcher was interested in exploring the perceived stigma in Thai women infected with HIV because there would likely be some differences. It was anticipated that the study findings could be used to implement nursing care practices to provide more appropriate care to Thai women infected with HIV.

The Scope of the study

This research utilizes the concept of perceived stigma among women infected with HIV by Berger (Berger, Ferrans & Lashley, 2001). Perceived stigma can be divided into two forms: the perception of societal attitudes towards people with HIV, and knowledge of self as being HIV-positive. The main concept of perceived stigma is the perception of the barriers from society and limited opportunity to receive services such as dental care and to make job applications, as well as the negative change in social identity (Berger, Ferrans & Lashley, 2001). Perceived stigma can be divided into four aspects, as follows (Arun Katekae, 2005):

1. Personalized stigma refers to the perception of situations and the reactions of other people when they know about a person's infection status, including the loss of friends, avoidance, disgust, and isolation by others.

2. Disclosure concern refers to the control of information, concealment of the truth about HIV infection, and the fear that people who know about the infection status will reveal the secret to others.

3. Negative self-image refers to bad feelings about self-image, such as being blemished, feeling shameful, and having guilty feelings.

4. Concern with public attitudes about people infected with HIV refers to what other people might feel about people with HIV infection. For example, people with HIV infection are fired from their jobs, are discriminated against in society, and make other people feel fearful about being near them.

In this study, the selected variables include age, level of education, marital status, duration of diagnosis with HIV infection, and social support. These variables may affect the perceived stigma among Thai women infected with HIV.

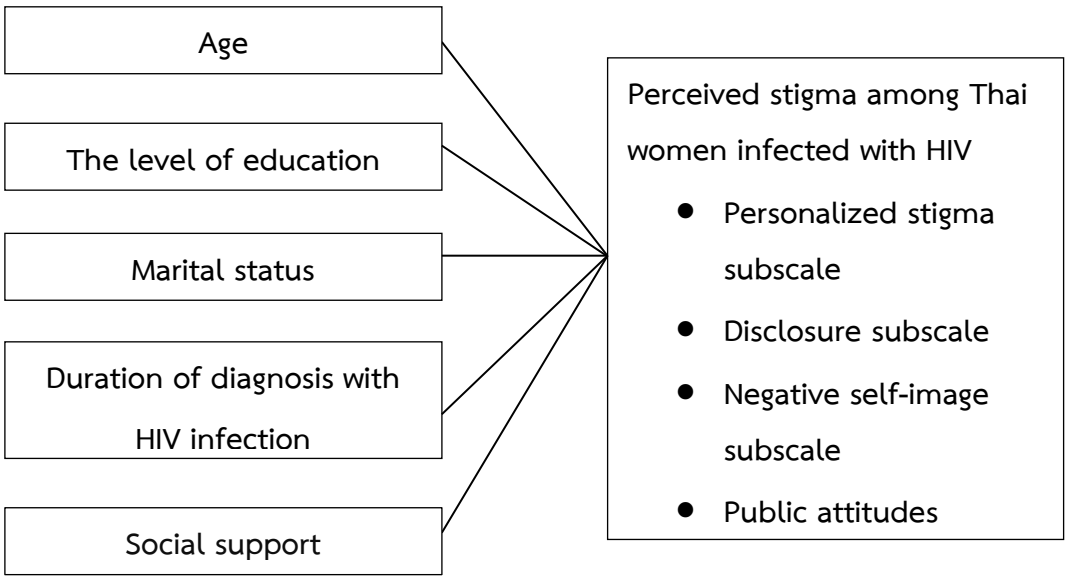

Figure 1 Conceptual

Study design

The research used a descriptive and correlation research approach that utilized quantitative data to study the perceived stigma of Thai women infected with HIV. This chapter presents the research methods, including population and samples, research instruments, protection of the rights of human subjects, data collection, and data analysis.

Inclusion criteria

This research was a study of Thai women who were infected with HIV and admitted for treatment at the Infectious disease outpatient department, Ramathibodi Hospital. Purposive sampling was employed as follows:

1. Thai women aged between 18 and 60 years old.

2. The women were diagnosed with HIV by a doctor and returned positive laboratory tests. There was a laboratory test to diagnose the infection with HIV.

3. They perceived that they had HIV infections and were ready to answer the questionnaire.

4. Sample participants were able to read, write, speak, and understand the Thai language.

Exclusion criteria

1. The women had an opportunistic infection because comorbidity might have affected the questionnaire response due to the signs and symptoms that appear.

2. Women who have known the diagnosis for less than one month.

Sample size

The sample size was determined by power analysis, acquisition of sample size based on effect size using an acceptable level of statistical significance of 0.05, and the power of 0.95 (Nikus Fido, Aman & Brihnu, 2016; Abebayehu Bitew Aniley et al., 2016). In this study, G*Power was used for calculating the sample, while the minimum sample size of the research study was 75. The expected drop-out rate is 10%. Thus, a total of 80 Thai women infected with HIV were recruited into this research study (Erdfelder, Faul & Buchner, 1996).

Setting

This research collected data from the infectious disease outpatient department, Ramathibodi Hospital. There was an infectious disease clinic open on Wednesdays and Fridays during office hours from 9 am to 4 pm.

Protection of the rights of human subjects

This research was conducted after gaining approval and ethical clearance from the board of human rights related to human experimentation at the Faculty of Medicine Ramathibodi Hospital, Mahidol University. After the study was granted approval and it was permissible to collect data, eligible subjects were approached and invited to participate in this research. For data collection, the researcher asked for cooperation and explained the project research and the rights to eligible subjects. While answering the questionnaire, subjects had the right to withdraw if they felt uncomfortable or wanted to withdraw from participation in the research for other reasons. Refusal to participate in the study did not affect treatment and service. This research will be kept confidential and will be presented overall. The researcher did not disclose the names of the subjects. Any subject who agreed to participate was informed; after that, they signed a verbal consent or written consent form.

Research instrument

The questionnaires were used to explore data about the stigma perceptions of Thai women infected with HIV. They included three instruments: the demographic data form, HIV stigma scale, and the questionnaires of social support.

1) The demographic data
2) Perceived HIV stigma questionnaire of people infected with HIV

Berger created a perceived stigma questionnaire for people infected with HIV (Berger et al., 2001) that had a reliability of 0.96. The researcher applies this perceived stigma questionnaire for people infected with HIV, which was translated into the Thai language by Benjamas Suksatit (2004). This questionnaire is widely used in HIV-infected people in many countries. The reliability of 0.91 (Jeyaseelan, 2013) was obtained for instrument quality in terms of content validity from five experts, including four nursing instructors and one medical expert in infectious diseases. It was revised based on recommendations and applied to 30 HIV-infected people. The reliability of the Cronbach's Alpha Coefficient was 0.96. When used with 50 real sample participants, the reliability of the Cronbach's Alpha Coefficient was 0.95 (Benjamas Suksatit, 2004).

In this study, the researchers requested permission from the owner of the instruments. Three specialists in HIV infection checked the quality of the instruments and verified the Thai version according to the format of Benjamas Suksatit. The instrument was tested on 30 women infected with HIV. The reliability was 0.94. The researcher applied the instrument to 80 people in a real sample group and analyzed the results to determine the Cronbach's Alpha Coefficient at 0.93.

3) The questionnaire concerning social support

The questionnaire was developed from the social support concept of Weiss (1974) by Suwannaporn Mitsuwan (2007). Previous research checked the quality of the instruments in content validity. The results have an index content validity of 0.90 and reliability was calculated by applying the improvement social support questionnaires for which the content validity and analysis reliability were checked using the Cronbach's Alpha Coefficient at 0.84. This instrument was used in Thailand. Moreover, the sample was also similar, comprising women infected with HIV. In this study, the researchers requested permission from the owner of the instruments to apply them to the perceived social support questionnaire, and the instrument was tested with 30 women infected with HIV, which showed the reliability was 0.91. The researcher applied it to 80 people in a real sample group and then analyzed the results to determine the Cronbach's Alpha Coefficient at 0.92.

Data analysis

The computer program IBM SPSS Statistics 23 was used to analyze the statistics, and the research data were divided as follows:

1. Analyze the demographic data using descriptive statistics, which were reported by frequency, percentage, range, mode, median, and standard deviation.

1.1 Frequency, percentage of reported demographic data (e.g., marital status, religion, highest formal education level, occupation, income, the reason for having HIV testing, route of HIV infection, person to whom the patient disclosed HIV infection, medication treatment, number of symptoms and symptoms present).

1.2 Range, mode, median, mean, and standard deviation reported demographic data (e.g., duration of formal education, the period since being diagnosed with HIV/AIDS. These variables were not normally distributed).

2. Apply the t-test, in which the data were normally distributed, pearson correlation, and chi-square, to find the relationship between personal factors including age, level of education, marital status, duration of diagnosis with HIV infection, social support, and perceived stigma among Thai women infected with HIV.

Results

Personal general information concerning Thai women infected with HIV was obtained by analyzing the general personal information of the sample group of Thai women infected with HIV, comprising a total of 80 subjects. It was shown that their mean age was 46 years (SD=8.1, Median=46, Min=21, Max=60). Most were married or living with a partner (38.8%),

followed by divorced/widowed (37.5%). Almost all practiced Buddhism (93.8%), while only four subjects were Muslim (5.0%). Their educational level was mainly high school graduates (35.0). Most of the subjects were daily laborers (23.8%), followed by merchants (18.8%). Their monthly income was mostly less than 10,000 baht (31.3%) or in the range of 10,001-20,000 baht (31.3%).

By analyzing a total of 80 subjects who were diagnosed as HIV-infected, the duration of diagnosis with HIV infection could be found (mean=11.56, SD=5.276, min=1, max=22). The main reason for being investigated and diagnosed as HIV infected was because they had symptoms (37.5%), followed by HIV screening during pregnancy (23.8%). The cause of infection was mainly due to sexual intercourse (86.3%). While the cause for HIV transmission from mother to child was found the least (2.5%), all patients in the sample group always followed up with treatment continuously (100%). Most of them were given anti-retroviral drugs. Five percent were also given other medications, along with anti-retroviral drugs. There were 20% of the patients who disclosed their HIV infection status, while 61.3% acknowledged the HIV test results of their spouses, as detailed in Table 1.

Table 1 Demographic data of Thai women infected with HIV (n=80)

Variables	N	%
Age		
Mean 46, SD 8.1, Median 46, Min 21, Max 60	80	100
Marital status		
Single	13	16.3
Married and lived with a partner	31	38.8
Married but did not live with a partner	6	7.5
Divorced/Widowed	30	37.5
Religion		
Buddhism	75	93.8
Islam	4	5.0
Christianity	1	1.3
Educational level		
Elementary education	15	18.8
High school	28	35.0
Diploma/ Certificate	15	18.8
Bachelor’s degree	18	22.5
Higher than bachelor’s degree	4	5.0

Table 1 Demographic data of Thai women infected with HIV (n=80) (cont.)

Variables	N	%
Occupation		
Daily laborer	19	23.8
Private employees	10	12.5
Farmer/Fishermen	3	3.8
Business owners	7	8.8
Government officer	6	7.5
Housewife	12	15.0
State enterprise officer	1	1.3
Merchant	15	18.8
Unemployed	3	3.8
Other	4	5.0
Income (baht/month)		
≤ 10,000	25	31.3
10,001-20,000	25	31.3
20,001-30,000	17	21.3
> 30,000	13	16.3
Duration of diagnosis with HIV infection		
Mean 11.56, SD 5.276, Min 1, Max 22	80	100
Reason for having an HIV test		
The positive result of HIV test of a spouse	8	10.0
Having symptoms	30	37.5
HIV screening during pregnancy	19	23.8
Risky sexual behavior of a spouse	8	10.0
Annual health check-up	11	13.8
Check-up to apply for a job	2	2.5
Other	2	2.5
Source of HIV infection		
Sexual relationship	69	86.3
Tattoo	1	1.3
Maternal to child transmission	2	2.5
Other (do not know the reason)	8	10.0

Table 1 Demographic data of Thai women infected with HIV (n=80) (cont.)

Variables	N	%
What kind of medication which patients received? (answer more than one choice)		
Anti-retroviral drug (only)	76	95.0
Anti-retroviral drug + other drugs	4	5.0
Whom patient disclosed their HIV test? (answer more than one choice)		
Spouse	19	23.8
Parents	8	10.0
Sibling	8	10.0
Friend/Colleague	1	1.3
More than one person	28	35.0
No disclosure	16	20.0
Spouse	19	23.8
Did patients know the HIV test results of their spouse		
Yes	49	61.3
No	31	38.8

The level of perceived stigma among Thai women infected with HIV

According to the statistical analysis of the overall perceived stigma for the sample group, it was shown that the minimum score for most of the perceived stigma was 40, while the maximum score was 158 (mean=102.6, SD=27.9). The score for perceived stigma of the sample was not different, and statistical analysis showed that perceived stigma was at a medium level (51.3%), followed by a high level of perceived stigma (27.5%) and a low level of perceived stigma (21.3%), as detailed in Table 2.

According to the statistical analysis of overall perceived social support, the sample group showed a high level of perceived social support (73.8%) and a medium level of perceived social support (26.3%).

Table 2 Perceived stigma level of Thai women infected with HIV (n=80)

Stigma level	N	%	Range score
Low	17	21.3	40-79 (1.00-1.91)
Medium	41	51.3	83-137 (2.00-3.42)
High	22	27.5	126-157 (3.15-3.92)

For the relationship between age, duration of diagnosis with HIV infection, and perceived stigma among Thai women infected with HIV, t-test comparisons showed that age had a relationship with the perceived stigma of Thai women infected with HIV (p=0.01). Duration of diagnosis with HIV infection and perceived stigma among Thai women infected with HIV had no relationship with perceived stigma of Thai women infected with HIV (p=0.90), as detailed in Table 3.

Table 3 Relationship between age, duration of diagnosis with HIV infection, and perceived stigma among Thai women infected with HIV (n=80)

Variables	Mean	SD	T	*p*-value
Age	45.96	8.09	47.91	0.01*
Duration of diagnosis with HIV infection	2.56	0.78	1.22	0.90

**p<0.05*

The relationship between social support and level of perceived stigma among Thai women with HIV infection was shown to have pearson correlation (p=0.20). Social support had no relationship with the perceived stigma of Thai women infected with HIV with statistical significance at p=0.05, as detailed in Table 4.

Table 4 Relationship between social support and perceived stigma among Thai women infected with HIV(n=80)

Variables	Perceived stigma	
	Spearman's rho	p-value
Social support	0.349	0.20

**p<0.05*

By reviewing the relationship between age and the four aspects of perceived stigma among Thai women infected with HIV, it appeared that duration of diagnosis with HIV infection had no significant relationship with the disclosure aspect (p=0.89), the public attitudes aspect (p=0.78), the personalized stigma aspect (p=0.79), or the negative self-image aspect (p=0.56). The relationship between duration of diagnosis with HIV infection and the four aspects of perceived stigma among Thai women infected with HIV appeared to show that duration of diagnosis with HIV infection had no significant influence upon the disclosure aspect (p=0.67), or the personalized stigma aspect (p=0.79). However, duration of diagnosis with HIV infection

had a significant influence upon the public attitudes aspect (p=0.01) and negative self-image aspect (p<0.01).

The relationship between social support and the four aspects of perceived stigma among infected Thai women appeared to show that social support had no relationship with the public attitudes aspect (p=2.88), although social support had significance in the disclosure aspect (p=0.002), personalized stigma aspect (p= 0.05), and negative self-image aspect (p=0.033).

The relationship between education and the four aspects of perceived stigma among Thai women infected with HIV appeared to show that education had no relationship with the four aspects of perceived stigma with the significance of the disclosure aspect (p=0.407), public attitudes aspect (p=0.932), personalized stigma aspect (p=0.184), and negative self-image aspect (p=0.942). The relationship between marital status and the four aspects of perceived stigma among Thai women infected with HIV appeared to show that marital status had no relationship with the disclosure aspect (p=0.579), the public attitudes aspect (p=0.713), and the negative self-image aspect (p=0.264), although marital status did have a relationship with the personalized stigma aspect (p=0.030).

Discussion

This study showed that recognition of overall perceived stigma and each aspect were at medium levels, explaining that Thai society rarely acknowledges HIV-infected people; those who disclose themselves as being infected will be “branded” by society. Therefore, it affects work and makes the HIV-infected person fearful of disclosure (Skinner D & M. (2016), which was different from some studies in Thailand that found perceived stigma involved concern over disclosure of the status of infection at a high level (Mattika Chaichan & Pornnapa Kampraw, 2014). The partners of HIV patients are also affected by the community. Spouses are sometimes condemned as if they also have HIV infection (Skinner D & M., 2016). These results led to HIV-infected people losing jobs or failing to make progress in their jobs. There were fewer career options because of the required blood test before applying for a job (Social Research Institute, 2017).

Perceived stigma also affected the non-disclosure of infection to a spouse. According to a recent study, about 28.1-40.0 percent of women infected with HIV did not disclose the diagnosis of infection to their spouses (Kiula et al., 2013), similar to studies in Thailand that found roughly 30 percent of Thai women infected with HIV did not disclose the results of infection to their spouses (Supattra Chaipolbal, 2016) due to fear of reprimand, fear of being

the object of disgust, and fear of their spouse leaving them, meaning a loss of financial support from their spouse. HIV-infected women were often reluctant to disclose their infections due to fear of being stigmatized by society and facing discrimination (Black & Miles, 2002).

In accordance with international studies, it was found that the level of perception of stigma in the public attitudes aspect and negative self-image aspect have a positive relationship with suffering in the minds of HIV-infected people, with statistical significance, including being blamed by friends, being asked by the family not to disclose their status, family abandonment, feeling uncomfortable in relationships, and poor relationships from health agencies (Stutterheim et al., 2007). Therefore, stigma awareness and fear of consequences, as well as the guilt of stigma, resulted in HIV-infected people having concerns about disclosing their status. Some chose to disclose their status in terms of their infection rather than not disclose, which resulted in a lack of support both from family and society, as well as the inability to access health services. Also, HIV-infected people with bad experiences about stigma will be less likely to continue with their follow-up appointments and there may be a lack of continuity in medication (Vanable, Carey, Blair & Blair, 2006).

On the other hand, this study found that social support and the perceived stigma of Thai women infected with HIV had no significant relationship (p=1.00), which explained that Thai families tend to be large, especially in the past. There were many family members in the same house; they would be in the same unit. Nowadays, Thai families are becoming more immediate and nuclear. Society and the economy have changed, which affects the future of Thai family characteristics. It will change in various aspects, including social support from family members. However, family relationships are still important factors associated with the disclosure of HIV infection results, which was consistent with Medley et al., whose research found that women who had self-confidence and had a good relationship disclosed their HIV infection results more often than women without self-confidence. This shows that the essential duty of the family must be to support its members from childhood to adulthood by giving love, warmth, and practicing being givers and recipients to develop emotionally stable people with confidence in their lives. Besides, the family can be a source of encouragement and solace to overcome obstacles when members face obstacles or frustrations (Kwanchit Laothong, 2018; Medley, 2004; Ezechi & Gab-Okafor, 2009).

When analyzing the data for each aspect of perceived stigma, however, it was found that social support had significance with the disclosure aspect (p=0.002), personalized stigma aspect (p=0.05), and negative self-image aspect (p<0.003). This was consistent from previous studies of Thai women infected with HIV; social support was related to perceived stigma with

statistical significance (Supattra Chaipolbal, 2017). It was also consistent with international studies, which found that the level of perceived stigma had a positive relationship with the mental suffering of HIV-infected people with statistical significance, including being blamed by friends, being recommended by family members not to disclose their status, family abandonment, feeling uncomfortable in relationships, words that are too merciful or indifferent, and negative relationships with health agencies (Stutterheim et al., 2007).

Recommendations

Studies and research in nursing

1. There should be a study of the factors that can predict perceived stigma in each aspect to classify patients into areas, such as the emotional and social categories. This will enable the obtaining of new knowledge that will lead to the further development of perceived social support in the future.

2. Intervention programs should be conducted to reduce stigma perception because this study found a relationship between the factors related to perceived stigma among Thai women infected with HIV. Therefore, quasi-experimentation should be developed to deal with those factors, such as self-efficacy promotion programs to address perceived stigma. The program should be managed to suit the age and context of each area.

3. The study should be replicated in other geographical locations of the country to ensure the findings are not unique to young adult women in Bangkok infected with HIV who are aged between 18 and 60 years old.

Limitations of the study

Using Berger's Stigma questionnaire may present limitations when used with a sample of women infected with HIV from their mothers because some questions are not related to this group of people. In subsequent studies, the questionnaire should be chosen to reflect the target group while considering the advantages and suggestions for using the questionnaire, including the use of questionnaires to increase the validity of the research.

This study had a single unit of data, which was Ramathibodi Hospital, which might not be relevant in the cases of other Thai Women.

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