

Health Psychology Review

Publication details, including instructions for authors and
subscription information:

<http://www.tandfonline.com/loi/rhpr20>

Predictors of internalised HIV-related stigma: a systematic review of studies in sub-Saharan Africa

Marija Pantelic^a, Yulia Shenderovich^b, Lucie Cluver^{ac} & Mark
Boyes^{ad}

^a Department of Social Policy and Intervention, University of
Oxford, 32 Wellington Square, Oxford OX1 2ER, UK

^b Department of Psychiatry, University of Cambridge, Douglas
House, 18b Trumpington Road, Cambridge CB2 8AH, UK

^c Department of Psychiatry and Mental Health, University of Cape
Town, Cape Town, South Africa

^d School of Psychology and Speech Pathology, Curtin University,
GPO Box U1987, Perth, WA 6845, Australia

Accepted author version posted online: 03 Jan 2015. Published
online: 21 Apr 2015.



[Click for updates](#)

To cite this article: Marija Pantelic, Yulia Shenderovich, Lucie Cluver & Mark Boyes (2015):
Predictors of internalised HIV-related stigma: a systematic review of studies in sub-Saharan Africa,
Health Psychology Review, DOI: [10.1080/17437199.2014.996243](https://doi.org/10.1080/17437199.2014.996243)

To link to this article: <http://dx.doi.org/10.1080/17437199.2014.996243>

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the
“Content”) contained in the publications on our platform. However, Taylor & Francis,
our agents, and our licensors make no representations or warranties whatsoever as to
the accuracy, completeness, or suitability for any purpose of the Content. Any opinions
and views expressed in this publication are the opinions and views of the authors,
and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content
should not be relied upon and should be independently verified with primary sources
of information. Taylor and Francis shall not be liable for any losses, actions, claims,
proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or
howsoever caused arising directly or indirectly in connection with, in relation to or arising
out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at <http://www.tandfonline.com/page/terms-and-conditions>

Predictors of internalised HIV-related stigma: a systematic review of studies in sub-Saharan Africa

Marija Pantelic^{a*}, Yulia Shenderovich^b, Lucie Cluver^{a,c} and Mark Boyes^{a,d}

^aDepartment of Social Policy and Intervention, University of Oxford, 32 Wellington Square, Oxford OX1 2ER, UK; ^bDepartment of Psychiatry, University of Cambridge, Douglas House, 18b Trumpington Road, Cambridge CB2 8AH, UK; ^cDepartment of Psychiatry and Mental Health, University of Cape Town, Cape Town, South Africa; ^dSchool of Psychology and Speech Pathology, Curtin University, GPO Box U1987, Perth, WA 6845, Australia

(Received 1 April 2014; accepted 4 December 2014)

This systematic review aims to synthesise evidence on predictors of internalised HIV stigma amongst people living with HIV in sub-Saharan Africa. Preferred Reporting Items for Systematic Reviews and Meta-Analyses guidelines were used. Studies were identified through electronic databases, grey literature, reference harvesting and contacts with key researchers. Quality of findings was assessed through an adapted version of the Cambridge Quality Checklists. A total of 590 potentially relevant titles were identified. Seventeen peer-reviewed articles and one draft book chapter were included. Studies investigated socio-demographic, HIV-related, intra-personal and interpersonal correlates of internalised stigma. Eleven articles used cross-sectional data, six articles used prospective cohort data and one used both prospective cohort and cross-sectional data to assess correlates of internalised stigma. Poor HIV-related health weakly predicted increases in internalised HIV stigma in three longitudinal studies. Lower depression scores and improvements in overall mental health predicted reductions in internalised HIV stigma in two longitudinal studies, with moderate and weak effects, respectively. No other consistent predictors were found. Studies utilising analysis of change and accounting for confounding factors are necessary to guide policy and programming but are scarce. High-risk populations, other stigma markers that might layer upon internalised stigma, and structural drivers of internalised stigma need to be examined.

Keywords: stigma; HIV/AIDS; systematic review; self-perception; self-image; shame

Background

Three decades into the fight against HIV, stigma remains a major ‘roadblock’ to HIV prevention and treatment (UNAIDS, 2007). In 2011, UN member states committed to eliminating HIV/AIDS-related stigma by 2015 (UNAIDS, 2011). Existing intervention studies heavily focus on reducing enacted stigma (Stangl, Lloyd, Brady, Holland, & Baral, 2013), which refers to negative public attitudes or discrimination towards people living with HIV (PLHIV; Horwitz et al., 2013). Less is known about how to reduce internalised HIV-related stigma, which occurs when an HIV-positive person endorses negative attitudes associated with HIV and accepts them as applicable to his or her self (Link, 1987; Link, Cullen, Struening, Shrout, & Dohrenwend, 1989). Internalised stigma

*Corresponding author. Email: marija.pantelic@spi.ox.ac.uk

is characterised by feelings of shame, guilt, worthlessness and difficulties around HIV status disclosure (Lee, Kochman, & Sikkema, 2002; Tsai et al., 2012).

Following labelling theory (Link et al., 1989; Scheff, 1966), people typically develop perceptions about public attitudes towards HIV prior to their own HIV diagnosis or antiretroviral treatment (ART) initiation. Labels such as an HIV diagnosis or ART initiation may therefore result in ‘internalized expectations of rejection’ (Link, 1987). Internalised stigma can have detrimental public health consequences through two social psychological mechanisms (Link et al., 1989). First, HIV-positive individuals may devalue themselves because ‘they now belong to a category that they believe most people view negatively’ (Link, 1987). Second, by fuelling fear of rejection from others, internalised stigma may lead to harmful responses such as secrecy, withdrawal and isolation. In line with this, longitudinal evidence from Uganda suggests that internalised stigma predicts non-disclosure of HIV status (Tsai, Bangsberg, Kegeles, et al., 2013). Non-disclosure has in turn been linked to increased HIV risk behaviours (Simbayi et al., 2007a). Systematic review-level evidence also suggests that internalised HIV stigma hinders adherence to ART (Katz et al., 2013), which is essential for preventing virological failure (Gross et al., 2006), delaying mortality (Lima et al., 2009) and reducing HIV transmission (Loutfy et al., 2013).

Sub-Saharan Africa is home to 70% of the world’s PLHIV but no well-established programmes to reduce internalised HIV stigma have been identified the region. A recent systematic review found only two interventions targeting internalised HIV stigma in sub-Saharan Africa (Stangl et al., 2013). Both interventions aimed to improve coping through empowerment and knowledge building. Uys et al. (2009) used a multiple-case study approach to evaluate programmes designed by small groups of 7–10 nurses and 7–10 HIV-positive patients in five health care facilities in Lesotho, Malawi, South Africa, Swaziland and Tanzania. These programmes did not follow an implementation manual. Rather, they were each designed, implemented and evaluated by teams who had undergone a 2-day ‘project initiation workshop’.

Taken together, the programmes resulted in a significant reduction in negative self-perception among the patients ($M_1 = .82$; $M_2 = .36$, $p < .001$). Tshabalala and Visser (2011) evaluated a structured cognitive-behavioural therapy intervention in a small mixed methods randomised control trial with HIV-positive women in South Africa (10 HIV-positive women in the intervention group and 10 HIV-positive women in the waitlist control group). The intervention resulted in significantly greater reductions in internalised stigma in the intervention group compared to the control group. These studies are a step in the right direction and suggest it is feasible to reduce internalised HIV stigma by acting on individual-level factors that contribute to it. However, findings should be replicated by large randomised trials before firm inferences are made. Moreover, there is no evidence of community or macro-level interventions to reduce internalised stigma in sub-Saharan Africa, but a growing body of work suggests that HIV stigma and its internalisation are entrenched in wider structural inequalities (Campbell & Deacon, 2006; Gilmore & Somerville, 1994; Tsai, Bangsberg, & Weiser, 2013).

In order to design and test future interventions, we must first understand the full range of predictors of internalised HIV stigma in sub-Saharan Africa (Fraser, Richman, Galinsky, & Day, 2009). To our knowledge, no systematic review on predictors of internalised HIV stigma in sub-Saharan Africa has been conducted to date, despite the region’s disproportionate HIV burden. Logie and Gadalla (2009) conducted a systematic

review and meta-analysis of health and demographic correlates of both enacted and internalised HIV stigma in North America, and found one study assessing correlates of internalised stigma in the USA (Lee et al., 2002). However, the hypothesised exposure variables in this study did not meet the temporal requirement of predictor variables. Moreover, we should also be extremely cautious about the transferability of North American studies, where HIV disproportionately affects otherwise stigmatised minorities such as men who have sex with men, people who inject drugs, Hispanics and African-Americans (CDC, 2013; Katiria Perez & Cruess, 2014). In contrast, in sub-Saharan Africa, HIV is prevalent in the general population.

Therefore, the aim of this systematic review is to synthesise existing evidence on predictors of internalised HIV stigma among PLHIV in sub-Saharan Africa. We hope that this review of observational studies will advance theory and inform intervention development in sub-Saharan Africa. Preliminary literature searches detected few studies that used prospective cohort data and would meet the temporal requirements of predictor variables. Therefore this review also included cross-sectional studies that specified internalised HIV stigma as the dependent variable. It is important to note that such studies were not methodologically equipped to determine predictors but rather correlates of internalised stigma. They were included so as to advance theory and hypothesise predictors to be assessed in future longitudinal research. Cross-sectional studies considering internalised HIV stigma as an independent variable were excluded from this review due to lack of theory to hypothesise that these correlates might be predictors of internalised stigma. More information about the scope of the review can be found in Supplementary File 2.

Methods

Search strategy

This paper adheres to Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines for systematic reviews (Moher, Liberati, Tetziaff, & Altman, 2009). The full protocol for this systematic review is accessible online (<http://www.youngcarers.org.za/assets/pdfs/Pantelic-Shenderovich-Cluver-Boyes-2014.pdf>). Studies were identified through electronic searches of bibliographic databases and grey literature websites, examining citations of retrieved studies and contacting researchers. Our search was restricted to reports after 1983, the year of the first AIDS diagnoses in Africa (Ras, Simson, Anderson, Prozesky, & Hamersma, 1983). Larger databases (PsycARTICLES, Embase, Global Health, Ovid MEDLINE and PsycINFO) were searched utilising sensitive search terms including subject heading (MeSH) and free text search terms for sub-Saharan Africa, PLHIV and internalised HIV-related stigma or shame (see Supplementary File 4). Smaller databases such as Cumulative Index to Nursing and Allied Health Literature (CINAHL) and WHO Afro Library used a simpler, more inclusive search string. The PROSPERO register of systematic reviews was also searched. Final searches were conducted on 1 April 2014. References listed in the included studies as well as in other reviews on HIV/AIDS stigma (Mbonu, van den Borne, & De Vries, 2009; Sengupta, Banks, Jonas, Miles, & Smith, 2011; Stangl et al., 2013; Tsai, Bangsberg, & Weiser, 2013) were also reviewed for eligibility. Email requests for unpublished and ongoing investigations were sent in November–December 2013 to key researchers working on HIV stigma.

Screening

Following guidelines in the Cochrane Collaboration Handbook (Deeks, Higgins, & Altman, 2008), search results were merged and de-duplicated. The initial screening involved the lead author's (MP) examination of titles and abstracts to remove irrelevant reports. Full-text documents were retrieved and examined in detail for compliance with eligibility criteria (Supplementary File 3). Where needed, authors were contacted by email to retrieve reports, clarify study eligibility and request additional information.

Data abstraction and quality assessment

Data were extracted using a pre-designed piloted form (see Supplementary File 6 and protocol) by one reviewer (MP). This was checked independently by a second reviewer (YS) and discrepancies were resolved by discussion. Articles reporting analyses from the same data-set were checked to ensure there was no data duplication. Where data were duplicated, estimates from the largest sample were used. Quality of findings in included studies was assessed using an adapted version of the Cambridge Quality Checklists (CQC; Murray, Farrington, & Eisner, 2009), developed for drawing conclusions about causes from observational studies (see Supplementary File 7). The causal predictor score is the most important indicator as it assesses the extent to which the risk factor is causally related to the outcome. The causal score is determined based on two key features: (1) the extent to which within-individual changes in internalised stigma are associated with within-individual changes in the predictor (analysis of change); and (2) whether the study design and/or statistical analysis account for alternative explanations of the findings. To score highest among observational studies, models have to assess within-individual change in internalised stigma and control for relevant confounding variables.

For the purposes of this systematic review, we adapted CQC to capture reporting quality, in addition to methodological rigor. Studies not reporting reliability of the internalised HIV stigma measure used were ranked lower than those reporting reliability below 0.70. Response rates were scored for cross-sectional designs. Given that the prospective cohort studies reported only retention rates (without response rates at baseline), only retention rates were assessed for longitudinal designs. Studies focusing on PLHIV in sub-Saharan Africa tend to recruit through health care facilities. We therefore adapted CQC sampling scores to assess the method used for the selection of facilities, in addition to the sampling of participants within facilities.

As the included studies assessed more than one internalised stigma predictor, CQC was applied to each association between a correlate and internalised stigma. This allowed for differentiation between the types of analyses used for investigated predictors of internalised stigma. For example, Visser and Sipsma (2013) report a simple correlation between enacted stigma and internalised stigma, whereas other predictors of internalised stigma in the study were assessed in a multivariate model that received a higher causality score for accounting for confounders.

Any measures of between group differences (e.g., odds ratio, risk ratio, difference in means) or associations between constructs (e.g., r , $Beta$, B) were extracted. If these were unavailable, where possible Cohen's d was calculated to illustrate size of effect.

Risk of bias across studies

We sought to minimise risk of publication bias by actively searching for grey literature and ongoing studies. However, the absence of registration procedures for observational

studies limits the ability to assess reporting bias. Specifically, the lack of study protocols does not allow differentiation between hypothesis-driven from post hoc data analyses (Loder, Groves, & MacAuley, 2010).

Data synthesis

A meta-analysis was not conducted due to the diversity of primary studies (Furlan, Pennick, Bombardier, & van Tulder, 2009). Furthermore, cross-sectional data used in the majority of included studies limit causal inferences (Garg, Hackam, & Tonelli, 2008). Meta-analyses can test consistency of a relationship but not causality, so providing a single effect size could be misleading (Weed, 2010).

Results

The search process identified 590 potentially relevant articles and reports. Of these, 262 titles were generated through the database search and 328 titles were generated through harvesting references and communicating with authors. After removing duplicates, 495 abstracts were retained for further review (Figure 1). Next, 38 titles were selected for full-text review. Finally, a total of 18 studies, including 17 peer-reviewed articles and one draft book chapter (Visser & Sipsma, 2013) were included in this systematic review.

Study characteristics

Table 1 summarises the characteristics, quality assessment, findings and effect sizes (where reported) of included studies in chronological order. Represented in the 18 titles are 13 unique samples with 9088 PLHIV in South Africa, Lesotho, Malawi, Tanzania, Swaziland, Mozambique, Uganda, Kenya and Burkina Faso. There was a general consensus between studies about the definition of internalised HIV stigma: negative self-perception due to HIV status and the resultant feelings of shame, difficulties around disclosure and self-exclusion.

All studies recruited participants through health care facilities, and four additionally recruited via support groups, community organisations, social service providers and gay venues (Holzemer et al., 2007; Kalichman et al., 2009; Makoae et al., 2009; Simbayi et al., 2007b).

Ten articles assessed predictors of internalised stigma as a primary objective (Table 1). Five articles were psychometric assessments of measurements and analysed correlates of internalised stigma as part of construct validity checks (Holzemer et al., 2007; Kalichman et al., 2009; Kingori et al., 2013; Tsai et al., 2012; Visser, Kershaw, Makin, & Forsyth, 2008). Three articles aimed to assess predictors of another outcome and assessed correlates of internalised stigma as part of exploratory analyses to inform more complex modelling of other outcomes (Neuman & Obermeyer, 2013; Pearson et al., 2009; Simbayi et al., 2007b).

Most studies included only adults. One study (Nattabi, Li, Thompson, Orach, & Earnest, 2011) included adolescents (15–49 age range), however, the analysis did not differentiate between adolescents and adults. No studies included children below the age of 15. One study (Makoae et al., 2009) did not specify the age range of the sample.

In terms of key high-risk populations, three articles focused on women attending antenatal care clinics (Cuca, Onono, Bukusi, & Turan, 2012; Visser & Sipsma, 2013; Visser et al., 2008). Cloete, Simbayi, Kalichman, Strebel, and Henda (2008) included

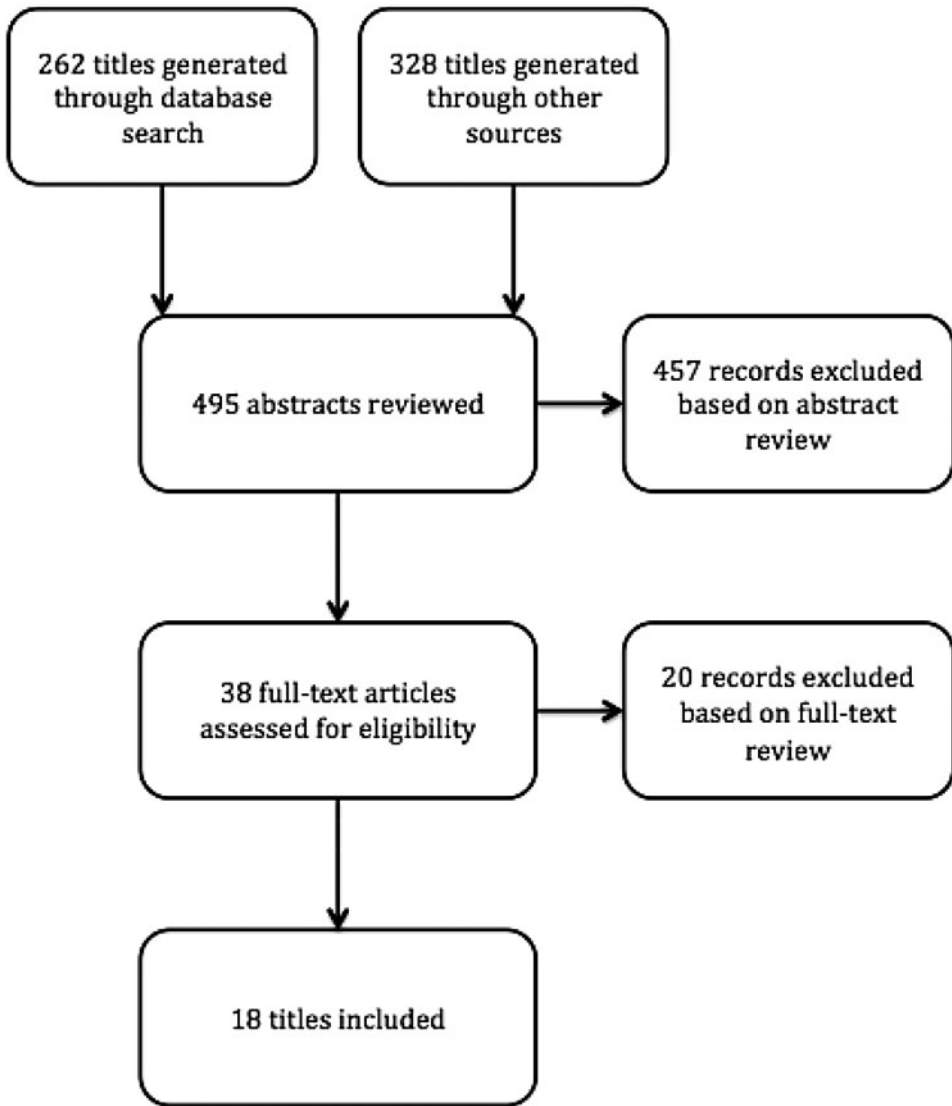


Figure 1. PRISMA flow diagram.

men who have sex with men and compared them to men who have sex with women. Perinatally infected youth were not studied.

Quality assessment

Study design

Six articles reported on prospective cohort data (Cuca et al., 2012; Makoae et al., 2009; Peltzer, 2012; Tsai, Bangsberg, Bwana, et al., 2013; Wagner, Ghosh-Dastidar, Garnett, Kityo, & Mugenyi, 2013) and one reported on both prospective cohort data and cross-sectional data (Pearson et al., 2009). Cross-sectional data were used to assess correlates of internalised stigma in the remaining 11 articles.

Table 1. Summary of included studies.

First author (year)	Location	Primary outcome	Target population	<i>n</i>	Female (%)	Study design	CQC score ^a (%)	Predictors/correlates of internalised stigma
Simbayi (2007)	South Africa	N	Adults	1063	60.5	CS	39	Male gender ($d = .26, p < .01$)
							39	Age (<i>NS</i>)
							39	Race (<i>NS</i>)
							39	Discrimination/enacted stigma ($r = .31, p < .001$)
							39	Low social support ($r = -.29, p < .01$)
							39	Alcohol use ($r = .1, p < .01$)
							39	Drug use ($r = .16, p < .01$)
							39	Fewer years HIV+ ($r = -.09, p < .01$)
							39	HIV symptoms (<i>NS</i>)
							39	ART use (<i>NS</i>)
Holzemer (2007)	Lesotho, Malawi, South Africa, Swaziland, Tanzania	P	Adults	1477	74.1	CS	35	HIV symptoms ($r = .09, p < .05$)
							35	Life satisfaction ($r = -.23, p < .05$)
							35	Overall functioning ($r = -.23, p < .05$)
							35	Enacted stigma: social isolation ($r = .42, p < .05$)
							35	Enacted stigma: fear of contagion ($r = .24, p < .05$)
							35	Enacted stigma: workplace stigma ($r = .17, p < .05$)
							35	Enacted stigma: health care neglect ($r = .23, p < .05$)
Visser (2008)	South Africa	P	Women	317	100	CS	<i>To avoid data duplication, estimates from Visser 2013 were extracted as it reported findings from a larger sample size</i>	
Cloete (2008)	South Africa	Y	MSM and MSW	422	0	CS	43 MSM versus MSW (<i>NS</i>)	
Kalichman (2009)	South Africa sample	P	Adults	1068	61	CS	44	Depression ($r = .27, p < .01$)
							44	Social support ($r = -.32, p < .01$)
							44	HIV symptoms (<i>NS</i>)
							44	Enacted stigma (discrimination) ($d = .43, p < .01$)

Table 1 (Continued)

First author (year)	Location	Primary outcome	Target population	<i>n</i>	Female (%)	Study design	CQC score ^a (%)	Predictors/correlates of internalised stigma
Kalichman (2009)	Swaziland sample			1087	67		44	Depression ($r = .31, p < .01$)
							44	Social support ($r = -.08, p < .05$)
							44	HIV symptoms ($r = .18, p < .01$)
							44	Enacted stigma (discrimination) (<i>NS</i>)
Makoae (2009)	Lesotho, Malawi, South Africa, Swaziland and Tanzania	Y	Adults	1454	54.2 non ART takers; 45.7 ART takers	PCS	61	Time – internalised stigma significantly decreased over time for everyone, both on ARV and not ($d = .49, p < .001$)
							61	Time by ARV use- those taking ARV's showed significantly less reduction in internalised stigma ($d = .18, p < .05$)
Pearson (2009)	Mozambique	N	Adults initiating ART	277	56.3	PCS	74	Time: internalised stigma significantly increased over time from ART initiation ($t = 4.49, p < .001$)
							57	Lower depression ($r = -0.13, p < .05$)
							57	Lower perceived social support ($r = -0.12, p < .05$)
							57	Fewer people disclosed to ($r = -0.24, p < .001$)
							57	Disclosure to family member – compared to others ($t = 3.41, p < .001$)
							57	Disclosure to friend – compared to others ($t = 4.21, p < .001$)
							57	Disclosure to co-worker – compared to others ($t = 3.01, p < .01$)
							57	Disclosure to spouse or partner (<i>NS</i>)
Nattabi (2011)	Uganda	Y	People aged 15-49	497	50	CS	48	Age group (30 used as cut-off for dichotomous variable) (<i>NS</i>)
							48	Female gender ($r = .09, p < .05$)
							48	HIV status of partner (<i>NS</i>)

Table 1 (Continued)

First author (year)	Location	Primary outcome	Target population	<i>n</i>	Female (%)	Study design	CQC score ^a (%)	Predictors/correlates of internalised stigma
Sorsdahl (2011)	South Africa	Y	Adults	400	78.5	CS	48	Months on HAART (<i>NS</i>)
							48	Months since HIV diagnosis (<i>NS</i>)
							48	Months attending HIV clinic (<i>NS</i>)
							48	Desire more children (<i>NS</i>)
							48	HAART use (<i>NS</i>)
							48	Younger age ($OR = .95, p < .001$)
							48	Female gender ($OR = .59, p < .05$)
							48	Xhosa language (<i>NS</i>)
							48	Years of education ($OR = 1.26, p < .01$)
							48	Employment (<i>NS</i>)
Peltzer (2012)	South Africa	Y	Adults	499	70.5	CS	48	Shorter time of knowing HIV status ($OR = .87, p < .001$)
							61	Lack of disclosure ($OR = 3.11, p < .05$)
Tsai (2012)	Uganda	P	Adults	456	69.5	CS	39	Time on ART ($d = 0.29, p < .01$)
							39	Depression symptom severity ($r = .28, p < .05$)
							39	Mental health-related quality of life ($r = -.38, p < .05$)
							39	HIV symptom burden ($r = .38, p < .05$)
Wagner (2012)	Uganda	Y	Adults	602	68	PCS	39	Physical health-related quality of life ($r = -.24, p < .05$)
							83	ART use (<i>NS</i>)
							83	Time on ART (<i>NS</i>)
							83	Time by ART use ($\beta = -.30, p < .001$)
							83	Change in physical health functioning ($\beta = -.008, p < .001$)

Table 1 (Continued)

First author (year)	Location	Primary outcome	Target population	<i>n</i>	Female (%)	Study design	CQC score ^a (%)	Predictors/correlates of internalised stigma
Cuca (2012)	Kenya	Y	Pregnant women	147	100	CS	52	Age (25 cut-off used) (<i>NS</i>)
							52	Woman's major contribution to support household is housework (<i>NS</i>)
							52	Family knows HIV+ status (<i>NS</i>)
							52	Perceives community stigma (<i>NS</i>)
							52	Post-partum depression (OR = 4.6, 95% CI: 1.7, 12.9, $p < .01$)
Neuman (2013)	Burkina Faso, Kenya, Malawi, Uganda	N	Adults	536	67.4	CS	39	Female gender (<i>NS</i>)
							39	Age (categorised into three age groups) (<i>NS</i>)
							39	Educational attainment (<i>NS</i>)
							39	Urban location (<i>NS</i>)
Kingori (2013)	Kenya	P	Adults	370	60.4	CS	35	Depression ($r = .345$, $p < .000$)
Tsai (2013)	Uganda	Y	Adults	262	66	PCS	83	Time on ART ($d = .70$, $p < .05$), mediated by reduced HIV-related symptoms, improved physical and mental health and lower depression scores
Visser (2013)	South Africa	Y	Pregnant women	609	100	CS	43	Attributed stigma (perceive other people in community to be highly stigmatising) ($r = .334$, $p < .01$)
							57	Older age ($\beta = .123$, $p < .01$)
							57	Lower educational attainment ($\beta = -.115$, $p < .01$)
							57	Victim of sexual violence (<i>NS</i>)
							57	Disclosed HIV status ($\beta = -.085$, $p < .05$)
							57	HIV knowledge (<i>NS</i>)
							57	Low self-esteem ($\beta = -.197$, $p < .01$)
							57	Depression ($\beta = .179$, $p < .01$)
57	Low social support ($\beta = -.114$, $p < .01$)							

Table 1 (Continued)

First author (year)	Location	Primary outcome	Target population	<i>n</i>	Female (%)	Study design	CQC score ^a (%)	Predictors/correlates of internalised stigma
Takada (2014)	Uganda	Y	Adults	422	71%	PCS	87	Age (<i>NS</i>) Gender (<i>NS</i>) Marital status (<i>NS</i>) Education (<i>NS</i>) Household asset wealth (<i>NS</i>) Emotional support (<i>NS</i>) Tangible support (<i>NS</i>) Poor HIV-related physical health ($\beta = -0.018$, $p < .001$) Depression ($\beta = 0.49$, $p < .001$)

ARV, antiretroviral; HAART, highly active antiretroviral therapy; MSM, men who have sex with men; MSW, men who have sex with women.

Notes: In the 'Primary outcome' column, 'Y' indicates that internalised stigma was a primary outcome of interest, 'N' indicates that an outcome other than internalised stigma was primary and 'P' indicates that the study was a psychometric assessment of an internalised stigma measurement.

CS indicates a cross-sectional study design; PCS indicates a prospective cohort study design.

In the 'Predictors of internalised stigma' column, 'NS' indicates non-significant association ($p > .5$).

^aOne hundred per cent would indicate the maximum possible score of 23; decimals were rounded up to the nearest whole per cent.

Most studies used large samples ($n \geq 400$). All studies recruited from health care facilities. Two articles reported purposively sampling the main HIV/AIDS clinics where patients from other health facilities are referred (Nattabi et al., 2011) and clinics with representative HIV testing services and health care provision (Neuman & Obermeyer, 2013). One study reported convenience sampling of facilities (Sorsdahl, Mall, Stein, & Joska, 2011) and 14 did not report a method for selection. None of the studies reported total or random sampling of facilities.

Within facilities, five studies used total or random sampling of participants (Cuca et al., 2012; Pearson et al., 2009; Takada et al., 2014; Tsai, Bangsberg, Bwana, et al., 2013; Wagner et al., 2013); one used purposive sampling (Cloete et al., 2008); and five used convenience sampling (Kalichman et al., 2009; Neuman & Obermeyer, 2013; Sorsdahl et al., 2011; Visser & Sipsma, 2013; Visser et al., 2008). The remaining six articles did not report methods used to sample participants within facilities.

Internalised HIV stigma measurement validity and reliability

The most common measurement used in seven included articles was the Internalized AIDS-related Stigma Scale, developed by Kalichman and colleagues (2009; Cloete et al., 2008; Kalichman et al., 2009; Peltzer, 2012; Simbayi et al., 2007b; Takada et al., 2014; Tsai et al., 2012; Tsai, Bangsberg, Bwana, et al., 2013). Five articles (Cuca et al., 2012; Holzemer et al., 2007; Makoae et al., 2009; Nattabi et al., 2011; Sorsdahl et al., 2011) reported use of the negative self-perception subscale of the HIV/AIDS Stigma Instrument. Two reports used the Serithi Internalised Stigma Scale developed by Visser and colleagues (2008; Visser & Sipsma, 2013). Kingori and colleagues (2013) used the HIV Felt Stigma Questionnaire, and Pearson and colleagues (2009) used the Berger HIV Stigma Scale. Neuman and Obermeyer (2013) developed two items asking about feelings of worthlessness and guilt to assess internalised stigma.

Thirteen articles used internalised stigma measures that underwent some assessment of construct validity (i.e., correlations with theoretically linked constructs). One article additionally reported assessing face validity of the internalised stigma measurement through expert review (Kingori et al., 2013). One article tested measurement invariance (both configural and metric) (Holzemer et al., 2007). One article reported use of non-parametric equality-of-medians tests (Tsai et al., 2012). Thirteen articles reported high measurement reliability for internalised stigma, with alphas at or above .70 and one article reported reliability below .70 (Neuman & Obermeyer, 2013). However, given that the latter measurement consisted of only two items, Cronbach's alpha $<.70$ might be a result of the measure's brevity. The remaining articles did not report internalised stigma measurement reliability in the study sample.

Response and retention rates

Five articles reported a response or retention rate $\geq 70\%$ (Nattabi et al., 2011; Pearson et al., 2009; Simbayi et al., 2007b; Tsai, Bangsberg, Bwana, et al., 2013; Wagner et al., 2013). Three studies (Cuca et al., 2012; Makoae et al., 2009; Peltzer, 2012) reported response or retention rates below 70%. Ten articles did not report response or retention rates.

Causality scores

Only two articles assessed within-individual change in internalised stigma over time whilst taking into consideration potential confounding variables (Takada et al., 2014;

Tsai, Bangsberg, Bwana, et al., 2013). Another article conducted within-group change in internalised stigma over time while adequately controlling for confounders (Wagner et al., 2013). One article explored within-group changes in internalised stigma over time without taking confounders into consideration (Peltzer, 2012). Two articles took potential confounds into account without analysis of change (Cloete et al., 2008; Visser & Sipsma, 2013). The remaining articles did not control for confounders or did not explicitly state the choice of confounders when predicting internalised stigma.

Internalised stigma prevalence, observed predictors and correlates

Reports of any indicators of internalised stigma ranged between 26.9% and 66% (Cloete et al., 2008; Cuca et al., 2012; Kingori et al., 2013; Neuman & Obermeyer, 2013; Sorsdahl et al., 2011; Visser & Sipsma, 2013). We identified four categories of internalised stigma predictors and correlates: (1) socio-demographic, (2) HIV- and treatment-related, (3) intra-personal and (4) interpersonal factors. Each category and its correlates are described below. We report effect sizes where consistent directionality was observed between an investigated correlate and internalised stigma. We have summarised the directionality of findings for each correlate of internalised stigma in Supplementary File 8.

Socio-demographic factors

Socio-demographic factors assessed were age (Cuca et al., 2012; Nattabi et al., 2011; Neuman & Obermeyer, 2013; Simbayi et al., 2007b; Sorsdahl et al., 2011; Takada et al., 2014; Visser & Sipsma, 2013), gender (Nattabi et al., 2011; Neuman & Obermeyer, 2013; Simbayi et al., 2007b; Sorsdahl et al., 2011; Takada et al., 2014), urban household location (Neuman & Obermeyer, 2013), race (Simbayi et al., 2007b), Xhosa language (Sorsdahl et al., 2011), educational attainment (Neuman & Obermeyer, 2013; Sorsdahl et al., 2011; Takada et al., 2014; Visser & Sipsma, 2013), employment status (Sorsdahl et al., 2011), marital status (Takada et al., 2014) and whether a woman's main contribution to the household was housework (Cuca et al., 2012). Findings on the relationships between internalised stigma and age, gender and educational attainment produced inconsistent directionality. One study found older age to be associated with higher levels of internalised stigma (Visser & Sipsma, 2013), another one found younger age to be associated with higher odds of experiencing internalised stigma (Sorsdahl et al., 2011) and another found no significant association (Takada et al., 2014). Two studies found a positive association between female gender and internalised stigma (Nattabi et al., 2011; Sorsdahl et al., 2011). Another study detected more internalised stigma among men than women (Simbayi et al., 2007b). One study found no relationship between gender and internalised stigma (Takada et al., 2014). Sorsdahl and colleagues (2011) found higher educational attainment to predict higher odds of internalised stigma, whereas Visser and Sipsma (2013) found higher educational attainment to predict lower levels of internalised stigma. Takada and colleagues (2014) found no relationship between educational attainment and internalised stigma. No other socio-demographic factors were significant internalised stigma correlates. Overall, no consistent relationships between socio-demographic factors and internalised stigma were observed.

HIV- and treatment-related factors

The following variables were assessed as potential HIV- and treatment-related correlates of internalised stigma: time since diagnosis (Cloete et al., 2008; Makoae et al., 2009;

Nattabi et al., 2011; Sorsdahl et al., 2011), HIV symptomatology and physical health (Holzemer et al., 2007; Kalichman et al., 2009; Simbayi et al., 2007b; Takada et al., 2014; Tsai et al., 2012; Tsai, Bangsberg, Bwana, et al., 2013), ART use (Nattabi et al., 2011; Simbayi et al., 2007b; Wagner et al., 2013), time on ART (Nattabi et al., 2011; Pearson et al., 2009; Tsai, Bangsberg, Bwana, et al., 2013; Wagner et al., 2013), interaction of time by ART (Makoae et al., 2009), time attending health care facility (Nattabi et al., 2011; Simbayi et al., 2007b) and HIV-related knowledge and misconceptions (Visser & Sipsma, 2013; Visser et al., 2008). Time since diagnosis was associated with less internalised stigma in two cross-sectional studies (Simbayi et al., 2007b; Sorsdahl et al., 2011) with small effect sizes ($r = -.09$, $p < .01$ and $OR = .87$, 95% CI .80–.95, respectively). Longitudinally, Visser and Sipsma (2013) also detected a significant decrease in internalised stigma since diagnosis over a three-year time period. This decline became non-significant when accounting for changes in HIV knowledge and knowing someone with HIV, suggesting potential mediation effects but mediation analysis was not conducted. Makoae et al. (2009) also found that internalised stigma decreased over time for both patients taking and not taking ART.

When compared to no ART use, ART use was not associated with internalised stigma in two cross-sectional (Nattabi et al., 2011; Simbayi et al., 2007b) and one prospective cohort study (Wagner et al., 2013). Time on ART produced inconsistent effects on internalised stigma. Longer time on ART resulted in: an increase in internalised stigma in one study (Pearson et al., 2009); an initial decrease followed by an increase in another study (Peltzer, 2012); and an overall decline in a third study (Tsai, Bangsberg, Bwana, et al., 2013). Peltzer and colleagues found that internalised stigma decreased at 6 and 12 months post-ART initiation but then increased to baseline levels at 20-month follow-up. Tsai et al. (2013) found that the relationship between reduction in internalised stigma and time on ART was mediated by a reduction in HIV symptoms, improved physical and mental health and lower depression scores. However, similarly to Peltzer (2012), they found a slight upward trend in internalised stigma towards the end of the 40-month follow-up.

The interaction between time and ART use on internalised stigma also rendered inconsistent findings. Makoae and colleagues (2009) found that respondents not taking ART experienced a greater decrease in internalised stigma than those taking ART. Conversely, Wagner and colleagues (2013) found that reduction in internalised stigma over time was significantly greater in the ART group compared to the non-ART group. With physical health functioning included in the latter model, the adjusted beta weight for time by ART decreased (from $\beta = -.30$ to $\beta = -.21$), suggesting that the reductions in internalised stigma among ART users might be mediated by improved health. However the paper did not include mediation analysis.

Despite inconsistent findings on how internalised stigma changes over time on ART, indicators of poor HIV-related health and treatment outcomes were consistently associated with more internalised stigma. Specifically, HIV symptom burden weakly correlated ($r = .09-.38$) with more internalised stigma in three cross-sectional studies (Holzemer et al., 2007; Kalichman et al., 2009; Tsai et al., 2012). Poor physical health was also weakly associated with more internalised stigma in one cross-sectional (Tsai et al., 2012; $r = .24$) and two prospective cohort studies (Takada et al., 2014, $\beta = -0.018$; Wagner et al., 2013, $\beta = -0.008$). Holzemer and colleagues (2007) found that higher HIV-related life satisfaction and overall functioning were weakly associated with lower levels of internalised stigma ($r = -.23$ and $r = -.23$).

Intra-personal factors

At the intra-personal level, depression (Cuca et al., 2012; Kalichman et al., 2009; Kingori et al., 2013; Pearson et al., 2009; Takada et al., 2014; Tsai et al., 2012; Visser & Sipsma, 2013; Visser et al., 2008), mental health-related quality of life (Tsai et al., 2012), self-esteem (Visser & Sipsma, 2013; Visser et al., 2008), alcohol and drug use (Simbayi et al., 2007b) and the desire to have children (Nattabi et al., 2011) were assessed. Higher mental health-related quality of life was moderately associated with lower levels of internalised stigma ($r = -.38$) in one cross-sectional study (Tsai et al., 2012). Higher levels of depression were moderately associated with more internalised stigma in six cross-sectional studies (OR = 4.6 in Cuca et al., 2012; $r = .27$ and $.31$ in Kalichman et al., 2009; $r = .35$ in Kingori et al., 2013; $r = .28$ in Tsai et al., 2012; $\beta = .179$ in Visser & Sipsma, 2013) and with lower levels of internalised stigma in one cross-sectional analysis (Pearson et al., 2009). One prospective cohort study found a weak relationship between poor mental health and internalised stigma with an adjusted incidence rate ratio of .79 (Tsai, Bangsberg, Bwana, et al., 2013). Another prospective cohort study found a moderate relationship ($\beta = 0.49$, $p < .001$) between clinical depression and increases in internalised stigma over time (Takada et al., 2014). Higher self-esteem was associated with lower levels of internalised stigma among HIV-positive women ($\beta = -.197$ in Visser & Sipsma, 2013). One study found alcohol and drug use to be weakly correlated with higher levels of internalised stigma cross-sectionally ($r = .1$ and $r = .16$, respectively, in Simbayi et al., 2007a).

Interpersonal factors

At the interpersonal level, social support (Kalichman et al., 2009; Pearson et al., 2009; Simbayi et al., 2007b; Takada et al., 2014; Visser & Sipsma, 2013), perceived stigma (Cuca et al., 2012; Visser & Sipsma, 2013), enacted stigma (Simbayi et al., 2007b), different types of HIV status disclosure (Cuca et al., 2012; Pearson et al., 2009; Sorsdahl et al., 2011; Visser & Sipsma, 2013), HIV status of partner (Nattabi et al., 2011), homosexual versus heterosexual preferences among men (Cloete et al., 2008) and history of sexual abuse among women (Visser & Sipsma, 2013) were assessed. All cross-sectional studies assessing social support found that it was weakly associated with lower levels of internalised stigma: $r = -.32$ and $r = -.08$ in Kalichman et al. (2009); $r = -0.12$ in Pearson et al. (2009); $r = -.29$ in Simbayi et al. (2007a); $r = -.11$ in Visser and Sipsma (2013). However, the only prospective cohort study assessing whether social support predicts changes in internalised stigma over time found no significant relationship between emotional and tangible social support and internalised stigma (Takada et al., 2014). Perceived stigma (Visser & Sipsma, 2013) and different forms of enacted stigma (Holzemer et al., 2007; Kalichman et al., 2009; Simbayi et al., 2007b) were weakly to moderately associated with higher levels of internalised stigma in bivariate cross-sectional analyses ($r = .17-.42$).

Various aspects of serostatus disclosure were assessed. Respondents who had not disclosed their HIV status to others reported higher odds of internalised stigma in one cross-sectional study (OR = 3.11 in Sorsdahl et al., 2011) and lower levels of internalised stigma in another ($\beta = -0.085$ in Visser & Sipsma 2013). Having disclosed one's HIV status to fewer people was weakly associated with higher levels of internalised stigma ($r = -0.24$) cross-sectionally (Pearson et al., 2009). Pearson and colleagues (2009) also

found that having disclosed to family, friends or co-workers was associated with lower levels of internalised stigma when compared to having disclosed to other people.

Discussion

This review included 7 papers on predictors and 11 papers on correlates of internalised HIV stigma. These papers represented 13 unique samples and a total of 9088 PLHIV across nine sub-Saharan African countries. Of the factors that were analysed longitudinally:

- (1) *ART use did not significantly influence internalised HIV stigma in the only study that examined this predictor prospectively.*
- (2) *Improved physical health (measured as improved physical functioning and fewer HIV-related symptoms) weakly predicted reductions in internalised HIV stigma in three longitudinal studies.* One of these studies tested a lagged mediation model in which fewer HIV-related symptoms and improved physical health mediated the relationship between time on ART and reduced internalised stigma.
- (3) *Lower depression scores and improvements in overall mental health predicted reductions in internalised HIV stigma in two longitudinal studies, with moderate and weak effects, respectively.* One of these studies tested a lagged mediation model, which suggested that the decrease of internalised stigma over time on ART was mediated via improved mental health (in addition to improved physical health as summarised above).
- (4) *Time on ART produced inconsistent findings.* Internalised HIV stigma decreased over time in two studies, increased over time in another two studies, initially decreased but then returned to baseline levels in one study and produced non-significant effects in one study.
- (5) *The interaction of time and ART use produced inconsistent findings.* One study found that internalised stigma decreased more over time for those on ART, compared to those not on ART. Another study found the opposite trend: internalised stigma decreased more for those not on ART, compared to those on ART.

Implications for research

As is common in a nascent field, the majority of included studies were cross-sectional, with two-thirds of included studies scoring below 50% on the CQC. Longitudinal evidence is now needed to establish causality. Future research is also needed to help resolve inconsistent directionality of findings. The present review highlights inconsistent findings on the relationship between internalised stigma and socio-demographic variables, as well as on how internalised stigma changes over time on ART. More prospective longitudinal studies with analyses controlling for planned confounds are needed to resolve these discrepancies.

Some of the noted discrepancies in findings might be a reflection of the differing ways in which internalised stigma was measured. Given that stigma manifestations are culturally and socially embedded, it would be difficult to use a single measurement across sub-Saharan Africa. Future studies would benefit from using tools with strong psychometric properties. However, a recent systematic review on psychometric properties of internalised stigma measurements confirmed that such tools are scarce (Stevelinck, Wu,

Voorend, & Van Brakel, 2012). More reliable stigma measurement tools relevant to the African contexts are needed.

There were some notable gaps in the literature. In terms of high-risk populations, internalised stigma was studied only among women attending antenatal clinics and men who have sex with men. Studies assessing factors contributing to compounded stigma among populations living with HIV in sub-Saharan Africa are also needed as no known interventions tackle compounded stigma (Stangl et al., 2013). Evidence from the USA suggests that high-risk behaviours linked to HIV such as same-sex intercourse and bartering sex contribute to the layering of HIV stigma (Swendeman, Rotheram-borus, Comulada, Weiss, & Ramos, 2006). The only included study to assess the role of HIV risk behaviour examined the association between homosexual orientation and internalised stigma (Cloete et al., 2008). An HIV risk highly pertinent to the African context is transactional sex (Jewkes & Dunkle, 2012) and research examining links between transactional sex and internalised stigma is needed.

Internalised stigma was not assessed among children, nor among adolescents living with HIV, despite high HIV incidence and prevalence in this age group in sub-Saharan Africa (UNAIDS, 2013). This high-risk group faces unique challenges (Li et al., 2010). Adolescence is characterised by social and biological transitions, often compromising youth's self-worth and general self-esteem (Wigfield, Eccles, Mac Iver, Reuman, & Midgley, 1991). Self-perception of adolescents living with HIV is likely to be further threatened by difficulties associated with transition from paediatric to adult HIV care, HIV status disclosure to peers (Wiener & Battles, 2006), the shame associated with young people's sexuality (Campbell, Nair, Maimane, & Nicholson, 2007), parental AIDS illness and death (Battles & Wiener, 2002; Cluver, Orkin, Boyes, Gardner, & Nikelo, 2012) and the resultant poverty, stigma and bullying victimisation (Cluver & Orkin, 2009). Longitudinal evidence also suggests that adolescents who have lost a parent due to AIDS are at heightened risk of psychological distress due to stigma-by-association (Boyes & Cluver, 2013). Therefore it is essential to investigate internalised stigma in this high-risk age group, particularly as African epidemics witness the first generation of perinatally infected children entering adolescence due to the late roll-out of ART in the region (Ferrand, Corbett, Wood, Hargrove, & Chiratidzo, 2012). Given that HIV transmission in sub-Saharan Africa is driven by heterosexual intercourse and mother-to-child transmission (UNAIDS, 2010), research is needed to assess potentially differing pathways to internalised stigma among perinatally versus post-natally infected child and adolescent populations.

No studies assessed how poverty relates to internalised HIV stigma. Two included papers discussed the potential role of poverty in limiting longitudinal reductions in internalised stigma (Peltzer, 2012; Tsai, Bangsberg, Bwana, et al., 2013). Having found increases in internalised stigma after initial declines over time on treatment, Tsai et al. (2013) argue that asset depletion might cause a floor effect in stigma reduction. Similarly, Peltzer (2012) suggests that persistent treatment-related costs and loss of the disability grants due to improved clinical outcomes might compromise health-related quality of life in South Africa. In the context of sub-Saharan Africa, poverty might exclude HIV-positive people from local 'solidarity networks' by undermining their ability to maintain economic contributions to community life (Tsai, Bangsberg, & Weiser, 2013). Poverty might also perpetuate stigmatisation by undermining adherence to treatment, for instance due to food shortage (Kalichman & Grebler, 2010), thereby resulting in worsened health outcomes and symptom visibility. A similar mechanism might exist between lack of

access to health care and stigma. Future studies should therefore examine potential causal relationships between material and service deprivation and HIV stigmas. Associations between internalised stigma and perceived and enacted stigma were only assessed in three papers through bivariate correlations. These relationships should be further examined through robust analyses to inform theory.

Limitations

The search did not include any language restrictions, but due to resource constraints, we were only able to include records written in English. However, our search did not detect any relevant non-English papers. The review focused on observational studies, and future randomised trials will be valuable in increasing capacity for causality inference (Smith & Ebrahim, 2002). However, the current shortage of randomised trials to reduce internalised stigma in sub-Saharan Africa (Stangl et al., 2013) rendered a review of observational studies necessary. Furthermore, a meta-analysis was not conducted as diversity between studies and cross-sectional findings limit inferences about causality and strength of effect.

Given that this review focused on *predictors* of internalised stigma, only studies that assessed internalised stigma as a dependent variable were included. This resulted in the omission of a considerable amount of cross-sectional work on correlates of internalised stigma. However, such studies were excluded because they hypothesised internalised stigma to be a cause (rather than effect) of the correlates under scrutiny. Findings from such studies by definition lack the needed theoretical underpinning to generate hypotheses about predictors of internalised stigma.

Conclusions

Research on predictors of internalised HIV stigma in sub-Saharan Africa is in its early stages. Therefore this review generated a wide range of implications for research, with no firm implications for practice. With only a year remaining before the 2015 target for eliminating HIV stigma, internalised stigma continues to be a problem. More foundational, longitudinal research is urgently needed to inform understanding of the causal paths and design interventions. In particular future studies can contribute to this field by utilising analyses of change and accounting for planned, literature-informed confounds. It is necessary to carry out studies on high-risk populations, different modes of HIV transmission, other stigma markers that might layer upon internalised stigma and drivers of internalised stigma at multiple levels. Based on findings from this review, improving the physical health and psychological well-being of PLHIV might contribute to slight reductions in internalised HIV stigma. However, it is essential that further research establishes additional effective interventions.

Acknowledgements

We would like to thank authors of primary studies included in this review for pioneering crucial work on internalised HIV/AIDS stigma in sub-Saharan Africa. We are also grateful for the assistance from researchers who have supplied the additional information and references needed to complete this review, in particular Alexander Tsai, Yvette Cuca, Eme Owoaye, Cynthia Pearson, Maretha Visser, Leickness Simbanyi, Seth Kalichman, Michael Evangeli, Nuala McGrath and Cilna de Kock.

Funding

This work was supported by the Joint Green Templeton College – Clarendon Scholarship, University of Oxford and the the European Research Council under the European Union's Seventh Framework Programme (FP7/2007-2013)/ERC agreement n°313421.

Supplemental material

Supplemental material for this article can be accessed here: <http://dx.doi.org/10.1080/17437199.2014.996243>.

References

- Battles, H. B., & Wiener, L. S. (2002). From adolescence through young adulthood: Psychosocial adjustment associated with long-term survival of HIV. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, 30, 161–168. Retrieved from <http://www.ncbi.nlm.nih.gov/pubmed/11869922>
- Boyes, M. E., & Cluver, L. D. (2013). Relationships among HIV/AIDS orphanhood, stigma, and symptoms of anxiety and depression in South African youth: A longitudinal investigation using a path analysis framework. *Clinical Psychological Science*, 1, 323–330. doi:10.1177/2167702613478595
- Campbell, C., & Deacon, H. (2006). Unravelling the contexts of stigma: From internalisation to resistance to change. *Journal of Community & Applied Social Psychology*, 16, 411–417. doi:10.1002/casp.901
- Campbell, C., Nair, Y., Maimane, S., & Nicholson, J. (2007). 'Dying Twice': A multi-level model of the roots of AIDS stigma in two South African communities. *Journal of Health Psychology*, 12, 403–416. doi:10.1177/1359105307076229
- CDC. (2013). *HIV in the United States: At a glance*. Washington, DC: Department of Health & Human Services USA. Retrieved from http://www.cdc.gov/hiv/pdf/statistics_basics_factsheet.pdf
- Cloete, A., Simbayi, L. C., Kalichman, S. C., Strebel, A., & Henda, N. (2008). Stigma and discrimination experiences of HIV-positive men who have sex with men in Cape Town, South Africa. *AIDS Care*, 20, 1105–1110. doi:10.1080/09540120701842720
- Cluver, L., & Orkin, M. (2009). Cumulative risk and AIDS-orphanhood: Interactions of stigma, bullying and poverty on child mental health in South Africa. *Social Science & Medicine*, 69, 1186–1193. doi:10.1016/j.socscimed.2009.07.033
- Cluver, L., Orkin, M., Boyes, M. E., Gardner, F., & Nikelo, J. (2012). AIDS-orphanhood and caregiver HIV/AIDS sickness status: Effects on psychological symptoms in South African youth. *Journal of Pediatric Psychology*, 37, 857–867. doi:10.1093/jpepsy/jss004
- Cuca, Y. P., Onono, M., Bukusi, E., & Turan, J. M. (2012). Factors associated with pregnant women's anticipations and experiences of HIV-related stigma in rural Kenya. *AIDS Care*, 24, 1173–1180. doi:10.1080/09540121.2012.699669
- Deeks, J. J., Higgins, J., & Altman, D. G. (2008). Analysing data and undertaking meta-analyses. In J. P. T. Higgins & S. Green (Eds.), *Cochrane handbook for systematic reviews of interventions: Cochrane book series* (pp. 243–296). The Cochrane Collaboration. Retrieved from www.cochrane-handbook.org
- Ferrand, R. A., Corbett, E. L., Wood, R., Hargrove, J., & Chiratidzo, E. (2012). AIDS among older children and adolescents in Southern Africa: Projecting the time course and magnitude of the epidemic. *AIDS*, 23, 2039–2046. doi:10.1097/QAD.0b013e32833016ce.AIDS
- Fraser, M. W., Richman, J. M., Galinsky, M. J., & Day, S. H. (2009). *Intervention research: Developing social programs*. New York, NY: Oxford University Press.
- Furlan, A. D., Pennick, V., Bombardier, C., & van Tulder, M. (2009). 2009 updated method guidelines for systematic reviews in the Cochrane Back Review Group. *SPINE*, 34, 1929–1941. doi:10.1097/BRS.0b013e3181b1c99f
- Garg, A. X., Hackam, D., & Tonelli, M. (2008). Systematic review and meta-analysis: When one study is just not enough. *Clinical Journal of the American Society of Nephrology: CJASN*, 3, 253–260. doi:10.2215/CJN.01430307

- Gilmore, N., & Somerville, M. A. (1994). Stigmatization, scapegoating and discrimination in sexually transmitted diseases: Overcoming 'them' and 'us'. *Social Science & Medicine*, *39*, 1339–1358. doi:10.1016/0277-9536(94)90365-4
- Gross, R., Yip, B., Lo, V., Iii, R., Wood, E., Alexander, C. S., ... Hogg, R. S. (2006). A simple, dynamic measure of antiretroviral therapy adherence predicts failure to maintain HIV-1 suppression. *The Journal of Infectious Diseases*, *6021*, 1108–1114.
- Holzemer, W. L., Uys, L. R., Chirwa, M. L., Greeff, M., Makoae, L. N., Kohi, T. W., ... Durrheim, K. (2007). Validation of the HIV/AIDS stigma instrument – PLWA (HASI-P). *AIDS Care*, *19*, 1002–1012. doi:10.1080/09540120701245999
- Horwitz, R. H., Tsai, A. C., Maling, S., Bajunirwe, F., Haberer, J. E., Emenyonu, N., & Bangsberg, D. R. (2013). No association found between traditional healer use and delayed antiretroviral initiation in rural Uganda. *AIDS and Behavior*, *17*, 260–265. doi:10.1007/s10461-011-0132-7
- Jewkes, R., & Dunkle, K. (2012). Transactional sex and HIV incidence in a cohort of young women in the stepping stones trial. *Journal of AIDS & Clinical Research*, *3*(5), 3–5. doi:10.4172/2155-6113.1000158
- Kalichman, S. C., & Grebler, T. (2010). Stress and poverty predictors of treatment adherence among people with low-literacy living with HIV/AIDS. *Psychosomatic Medicine*, *71*, 810–816.
- Kalichman, S. C., Simbayi, L. C., Cloete, A., Mthembu, P. P., Mkhonta, R. N., & Ginindza, T. (2009). Measuring AIDS stigmas in people living with HIV/AIDS: The internalized AIDS-related stigma scale. *AIDS Care*, *21*(1), 87–93. doi:10.1080/09540120802032627
- Katiria Perez, G., & Cruess, D. (2014). The impact of familism on physical and mental health among Hispanics in the United States. *Health Psychology Review*, *8*(1), 95–127. doi:10.1080/17437199.2011.569936
- Katz, I. T., Ryu, A. E., Onuegbu, A. G., Psaros, C., Weiser, S. D., Bangsberg, D. R., & Tsai, A. C. (2013). Impact of HIV-related stigma on treatment adherence: Systematic review and meta-synthesis. *Journal of the International AIDS Society*, *16*(3 Suppl 2), 18640. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3833107&tool=pmcentrez&rendertype=abstract>
- Kingori, C., Reece, M., Obeng, S., Murray, M., Shacham, E., Dodge, B., ... Ojaka, D. (2013). Psychometric evaluation of a cross-culturally adapted felt stigma questionnaire among people living with HIV in Kenya. *AIDS Patient Care and STDs*, *27*, 481–488. doi:10.1089/apc.2012.0403
- Lee, R. S., Kochman, A., & Sikkema, K. J. (2002). Internalized stigma among people living with HIV/AIDS. *AIDS and Behavior*, *6*, 309–319. doi:10.1023/A:1021144511957
- Li, R. J., Jaspal, H. B., O'Brien, V., Rabie, H., Cotton, M. F., & Nattrass, N. (2010). Positive futures: A qualitative study on the needs of adolescents on antiretroviral therapy in South Africa. *AIDS Care*, *22*, 751–758. doi:10.1080/09540120903431363
- Lima, V. D., Harrigan, R., Bangsberg, D. R., Hogg, R. S., Gross, R., Yip, B., & Montaner, J. S. G. (2009). The combined effect of modern highly active antiretroviral therapy regimens and adherence on mortality over time. *Journal of Acquired Immune Deficiency Syndrome*, *50*, 529–536. doi:10.1097/QAI.0b013e31819675e9
- Link, B. G. (1987). Understanding Labeling Effects in the Area of Mental Disorders: An Assessment of the Effects of Expectations of Rejection. *American Sociological Review*, *52*(1), 96–112. doi:10.2307/2095395
- Link, B. G., Cullen, F. T., Struening, E., Shrout, P. E., & Dohrenwend, B.P. (1989). A modified labeling theory approach to mental disorders: An empirical assessment. *American Sociological Review*, *54*, 400–423. doi: 10.2307/2095613
- Loder, E., Groves, T., & MacAuley, D. (2010). Registration of observational studies: The next step towards research transparency. *BMJ*, *340*, 375–376. doi:10.1136/bmj.c657
- Logie, C., & Gadalla, T. M. (2009). Meta-analysis of health and demographic correlates of stigma towards people living with HIV. *AIDS Care*, *21*, 742–753. doi:10.1080/09540120802511877
- Loutfy, M. R., Wu, W., Letchumanan, M., Bondy, L., Antoniou, T., Margolese, S., ... Rochon, P. A. (2013). Systematic review of HIV transmission between heterosexual serodiscordant couples where the HIV-positive partner is fully suppressed on antiretroviral therapy. *PLoS One*, *8*(2), e55747. doi:10.1371/journal.pone.0055747
- Makoae, L. N., Portillo, C. J., Uys, L. R., Dlamini, P. S., Greeff, M., Chirwa, M., ... Holzemer, W. L. (2009). The impact of taking or not taking ARVs on HIV stigma as reported by persons

- living with HIV infection in five African countries. *AIDS Care*, 21, 1357–1362. doi:10.1080/09540120902862576
- Mbonu, N. C., van den Borne, B., & De Vries, N. K. (2009). Stigma of people with HIV/AIDS in sub-Saharan Africa: A literature review. *Journal of Tropical Medicine*, 2009, 145891. doi:10.1155/2009/145891
- Moher, D., Liberati, A., Tetziaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *PLoS Medicine*, 6(6), 1–2. doi:10.1371/journal.pmed1000097
- Murray, J., Farrington, D. P., & Eisner, M. P. (2009). Drawing conclusions about causes from systematic reviews of risk factors: The Cambridge Quality Checklists. *Journal of Experimental Criminology*, 5(1), 1–23. doi:10.1007/s11292-008-9066-0
- Nattabi, B., Li, J., Thompson, S. C., Orach, C. G., & Earnest, J. (2011). Factors associated with perceived stigma among people living with HIV/AIDS in post-conflict northern Uganda. *AIDS Education and Prevention*, 23, 193–205. doi:10.1521/aeap.2011.23.3.193
- Neuman, M., & Obermeyer, C. M. (2013). Experiences of stigma, discrimination, care and support among people living with HIV: A four country study. *AIDS and Behavior*, 17, 1796–1808. doi:10.1007/s10461-013-0432-1
- Pearson, C. R., Micek, M. A., Pfeiffer, J., Montoya, P., Matediane, E., Jonasse, T., ... Gloyd, S. S. (2009). One year after art initiation: Psychosocial factors associated with stigma among HIV-positive Mozambicans. *AIDS and Behavior*, 13, 1189–1196. doi:10.1007/s10461-009-9596-0
- Peltzer, K. (2012). Health-related quality of life and antiretroviral therapy in Kwazulu-Natal, South Africa. *Social Behavior and Personality*, 40(2), 273–279.
- Ras, G. S., Simson, I. W., Anderson, R., Prozesky, O. W., & Hamersma, T. (1983). Acquired immunodeficiency syndrome. A report of 2 South African cases. *South African Medical Journal*, 64(4), 140–142.
- Scheff, T. J. (1966). *Being mentally ill: A sociological theory*. Chicago, IL: Aldine.
- Sengupta, S., Banks, B., Jonas, D., Miles, M. S., & Smith, G. C. (2011). HIV interventions to reduce HIV/AIDS stigma: A systematic review. *AIDS and Behavior*, 15, 1075–1087. doi:10.1007/s10461-010-9847-0
- Simbayi, L. C., Kalichman, S., Strebel, A., Cloete, A., Henda, N., & Mqeketo, A. (2007a). Disclosure of HIV status to sex partners and sexual risk behaviours among HIV-positive men and women, Cape Town, South Africa. *Sexually Transmitted Infections*, 83(1), 29–34. doi:10.1136/sti.2006.019893
- Simbayi, L. C., Kalichman, S., Strebel, A., Cloete, A., Henda, N., & Mqeketo, A. (2007b). Internalized stigma, discrimination, and depression among men and women living with HIV/AIDS in Cape Town, South Africa. *Social Science & Medicine*, 64, 1823–1831. doi:10.1016/j.socscimed.2007.01.006
- Smith, G. D., & Ebrahim, S. (2002). Data dredging, bias, or confounding. *BMJ (Clinical Research Ed.)*, 325, 1437–1438. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1124898&tool=pmcentrez&rendertype=abstract>
- Sorsdahl, K., Mall, S., Stein, D. J., & Joska, J. A. (2011). The prevalence and predictors of stigma amongst people living with HIV/AIDS in the Western Province. *AIDS Care*, 23, 680–685. doi:10.1080/09540121.2010.525621
- Stangl, A. L., Lloyd, J. K., Brady, L. M., Holland, C. E., & Baral, S. (2013). A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: How far have we come? *Journal of the International AIDS Society*, 16, 3–11.
- Stevenson, S. A. M., Wu, I. C., Voorend, C. G. N., & Van Brakel, W. H. (2012). The psychometric assessment of internalized stigma instruments: A systematic review. *Stigma, Research and Action*, 2(2), 100–118.
- Swendeman, D., Rotheram-borus, M. J., Comulada, S., Weiss, R., & Ramos, M. E. (2006). Predictors of HIV-related stigma among young people living with HIV. *Health Psychology*, 25, 501–509. doi:10.1037/0278-6133.25.4.501
- Takada, S., Weiser, S. D., Kumbakumba, E., Muzoora, C., Martin, J. N., Hunt, P. W., ... Tsai, A. C. (2014). The dynamic relationship between social support and HIV-related stigma in rural Uganda. *Annals of Behavioral Medicine: A Publication of the Society of Behavioral Medicine*, 48(1), 26–37. doi:10.1007/s12160-013-9576-5

- Tsai, A. C., Bangsberg, D. R., Bwana, M., Haberer, J. E., Frongillo, E. A., Muzoora, C., ... Weiser, S. D. (2013). How does antiretroviral treatment attenuate the stigma of HIV? Evidence from a cohort study in rural Uganda. *AIDS and Behavior, 17*, 2725–2731.
- Tsai, A. C., Bangsberg, D. R., Kegeles, S. M., Katz, I. T., Haberer, J. E., Muzoora, C., ... Weiser, S. D. (2013). Internalized Stigma, social distance, and disclosure of HIV seropositivity in rural Uganda. *Annals of Behavioral Medicine, 46*, 288–290.
- Tsai, A. C., Bangsberg, D. R., & Weiser, S. D. (2013). Harnessing poverty alleviation to reduce the stigma of HIV in sub-Saharan Africa. *PLoS Medicine, 10*(11), e1001557. doi:10.1371/journal.pmed.1001557
- Tsai, A. C., Weiser, S. D., Steward, W. T., Mukiibi, N. F. B., Kawuma, A., Kembabazi, A., ... Bangsberg, D. R. (2012). Evidence for the reliability and validity of the internalized AIDS-related stigma scale in rural Uganda. *AIDS and Behavior, 17*(1), 427–433. doi:10.1007/s10461-012-0281-3
- Tshabalala, J., & Visser, M. (2011). Developing a cognitive behavioural therapy model to assist women to deal with HIV and stigma. *South African Journal of Psychology, 41*(1), 17–28. doi:10.1177/008124631104100103
- UNAIDS. (2007). *Reducing HIV stigma and discrimination: A critical part of national AIDS programmes*. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS. (2010). *Global report: UNAIDS report on the global AIDS epidemic*. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS. (2011). *2011 United Nations general assembly political declaration on HIV/AIDS: Targets and elimination commitments*. Geneva: Joint United Nations Programme on HIV/AIDS.
- UNAIDS. (2013). *Global report: UNAIDS report on the global AIDS epidemic 2013*. Geneva: Joint United Nations Programme on HIV/AIDS.
- Uys, L., Chirwa, M., Kohi, T., Greeff, M., Naidoo, J., Makoae, L., ... Holzemer, W. L. (2009). Evaluation of a health setting-based stigma intervention in five African countries. *AIDS Patient Care and STDs, 23*, 1059–1066. doi:10.1089/apc.2009.0085
- Visser, M., Kershaw, T., Makin, J. D., & Forsyth, B. W. C. (2008). Development of parallel scales to measure HIV-related stigma. *AIDS and Behavior, 12*, 759–771. doi:10.1007/s10461-008-9363-7
- Visser, M., & Sipsma, H. (2013). The experience of HIV-related stigma in South Africa. In P. Liamputtong (Ed.), *Stigma, discrimination and living with HIV/AIDS: A cross cultural perspective* (pp. 205–227). Dordrecht: Springer.
- Wagner, G. J., Ghosh-Dastidar, B., Garnett, J., Kityo, C., & Mugenyi, P. (2013). Impact of HIV antiretroviral therapy on depression and mental health among clients with HIV in Uganda. *Psychosomatic Medicine, 74*, 883–890. doi:10.1097/PSY.0b013e31826629db
- Weed, D. L. (2010). Meta-analysis and causal inference: A case study of benzene and non-Hodgkin lymphoma. *Annals of Epidemiology, 20*, 347–355. doi:10.1016/j.annepidem.2010.02.001
- Wiener, L. S., & Battles, H. B. (2006). Untangling the web: A close look at diagnosis disclosure among HIV-infected adolescents. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 38*, 307–309. doi:10.1016/j.jadohealth.2005.03.024
- Wigfield, A., Eccles, J. S., Mac Iver, D., Reuman, D. A., & Midgley, C. (1991). Transitions during early adolescence: Changes in children's domain-specific self-perceptions and general self-esteem across the transition to junior high school. *Developmental Psychology, 27*, 552–565. doi:10.1037/0012-1649.27.4.552