

Sexual stigma and sympathy: Attitudes toward persons living with HIV in Jamaica

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Abstract

As the number of persons living with HIV continues to increase in Jamaica, attitudes and values become more important. This study aimed to examine the attitudes of university students in Jamaica toward persons living with HIV, including homosexual men, heterosexual men, women sex workers, other women, and children. One thousand two hundred and fifty-two students were surveyed between June 2001 and February 2002 using a 193-item questionnaire measuring a variety of HIV-related knowledge, attitudinal and behavioural items. Less than half of students reported sympathetic attitudes toward homosexual men or women sex workers living with HIV while a majority reported generally sympathetic attitudes toward heterosexual men and non-sex worker women living with the disease. Predictors of sympathy varied by target group. Male students were significantly less likely to report sympathy for homosexual men than for any other group. Spirituality was associated with sympathy for homosexual men and women sex workers, but not for the remaining two groups. Findings suggest that levels of negative attitudes are high in Jamaica and warrant attention to both individual and societal-level actions and interventions. In addition, messages and interventions must be targeted, recognizing both the differences in level of sympathy expressed toward different groups and predictors of sympathy across the groups.

Résumé

Alors que le nombre de personnes vivant avec le VIH continue d'augmenter en Jamaïque, les attitudes et les valeurs ont une importance croissante. Cette étude avait pour objectif d'examiner les attitudes d'étudiants en Jamaïque, à l'égard des personnes vivant avec le VIH, parmi lesquelles les hommes homosexuels, les hommes hétérosexuels, les professionnelles du sexe, les autres femmes et les enfants. 1252 étudiants ont été interrogés entre juin 2001 et février 2002, à l'aide d'un questionnaire en 193 points pour évaluer les connaissances, les attitudes et les comportements relatifs au VIH. Moins de la moitié des étudiants a déclaré des attitudes de sympathie à l'égard des hommes homosexuels ou des professionnelles du sexe vivant avec le VIH, alors qu'une majorité d'entre eux a déclaré des attitudes générales de sympathie à l'égard des hommes hétérosexuels et des femmes, autres que les professionnelles du sexe, qui vivent avec le VIH. Les facteurs prédictifs de sympathie varient selon les groupes ciblés. Les étudiants de sexe masculin déclarent significativement avoir moins de sympathie pour les hommes homosexuels que pour les autres groupes. La spiritualité est associée à la sympathie pour les hommes homosexuels et les travailleuses du sexe, mais pas pour les deux autres groupes. Les résultats suggèrent que les niveaux d'attitudes négatives sont élevés en Jamaïque et qu'ils incitent à une attention particulière pour des interventions aussi bien au niveau individuel que sociétal. De plus, les messages et les interventions doivent être ciblés, en reconnaissant à la fois les différences des

niveaux de sympathie exprimés vis-à-vis des différents groupes et les facteurs prédictifs de sympathie à travers les groupes.

Resumen

Ante el continuo aumento de personas contagiadas con el VIH en Jamaica, las actitudes y los valores de la sociedad adquieren más importancia. El objetivo de este estudio es analizar la actitud de los estudiantes universitarios en Jamaica hacia las personas infectadas con el VIH, entre ellas hombres homosexuales y heterosexuales, trabajadoras sexuales, otras mujeres y niños. Entre junio de 2001 y febrero de 2002, 1252 estudiantes participaron en un estudio en el que completaron un cuestionario de 193 puntos para medir toda una serie de conocimientos, actitudes y conductas en torno al tema del sida. Menos de la mitad de los estudiantes mostraron una actitud de compasión hacia los homosexuales y las trabajadoras sexuales contagiados con el VIH/sida, pero una mayoría mostraron compasión en general hacia los seropositivos como hombres heterosexuales y mujeres no relacionadas con el comercio sexual. Los pronósticos de compasión variaban según el grupo objetivo. Los estudiantes masculinos eran mucho menos propensos a mostrar simpatía hacia los homosexuales que ningún otro grupo. La espiritualidad se relacionaba con la compasión hacia los homosexuales y las trabajadoras sexuales pero no para los otros dos grupos. Los resultados indican que en Jamaica existen actitudes muy negativas y, por tanto, habría que prestar más atención a las intervenciones dirigidas a los individuos y a la sociedad. Asimismo hay que establecer objetivos en los mensajes y las intervenciones reconociendo las diferencias en el nivel de compasión expresada hacia los diferentes grupos y los pronósticos de compasión en todos los grupos.

Keywords: *Jamaica, university students, people living with HIV, sympathy, stigma*

Introduction

Jamaica is a country with concentrated HIV/AIDS epidemics occurring in the midst of a generalized epidemic. While an estimated 1.6% of the adult population is infected with HIV, prevalence rates as high as 25% have been reported among populations most at risk, including men who have sex with men and sex workers (Ministry of Health 2005a, United States Agency for International Development (USAID) 2003). Surveillance data indicate that the epidemic is not abating, with significant increases in the number of reported cases being identified each year since 2000 (Ministry of Health 2005a). As the number of persons living with HIV continues to increase in Jamaica, the negative effects of prejudicial attitudes and acts become more pronounced. When the person living with HIV also belongs to a socially excluded group, negative attitudes and acts tend to increase in severity, heightening their effects on the HIV-infected individual.

Stigma on the basis of actual or perceived sexual behaviours has been proposed to play a prominent role in negative attitudes toward and treatment of persons living with HIV in Jamaica. Previous studies have found that the association of HIV with generally stigmatized social groups has a halo effect that impacts all persons living with HIV (Carr 2002, White and Carr 2005). This becomes something of a concern when one realizes that Jamaica's growing HIV epidemic is unfolding in the context of widespread violence and discrimination (Human Rights Watch 2004).

As in many of parts of the world, men who have sex with men and sex workers have been considered the primary vectors of HIV transmission and the source of the continued spread of the disease. Reports from persons living with HIV reveal the occurrence of emotional and physical abuse from family and community members who associate the disease with homosexuality and involvement in sex work (Human Rights Watch 2004). Both men who have sex with men and sex workers living with HIV face a double-stigma. This

double-stigma drives them away from prevention as well as treatment if non-discrimination is not central to policy and practice.

Jamaica is at a turning point in its efforts to address increasing and overlapping epidemics of HIV; and concerns about both attitudes toward and treatment of people living with HIV have become a national priority (Ministry of Health 2005b). One possible strategy for improving overall attitudes toward people living with HIV, especially those from marginalized groups, is to increase the level of sympathy felt for these individuals. Sympathy can be defined as a feeling of sorrow or anguish associated specifically with the suffering or need of another; it can also be thought of as the act or capacity of entering into or sharing the feelings or interests of another (Eisenberg *et al.* 2002). Sympathy for others may lead to altruistic motivation aimed at reducing others' distress, which tends to induce prosocial—including helping—behaviours that are intended to achieve the reduction (Batson *et al.* 1986, Eisenberg *et al.* 1994, Batson *et al.* 1997, Sober and Wilson 1998, Batson *et al.* 2002). Increasing sympathy and sympathy-induced altruism can lead to improved attitudes toward stigmatized groups. By 'feeling' what the stigmatized person feels, the sympathetic individual may become more supportive of the situations in which stigmatized persons find themselves (Batson *et al.* 2004).

There are various elements that influence when and how much one feels sympathy. These can be especially relevant for people living with HIV, where target factors appear to play a significant role in attitudes toward them. Research has documented that less sympathy is expressed toward persons whose HIV status is attributed to seemingly controllable events, such as sexual intercourse and injecting drug use, compared to persons who contracted the infection through less controllable events, such as blood transfusions and perinatal transmission (Zagumny and Deckbar 1995, Becares and Turner 2004). Furthermore, persons living with HIV who are perceived to be homosexuals or sex workers receive even less sympathy and compassion than HIV-infected persons who are not considered to be members of these groups (de Bruyn 1998, International Center for Research on Women (ICRW) 2002). Recent qualitative research with persons living with HIV in Jamaica has confirmed these differentials (White and Carr 2005).

While the importance and implications of attitudes toward persons living with HIV have been highlighted, limited empirical research has been conducted that specifically examine attitudes *toward* persons living with HIV in Jamaica by persons *not* living with the disease; in fact, only two Jamaican-based studies have been identified (Dinnall and Bain 1994, Bain 1998). These studies included very small samples of health care professionals and church leaders and did not incorporate multi-level analyses to examine the correlates of attitudes. The limited foci of these studies suggest the need for further research of correlates of attitudes toward persons living with HIV in Jamaica among larger, more demographically diverse samples of persons. Understanding these factors is essential to improving attitudes toward individuals both infected and affected by HIV.

The present study sought to examine the prevalence and correlates of sympathy toward different categories of people living with HIV among a large sample of university students. The following hypotheses were developed:

- *Hypothesis 1:* Socio-demographic characteristics (age, sex, spirituality, church attendance, HIV education, HIV awareness, HIV transmission knowledge) are directly related to sympathetic attitudes toward persons living with HIV (Batson 1983, Handler *et al.* 1994, Schroeder *et al.* 1995, Thompson *et al.* 2001, Ezedinachi *et al.* 2002, Pita-Fernandez *et al.* 2004, Roebuck *et al.* 2005).

- *Hypothesis 2*: Levels of sympathetic attitudes vary depending upon the type of person who is living with HIV (Weiner *et al.* 1988, Breault and Polifroni 1992, Davis *et al.* 1999, Batson *et al.* 2002, Peltzer *et al.* 2004).

Methods

Data collection

Data were obtained from the University of the West Indies HIV/AIDS Knowledge, Attitudes and Behaviors Study 2001/2002, a collaborative research effort between the University of the West Indies and the Ministry of Health, Kingston, Jamaica. A 193-item questionnaire was developed related to HIV/AIDS education and prevention. The questionnaire was based upon social-psychological theories of behaviour change, including the Health Belief Model, the Theory of Reasoned Action, and Social Cognitive Theory (Becker 1974, Ajzen and Fishbein 1980, Bandura 1986). In addition, instruments from other universities conducting HIV research with students, the US Centers for Disease Control and Prevention (CDC), and the Ministry of Health, Jamaica, were used to facilitate the development and inclusion of standard questions that have been found to offer reliable and valid measures of HIV-related attitudes and behaviours across various samples (CDC 1992, Prince and Bernard 1995, Dilorio and Soet 1996, Ministry of Health 2000).

The survey instrument was reviewed and approved by the Research and Ethics Committee, Ministry of Health, and included items addressing knowledge of transmission, knowledge of the risks associated with specific sexual behaviours, attitudes toward persons living with HIV/AIDS, HIV testing behaviours, sexual history, attitudes toward condoms and safer sex, sexual behaviours with steady and non-steady sex partners, and drug and alcohol use during sexual activity.

The instrument was piloted with a sample of 15 students in order to assess the ease with which it could be completed, to determine whether the questions were easily understood, and to ensure the instrument could be completed in a timely fashion. Based upon the first piloting phase, revisions were made and the instrument was piloted again with ten additional students. Based upon the results from the second piloting phase, minor revisions were made and the instrument was finalized. Due to the nature of the questions and the possible perceived threat posed by questions of a sexual nature, the instrument was self-administered with no identifiers, providing anonymity to respondents.

A non-probability sampling frame was employed for the study. Data were gathered between June 2001 and February 2002 from 1252 students in various classes across the university faculties, representing 11% of the total student population for the enrolment period. While the study employed non-random sampling, statistical testing indicated no significant differences between the study sample and the university population in both age and sex distributions (University of the West Indies (UWI) 2002).

Variables

A number of variables were used in these analyses. Variables were recoded to facilitate the logistic regression analyses. The following operationalizations were used:

Sympathy. Students were asked to report what level of sympathy they felt toward five target groups of persons living with HIV, including homosexual men, heterosexual men,

women who were sex workers, women who were not sex workers, and children. Responses were measured using a five-point Likert scale, ranging from strongly sympathetic (1) to strongly unsympathetic (5). For each target group, responses were dichotomized into expressed sympathy (strongly sympathetic and sympathetic) [1] and no expressed sympathy (strongly unsympathetic, unsympathetic, neutral) [0].

HIV awareness. Students were asked whether they knew someone who was infected with HIV or had died from AIDS. Four response categories were used: yes, a family member or friend; yes, but not a family member or friend; no; and, don't know. A new variable was created by dichotomizing the responses: yes [1]; and, no/don't know [0].

HIV education. Students were asked whether they had attended a lecture, course, or community forum about HIV or AIDS in the 12 months before the survey. Those who reported having attended such an activity were coded as having received HIV/AIDS education [1], while remaining students were coded as not having received such education [0].

Knowledge of HIV transmission. Students were asked to report whether certain behaviours were viable modes of HIV transmission. The following items comprise the non-viable modes: through drinking fountains; through toilet seats; through tears; through sweat; and through sharing food. Students who reported at least one of the five modes as viable were coded as having inaccurate knowledge of non-viable modes of HIV transmission [1], while remaining students who reported that none of the five modes were viable were coded as having accurate knowledge of non-viable modes of HIV transmission [0].

Spirituality. Students were asked to report how spiritual they considered themselves. Those reporting being very spiritual were coded as such [1] with remaining responses (moderately, somewhat, slightly, and not at all) were coded as less spiritual [0].

Church attendance. Students were asked to report how often they had attended religious services in the month prior to the survey. Those reporting attending once a week or more were coded as frequent attendees [1] while those reporting attending less often were coded as infrequent attendees [0].

Age. Students were asked to report their age, in years, on their last birthday. Those reporting being under the age of 25 were coded as youths [1] while those 25 years of age and older were coded as adults [0]; a categorization based on the World Health Organization's (WHO) definition of youth (WHO 2000).

Sex. Students were asked to report whether they were male [1] or female [0].

Data analysis

Logistic regression analyses were conducted, using SPSS, Version 14, to test the study hypotheses. All model variables were dichotomized to facilitate the logistic regression analyses, with the comparison group for each variable coded [1] as described in the above section.

Results

Sample characteristics

The sample was predominantly female (70.5%), with a mean age of 26.5 years ($S_x=8.74$). The vast majority reported being moderately or very spiritual (78.1%), with slightly more than one-third attending religious services at least weekly (37.3%). The majority of students (76.5%) had not attended any type of HIV education forum or lecture in the previous 12 months, and about half (48.6%) reported knowing someone who was infected with HIV or had died from AIDS.

Figure 1 presents the percentage distributions for sympathy toward persons living with HIV from various risk groups. The vast majority of students (97.5%) reported sympathy toward children living with HIV. However, only a minority of the sample reported holding the same attitude toward those who were homosexual men or women sex workers living with HIV (40.1% and 44.4%, respectively). Significantly higher levels of sympathy were expressed toward heterosexual men and women who were not sex workers (67.2% and 81.3%, respectively).

Multivariate models

Table 1 presents the results of the logistic regression analyses examining sympathy toward the different target groups of people living with HIV and consists of four models. Sympathy toward children living with HIV was excluded in the logistic regression analyses due to the lack of variation in responses. For Model 1, expressed sympathy toward persons living with HIV who are homosexual men was the dependent variable; three of the seven independent variables were significant. Males, compared to females, were less likely to express sympathy (Odds Ratio (OR)=0.55, 95% Confidence Interval (CI)=0.41–0.73). Students who reported being very spiritual were more likely to express sympathy than were those who reported being less spiritual (OR=1.35, CI=1.01–1.80). Lastly, students who had attended an HIV forum or discussion in the previous year were also more likely, compared to those who did not attend, to express sympathy (OR=1.48, CI=1.10–1.99).

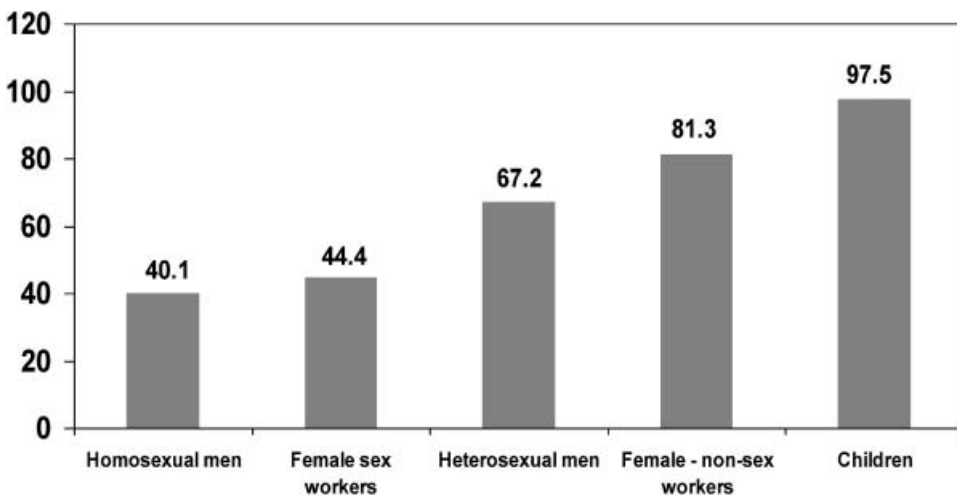


Figure 1. Percentage of students expressing sympathy toward different groups of persons living with HIV*.

Table 1. Logistic regression analyses examining sympathy toward persons living with HIV from various target groups.

Independent Variable	(1)	(2)	(3)	(4)
	Male – Homosexual (n=1091)	Female – Sex Worker (n=1088)	Male – Heterosexual (n=1097)	Female – non-Sex Worker (n=1099)
	$\chi^2(7)=44.71^{***}$	$\chi^2(7)=28.74^{***}$	$\chi^2(7)=16.49^*$	$\chi^2(7)=12.92^+$
	Odds Ratio (95% CI)	Odds Ratio (95% CI)	Odds Ratio (95% CI)	Odds Ratio (95% CI)
Sex	0.55 (0.41–0.73) ^{***}	1.08 (0.82–1.41)	1.03 (0.78–1.37)	0.89 (0.64–1.24)
Age	0.81 (0.63–1.05)	0.69 (0.53–0.89) ^{**}	0.85 (0.65–1.11)	0.83 (0.60–1.15)
Spirituality	1.35 (1.01–1.80) [*]	1.38 (1.04–1.84) [*]	1.34 (0.99–1.82) ⁺	0.86 (0.61–1.20)
Church Attendance	0.98 (0.74–1.29)	0.92 (0.70–1.21)	0.78 (0.59–1.04) ⁺	1.10 (0.77–1.59)
HIV Awareness	1.15 (0.88–1.48)	1.13 (0.88–1.46)	1.27 (0.97–1.66) ⁺	1.48 (1.07–2.04) [*]
HIV Education	1.48 (1.10–1.99) [*]	1.30 (0.97–1.75) ⁺	1.11 (0.81–1.53)	1.15 (0.78–1.70)
HIV Knowledge	0.87 (0.53–1.43)	0.57 (0.35–0.95) [*]	0.58 (0.36–0.94) [*]	0.69 (0.40–1.21)

The comparison group for each variable is as follows: sex (males); age (youths – <25 years); spirituality (very spiritual); church attendance (weekly or more); HIV awareness (know PLWHA); HIV education (previous formal HIV education); HIV transmission knowledge (inaccurate); and, sympathy toward PLWHA (expressed sympathy). * $p < 0.05$; ** $p < 0.01$; *** $p < 0.001$; + $p < 0.10$.

For Model 2, expressed sympathy toward persons living with HIV who were women sex workers was the dependent variable; three of the seven independent variables were significant. Youths, compared to adults, were less likely to express sympathy (OR=0.69, CI=0.53–0.89). Students who had inaccurate knowledge concerning HIV transmission, compared to those with accurate knowledge, were also less likely to express complete sympathy (OR=0.57, CI=0.35–0.95). Lastly, students who reported being very spiritual were also more likely to express sympathy than students who reported being less spiritual (OR=1.38, CI=1.04–1.84).

For Model 3, expressed sympathy toward persons living with HIV who are heterosexual men was the dependent variable; only one of the seven independent variables was significant. Students who had inaccurate knowledge concerning HIV transmission, compared to those with accurate knowledge, were less likely to express sympathy (OR=0.58, CI=0.36–0.94).

For Model 4, expressed sympathy toward persons living with HIV who were women, but not sex workers, was the dependent variable; only one of the seven independent variables emerged as significant. Students who reported knowing someone living with HIV/AIDS or had died from the disease, compared to those who reported not knowing such persons, were more likely to express sympathy (OR=1.48, CI=1.07–2.04).

Discussion

The results of this study indicate that Jamaican students hold less than sympathetic attitudes toward various groups of persons living with HIV, and that these attitudes vary depending upon target factors. While the overwhelming majority of respondents reported sympathy for children, less sympathy was expressed for certain categories of adults. This finding supports previous research that has documented that less sympathy is expressed toward persons whose HIV status is attributed to ‘controllable’ events—such as sexual intercourse and injecting drug use—compared to persons who contracted the disease

through events such as blood transfusions and perinatal transmission (Weiner *et al.* 1988, Weiner 1993, Zagumny and Deckbar 1995, Becares and Turner 2004).

With respect to the adults living with HIV, sympathetic attitudes varied significantly. Less than half of the respondents were sympathetic to persons living with HIV who were either homosexual men or women sex workers, while the majority of persons reported sympathetic feelings toward persons living with HIV who were either heterosexual men and women who were not sex workers. This finding supports previous research that has established an association between sexual prejudice and negative attitudes toward persons living with HIV (Breault and Polifroni 1992, Davis *et al.* 1999, Batson *et al.* 2002, Hayes *et al.* 2002, Peltzer *et al.* 2004). Specifically, research has found that persons living with HIV who are perceived to be men who have sex with men or sex workers receive even less sympathy and compassion than those who are not considered to be members of these groups (de Bruyn 1998, ICRW 2002). When illness is believed to be the result of 'immoral' behaviour, HIV/AIDS may reinforce pre-existing sexual stigmas (Parker and Aggleton 2000). This can result in the members of these marginalized groups being blamed for their disease and, as such, decrease the level of sympathy expressed toward them. One interesting finding that is not supported by previous research is that more sympathy was expressed for women than men, irrespective of risk group. Previous research has found less favourable attitudes toward women, compared to men, living with the disease (de Bruyn 1993).

Not only did the levels of expressed sympathy differ by target group, predictors of sympathy also varied. For example, less sympathy toward homosexual men was associated with being male, whereas it was not associated with sympathy toward heterosexual men or either group of women. This may be explained by the high levels of homophobia in Jamaica that have been documented in some studies and recently acknowledged by Jamaica's National HIV/STI Control Programme (Human Rights Watch 2004, White and Carr 2005, Ministry of Health 2005b).

Spirituality was correlated with attitudes toward persons living with HIV who were members of sexually-stigmatized groups but not with sympathy toward other persons living with the disease. Spirituality as a correlate of sympathy should, therefore, be studied more fully to determine its varying effects. One surprising finding was the lack of association between church attendance and expressed sympathy across the groups. It has been posited that religion encourages persons to expand positive attitudes and to treat others as they would their own family (Batson 1983). As such, it was expected that persons who attended religious services more often would be more sympathetic. However, this association did not emerge. It is possible that frequency of church attendance is not a valid measure of religiosity. Future research may need to consider asking not only about the active practice of religion but also religious denomination. Recent research in the Caribbean has revealed significant differences in responses to HIV/AIDS by various religious denominations (Genrich and Brathwaite 2005). Considering the significance and influence of religion in Jamaica, it will be important to consider the religious impact of attitudes toward persons living with HIV held by different religious institutions, especially when attempting to improve such attitudes on a societal-level.

While the present study has provided insight into some of the factors associated with attitudes toward persons living with HIV in Jamaica, it is important to note certain limitations of the study that may impact the validity of the findings. The sample was a non-random sample, consisting of persons who volunteered to participate in the study. While the study sample was not statistically different from the university population in terms of

age and sex (UWI 2002), the generalizability of the results to the university population in Jamaica may, none the less, be limited.

Conclusion

These study findings indicate that if sympathy and empathy toward persons living with HIV are to be improved, targeted messages focusing on a specific sexual group may be needed. It has been reported that available research provides limited support for efforts that focus on changing stigmatizing attitudes through 'empathy inducement' or other psychological interventions (Aggleton *et al.* 2003). It could be, however, that messages disseminated in these interventions have been general, as opposed to target-group specific. Previous research, in which individuals from target groups were part of the intervention, has found a significant increase in empathy and positive attitudes toward the specific stigmatized group to which the included individual belonged (Batson *et al.* 1997, Ezedinachi *et al.* 2002, Rutledge and Abell 2005). These findings are encouraging and lend support to the claim that target-specific messages and interventions are needed if one hopes to significantly change attitudes toward persons living with HIV, especially those who belong to socially marginalized groups.

In developing and implementing future programmes aimed at the improvement of attitudes toward HIV-infected persons, care should be taken to target messages toward specific subgroups and then to include members of the targeted subgroup in the subsequent efforts. Additional research is needed, however, in order to better understand why the correlates of sympathy were significantly different, depending on the target group. It will be critical that comprehensive, multi-faceted programmes will need to have an understanding of not only levels of sympathy by target group, but equally important, the variation in predictors of sympathy by target group as well. This type of comprehensive approach may be more effective than current efforts in promoting a positive social environment for those living with or affected by HIV.

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