Feature

"You are always hiding. It's the worst way to live." *Exploring Stigma in African Immigrants Living With HIV in a Large Northwest U.S. Metropolitan Area*

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African immigrants living in the United States are disproportionately and uniquely affected by HIV. Evidence shows that stigma may contribute to this inequity. Applying a biopsychosocial model of health, our qualitative study explored HIV-related stigma and its impact on African immigrants living with HIV in a large northwestern U.S. metropolitan area. We conducted in-depth, semi-structured interviews with 20 African immigrants living with HIV. In the biological health realm, HIV-related stigma contributed to adverse health care environments, disruptions in care, and poor physical health. In the psychological health realm, it was associated with emotional vulnerability, depressive symptoms, and negative coping. In the social health realm, stigma lead to disclosure challenges, isolation, and poor social support. HIV-related stigma was an extensive and pervasive burden for this population. The biopsychosocial model was a helpful lens through which to explore HIV-related stigma and identify opportunities for future research and intervention.

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In the United States, African immigrants are disproportionately and uniquely affected by HIV. African immigrants have an HIV diagnosis rate estimated at six times the incidence in the general U.S. population (Blanas et al., 2013). Compared to other groups of

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people living with HIV (PLWH) in the United States, African immigrant PLWH have higher rates of diagnosis among women, higher rates of heterosexual transmission, and lower rates of transmission from injection drug use (Johnson, Hu, & Dean, 2010). These trends are similar to trends in sub-Saharan Africa, where heterosexual sex and perinatal transmission are the primary modes of transmission, and women account for 58% of PLWH (Kharsany & Karim, 2016). Furthermore, while immigrants from Africa represent numerous distinct countries, cultures, and communities, they are all vulnerable to immigration-related challenges including discrimination, racism, language barriers, lack of legal documentation, fear of termination from employment, unfamiliarity with the U.S. health care system, and a preference for spiritual or alternative care (American Psychological Association, Presidential Task Force on Immigration, 2012). Previous research has indicated that these factors may reduce the willingness and/or ability of African immigrants to utilize available HIV resources (Othieno, 2007).

HIV-related stigma is another significant issue for PLWH. Stigma has been defined as public perceptions about persons with an undesirable health condition (Scambler, 2009; e.g., HIV, mental illness) or social identity (Goffman, 1963; e.g., immigrant, indigent), resulting in stereotypes, prejudice, and discrimination. Stigma can be social, through overt behaviors of others, or internalized (also known as self-stigma) by incorporating negative stereotypes into one's sense of self (Van Brakel, 2006). Both forms of stigma have demonstrated negative implications for physical, psychological, and social outcomes (Link & Phelan, 2006). A small but growing body of research has described HIV-related stigma in African immigrant PLWH in the United States as a unique and culturally specific barrier to care (Foley, 2005; Koku, 2010; Ojikutu et al., 2013; Othieno, 2007). However, there remains a need for a conceptual framework to comprehensively assess and understand how HIV-related stigma manifests in African immigrant PLWH and the distinct mechanisms by which it impacts overall health and well-being.

The biopsychosocial model of health (Engel, 1977) may be a useful framework for understanding the impact of HIV-related stigma on a PLWH's life. Specifically, the biopsychosocial model underlines the idea that when a disease or disorder is present, a person suffers as a whole, in context, not merely in an isolated organ. This well-established model includes not only the physical health perspective of the biomedical lens, but also incorporates a person's psychological/emotional experiences, sociocultural context, and related behaviors into a comprehensive view of health and illness (Havelka, Lučanin, & Lučanin, 2009). Although the biopsychosocial model originated in the field of psychiatry, it has been used extensively in myriad settings, including clinical applications, treatment guidelines, and rehabilitation and disability research, and forms the basis for validated case complexity measures and the World Health Organization's International Classification of Functioning, Disability, and Health (Wade & Halligan, 2017). It is also a foundational component of patient-centered care (Smith, Fortin, Dwamena, & Frankel, 2013). In terms of HIV research, the biopsychosocial model has been used in studies on disclosure among gay men (Flowers & Davis, 2013) and parents who have HIV (Letteney, Krauss, & Kaplan, 2012), HIV-related chronic pain (Merlin et al., 2014), and aging with HIV (Vance & Robinson, 2004).

Figure 1 represents an ideal scenario for someone receiving an HIV diagnosis. Under the biopsychosocial model, this individual would (a) be connected to competent and compassionate clinical care (bio); (b) possess the resilience and coping skills to manage the emotional effects of receiving an HIV diagnosis (psycho); and (c) have supportive friends and family with whom to share the diagnosis (social). These positive biopsychosocial resources would then lead to long-term well-being, including a reduced risk of disease transmission.

In this study, we explore how African immigrant PLWH in a large northwest U.S. metropolitan area experience HIV-related stigma, and the subsequent effects on their biopsychosocial health.

Methods

Study Design and Sample

For this exploratory qualitative study, we conducted semi-structured individual interviews with African immigrant PLWH in 2013-2014. We recruited