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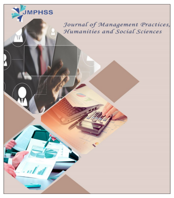

ORIGINAL CONTRIBUTION

The Effect of Stigmatization on Perceived Social Support and Quality of Life among Hiv/Aids Patients: A Gender-Based Analysis

Nadia Hameed [1*], Prof. Dr. Erum Irshad [2],

[1]Consultant Clinical Psychologist, Psychiatry and Behavioral Sciences Unit, Hayatabad Medical Complex, Peshawar, Pakistan

[2]Chairperson, Department of Psychology, University of Peshawar, Peshawar, Pakistan

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Abstract— The current study set out to find out how patients' views of social support and quality of life are impacted by stigma. Additionally, the quality of life of patients and gender variations in HIV stigma, social support, and other factors were compared. It was expected that male patients would do better than female patients on tests measuring stigma, perceived social support, and quality of life. A total of 269 HIV/AIDS patients, including those who were 18 years of age or older and either male (n=170) or female (n=99), made up the sample for the current study. Purposeful sampling was used to collect the sample from the Provincial AIDS Control Program (PACP) facility at the Hayatabad Medical Complex in Peshawar. The WHO Quality of Life Scale (WHOQOL, BREF), HIV Stigma Scale (HISS), and the Multidimensional Scale of Perceived Social Support (MSPSS) were administered separately. The data were analyzed using the independent t-test. The results showed a significant difference in the WHO quality of life score between HIV patients in men and women. However, there were no statistically significant differences between male and female HIV patients on the Multidimensional Scale of Perceived Social Support and the HIV stigma scale factors. In light of the research findings, further discoveries and potential long-term implications were examined at the conclusion.

Index Terms— HIV/AIDS, Perceived social support, Quality of life, People living with HIV, People who inject drugs.

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Introduction

The idea that men are superior to women due to their muscularity is one of the frequent societal assumptions. Men have more sexual freedom than women do in many societies, and they are permitted to engage in forceful sexual behavior with women, have sex with several partners, and have sex before marriage. Additionally, the fact that most cultures view men as the family's primary breadwinner has contributed to the likelihood of infection in their partners. Due to their frustration, inferiority complex, and low self-esteem, people who are unemployed or struggling financially are more likely to engage in maladaptive behavior patterns like drinking, using drugs, and engaging in sexual activity, which not only increases their risk of contracting HIV not only to them but also to their partners. Furthermore, it is concluded that the negative evaluation of people about HIV and the stigma attached with illness drastically affects the social, interpersonal, occupational life of an individual affected with HIV/AIDS. (UNAIDS, 2001). Cultural beliefs, misconceptions, and misinterpretation about

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*Email: nadiahameed.icp@gmail.com

HIV/AIDS and its transmission on a community level result in stigma and discrimination. In many societies, HIV is associated with malpractices and labeling infected individuals as characterless, disgraceful, and deviant. Therefore, HIV-positive individuals are stigmatized and discriminated due to preexisting belief systems (Kegeles et al. 1989; Panos 1990; Warwick et al. 1998).

HIV virus spreads frequently and significantly through unprotected sex and the secretion of bodily fluids released during sexual activity. Therefore, it is considered one of the common modes of transmission of virus transmission from an infected male to a woman, to another man, or vice versa. Similar to this, The Joint United Nations Programme on HIV/AIDS [UNAIDS], 2000, considers the existence of any sexually transmitted disease (STD) as one of the important factors contributing to HIV transmission during sexual activity.

Many cultures around the world discourage women from participating in decision-making. They don't discuss condom use or safe sex with their partners, which raises the chance of HIV transmission in the female partner if the male is already infected. Most of the time, HIV-positive male partners do not disclose their status to their female companions due to fear of stigma and associated rejection, criticism, and termination of the relationship (UNAIDS 2001).

On the other side, in our society, a group of people prefers to have a sexual relationship with a same-sex partner and engage in men-to-men sex. There are various reasons, including pleasure-seeking, attraction to same-sex relationships, the lack of access to female partners, and economic considerations. Therefore, the risk of HIV transmission increases when they have sexual contact with female sex partners (UNAIDS, 2001).

Research objective

The following objective were the focus of the current study, which took into account the literature review on stigma, perceived social support, and quality of life among HIV/AIDS patients.

- To study the gender-based differences in stigma related to HIV/AIDS social support and quality of life.

Literature Review

A study on perceived stigma among HIV patients by gender conducted in India found no differences in perceived stigma; both genders were stigmatized equally by society due to their health status. Instead, the majority of the women HIV patients reported experiencing hopelessness and psychological problems (Chivate et al., 2017).

Although there is limited research on the gender-based differences in people living with HIV and their quality of life. A study on the quality of life of female HIV patients and the demographic factors which affected their quality of life found that, despite advances in HIV treatment and public awareness of the disease's causes, women with the virus still find it difficult to accept their health condition and prefer to conceal it. Consequently, it has an undesirable impact on their general quality of life. Other factors affecting their quality of life include old age, poor literacy rates, financial situation, and income (Pereira Santos et al., 2016).

Similarly, a study conducted on a diverse population of HIV-infected patients (sex workers, heterosexual adults from the general population) discovered that social support plays an important role in both physical and mental well-being. It has been determined that there is a strong association between social support and risky behaviors such as drug addiction, negative self-image, and suicide in HIV patients (Qiao, S., Li, X. & Stanton, B., 2014).

While researching the connection between age, gender, social support, and psychological well-being, Oppong Asante (2012) brought attention to the fact that social support reduces the signs of stress, anxiety, and depression in HIV patients. In addition, compared to males, women with weak social support experienced higher stress, anxiety, and depression levels.

According to a study by Rueda et al. (2016), patients with HIV reported poor adherence to antiretroviral therapy due to associated stigma and a lack of social support, which also increases the intensity of depressive symptoms and exacerbates the physiological symptoms of HIV/AIDS. On the other hand HIV related stigma adversely affects the life people living with HIV/AIDS. Furthermore, it undesirably shakes the physical health, emotional and mental well-being of an individual.

The effects of HIV/AIDS are severe on the affected person and society. In order to optimize therapy and other therapeutic outcomes for HIV patients, it is crucial to evaluate the nature and quality of life of people living with HIV. Because HIV/AIDS is a stigmatizing disease and still an incurable condition, multiple bio-psycho-social implications have adverse impacts on people's quality of life (Herrmann et al., 2013).

In 2011, Vyavaharkar et al. carried out a cross-sectional study on women living with HIV in the Southeast of United States. The results showed that HIV patients' contentment with the available support system and their perceptions of the availability of assistance, including support from family, friends, and a significant other, all play a role in their decision to disclose their condition to others in their social circle. Additionally, the satisfaction of HIV patients with the support systems that are accessible helps to reduce sadness and other psychological diseases by positively influencing the disclosure of HIV sickness. Furthermore, it has been observed that effective self-disclosure may aid in lowering depression and enhancing quality of life among infected African American women.

Rationale

HIV/AIDS severely impacts persons who have the disease, their families, communities, and entire societies on a psychological, social, and financial level. The development of a wide range of psychological and social problems during the course of the illness, as well as the stigma that goes along with them, have a substantial impact on the outlook and standard of life of HIV-positive individuals. Even while these individuals may now successfully manage their illnesses and lead fulfilling lives, the stigma associated with it still discourages some people from getting the help they need. It is complicated by the negative opinions that people have toward the condition. Because of the stigma, persons with mental illnesses started to avoid social situations out of concern for how others might see them as individuals and out of fear of rejection in public.

In the context of Pakistani culture, it is imperative to consider the psychological load associated with HIV/AIDS and the role of social support and its effects on people's quality of life. In light of this, the current study's objective is to investigate the stigma attached to HIV/AIDS patients and how social support impacts those affected. It also takes into account aspects like access to social assistance, how stigmatization impacts a person with HIV/quality AIDS's of life and other issues. It is also investigated how gender-based stigma affects social support and the standard of living for HIV/AIDS patients. The study's findings are important, particularly for the medical professionals treating HIV/AIDS patients in our community. Suppose doctors and other health professionals are aware of stigma and how it impacts HIV/AIDS patients' social support networks. In that case, they will be better equipped to develop coping techniques that will lessen general psychological distress.

The current study brought attention to the differences between genders in HIV/AIDS patient stigma, social support, and quality of life. The fact that men are granted total authority over the family since they are the main breadwinners causes women to face a number of challenges in the local culture, including a lack of money, a lack of knowledge, and the inability to make decisions that even directly affect their own life. Even Nevertheless, women who take on all household duties, rear children, and provide for the entire family's needs are more likely to become ill. In most circumstances, this decreases their quality of life and increases their risk of sickness. To improve their general quality of life and well-being, it is essential to inform and guide them about their fundamental rights and increase their understanding of the significance of their involvement in decisions regarding safe sex, how to approach a healthcare facility, and how to adhere to treatment.

Hypotheses and operational definitions

Hypotheses

The current study was conducted to investigate the following hypotheses.

- Male patients living with HIV/AIDS will score high on stigmatization as compare to female patients living with HIV/AIDS.
- Female patients living with HIV/AIDS will score low on perceived social support as compare to male counterpart.
- Female patients living with HIV/AIDS will have poorer quality of life as compare to male patients living with HIV/AIDS.

Operational Definitions

HIV stigma

As “attribute that is profoundly offensive," stigma is described. A negative attribute could be overt and unnoticed but still reveal able if someone knew about it, like a criminal record or a history of mental illness, or it could be outwardly obvious, like skin color or size, but yet unnoticeable (Goffman, 1963, p 3). Simply it is the discrimination experienced by people with HIV/AIDS as a result of their illness (Berger et al., 2001). The four basic perspectives on HIV-related stigma are individual stigma, disclosure concerns, bad self-image, and worries about public opinion.

Social support

A person's perception of their own resources that can serve as a stress reliever in tough times and aid them in managing a variety of life conditions is referred to as perceived social support. They describe three forms of social support (support from family, friends, and significant others) that, when combined, can better people's lives and help them deal with challenging circumstances (Zimet et al., 1988).

Quality of life

According to the World Health Organization (WHO), "QOL" refers to a person's perception of where they are in life in relation to their goals, standards, and concerns in light of the cultural value and the overall system in which they are raised (WHO, 1996). The four sub-domains of social relationships, environmental factors, psychological well-being, and physical health are highlighted by the World Health Organization.

Methodology

The target population, sample, measures, methods, ethical considerations, scoring, statistical analysis, and operational definitions of various terminologies are all included in this section.

Sample

The overall number of participants in the trial was 269 people with varied stages of HIV/AIDS. In addition, patients who were 18 years of age or older made up the sample, including 170 men and 99 women. The average age of the population was 33.13 (SD: 9.37), but the average age of the HIV-positive patients was 34.65 (SD: 7.37) for women and 32.82 (SD: 9.74) for males. The sample included individuals from low, middle, and high socioeconomic classes. Participants from the Provincial AIDS Control Program (PACP) Centers in Peshawar's Hayatabad Medical Complex (HMC) were selected using a purposeful sampling technique.

Inclusion criteria

- Participants who were older than 18 were included.
- Married and single people were both included.
- Both educated and uneducated individuals were included.
- Both urban and rural areas were represented among the participants.

Exclusion Criteria

- Ages under 18 were disallowed

Instruments

Demographic information sheet

The demographic information sheet, which included the participants' fundamental demographic data, also contained an open-ended questionnaire addressing the sources of HIV transmission, knowledge about the illness by family members and friends, and their reactions.

HIV Stigma Scale (HISS)

There are 40 items on the HIV Stigma Scale. It evaluates HIV's psychological effects and stigma. It is intended to evaluate four dimensions of stigma associated with HIV in HIV-positive people: individual stigma, disclosure concerns, negative self-image, and concern about public opinions (Berger et al., 2001). A person's opinion of themselves and their thoughts, feelings, and emotions while others are aware of their illness are the focus of personalized stigma. The phrase "disclosure fears" refers to worries about telling people you're HIV-positive. What other people believe about people with HIV is at the center of concerns concerning public views. Poor self-perception emphasizes emotional state, particularly the negative self-perception experienced after receiving an HIV diagnosis (e.g., feeling of contamination, unhygienic, and not good as others due to HIV status). A 5-point Likert scale with the options strongly disagree (SD) and strongly agree (SA) is applied to each response (SA). The scale's items 8 and 21 are scored in reverse. While the value for the whole scale is.96, the coefficient alpha for the subscales ranges from.90 to.93.

Multidimensional scale of perceived social support (MSPSS)

The Multidimensional Scale of Perceived Social Support (MSPSS) developed by Zimet et al. in 1988. It has been used in various research with diverse populations and in multicultural settings (Bruwer et al., 2008; Zimet et al., 1988). It comprised of Family, Friends, and Significant Others subscales. It is a concise research tool with 12 items. Each sub-scale has four items. It is employed to determine how sufficient social support from each of the three sources is believed to be. It is scored on a seven-point Likert scale, where 1 indicates "very strongly disagree," and 7 indicates "very strongly agree." The scores for each of the subscales can be calculated by either dividing the total score, which ranges from 1 to 84, by four. Its internal reliability coefficient is 0.88 family subscale (.87), and for the friends, subscale is (.85).

WHO quality of life (BREF)

The WHO Quality of Life Group was responsible for developing the WHO Quality of Life Scale (1998). It has 26 items and is a condensed version of the WHOQOL. Each item is rated using a Likert scale with a maximum of 5. There are four subscales in it (physical health, psychological health, social relationship, and environmental factors). The scale's cronbach alpha coefficient, which gauges general quality of life, is an accurate predictor of (.88). Cronbach's alpha coefficient values for the four sub-domains are as follows: 1.81 for physical health, 1.77 for psychological well-being, 1.42 for social interactions, and 1.75 for the environment.

Procedure

The provincial AIDS control Program Center in Peshawar was contacted for help gathering data for the current study. The Special Centre for HIV/AIDS at the government-run Hayatabad Medical Complex was selected as the site for data gathering. It is a component of the provincial effort to combat AIDS (PACP). The creators of the scales being used in the study, Endeavor, were asked for their consent before the data collection process could begin. The director of the HIV/AIDS control center was contacted to obtain authorization for data collection. The hospital's ethical committee authorized the written narrative, scales, and authorization letter. The participants were approached once the ethics committee and the HIV/AIDS Center director approved. The participants were informed of the study's goal. Each subject signed their informed permission after getting to know one another. Each participant signed a confidentiality agreement promising to keep the data private. They were also informed that there are no limitations on their freedom to leave the study whenever they want. They were required to complete a demographic questionnaire, the HIV Stigma Scale (HSS), the Multidimensional Scale of Perceived Social Support (MSPSS), and the Quality of Life Scale after providing written consent to participate (QoL). Participants were advised to relax while taking the scales and were free to ask any questions if they had any trouble comprehending the items. Participants and the pertinent authorities were thanked and acknowledged for their participation and help during the data-gathering process after completing all administrative procedures.

Ethical consideration

The study's methodology complied with all recommendations made by the Advanced Studies and Research Board (ASRB) of the University of Peshawar, Pakistan. Additionally, authorization from the relevant institutions' authorities was obtained through the proper channels by contacting the ethics committee and the directors of the relevant Center. All research participants' worth, dignity, and well-being were upheld throughout the whole process. All information is provided with participants' permission. Additionally, they were assured of the secrecy of their data and viewpoints. They were made aware of their ability to revoke their participation in the study at any time.

Results

The statistical package for social sciences was used to examine the data for this investigation (SPSS). Further, the gender-based differences on the various measures employed in the current study were determined using an independent sample t-test analysis.

Table I

Mean differences and t-value of HIV and AIDS positive men and women on HIV stigma scale and its sub-domains (N=269)

	Male (n =170)		Female (n =99)				95% CI		
Scale	M	SD	M	SD	t(267)	P	LL	UL	Cohen's d
HISS	82.65	19.85	81.13	23.67	0.57	.58	-3.88	6.83	0.0812
PER	33.64	11.37	33.99	13.19	-.242	.826	-3.43	2.72	-0.031
DS	25.27	5.15	23.61	5.53	2.28	.031	.151	2.67	0.275
NSI	29.65	6.11	28.59	7.13	1.31	.195	-.565	2.77	0.174
PA	39.52	11.42	38.88	13.81	.362	.735	-2.51	3.58	0.065

Note. HISS= HIV Stigma Scale, PER = Personalized Stigma, DS= Disclosure Concern, NSI = Negative Self-Image, PA = Public Attitude, M = Mean, SD = Standard Deviation, CI = confidence Interval, LL = Lower Limit, UL = Upper Limit.

On the HIV stigma scale and its sub-domains, Table I illustrates the fundamental distinction between male and female HIV patients. The data indicate that male HIV patients experience a somewhat greater stigma mean than female HIV patients. As *p* >.05, the mean difference of 1.52 between males and females is not statistically significant. Statistics show that the subdomain of HIV stigma disclosure concern is significant (*p* .05.)

Table II

Mean differences and t-value of HIV and AIDS positive men and women on Multidimensional perceived social support scale and its sub-domains (N=269)

	Male (n =170)		Female (n =99)				95% CI		
Scale	M	SD	M	SD	t(267)	P	LL	UL	Cohen's d
MSPSS	57.09	16.55	55.45	16.31	.781	.439	-2.53	5.61	0.110
FAM	20.38	6.36	20.43	5.75	-.080	.954	-1.66	1.55	-0.009
FRI	15.78	7.67	14.13	7.86	1.71	.089	-.257	3.45	0.226
SO	20.94	5.61	20.88	6.00	.051	.961	-1.49	1.47	0.008

On the Multidimensional Perceived Social Support Scale and its sub-domains, the above table demonstrates the key differences between male and female HIV patients. The statistics show no difference between HIV males' and HIV women's MSPSS scores, indicating that HIV has an identical impact on both groups' social support networks.

Table III

Mean differences and t-value of HIV and AIDS positive men and women on Quality of life (QOL) scale and its sub-domains (N=269)

	Male (n =170)		Female (n =99)				95% CI		
Scale	M	SD	M	SD	t(267)	P	LL	UL	Cohen's d
QoL	88.71	13.73	84.62	11.49	2.49	.01	.839	7.28	0.324
PH	23.38	3.95	22.36	3.77	2.11	.03	.068	1.99	0.267
PSYH	19.67	3.75	18.76	3.16	2.56	.01	.231	1.99	0.323
SR	10.36	2.39	9.56	2.55	2.52	.01	.167	1.37	0.325
EH	23.31	4.06	22.48	3.92	1.65	.10	-.167	1.83	0.209

Note. QoL= Quality of Life, M= Mean, SD=Standard Deviation, CI= confidence interval, LL=Lower Limit, UL=Upper Limit.

The above table highlights the fundamental distinction between HIV-positive male and female patients on the quality of life (QoL) scale and its sub-domains. The data demonstrate that there is a substantial difference between HIV-positive men and women on the overall quality of life scale and its sub-domains, as indicated by a *p*-value of.05. In comparison to HIV positive women, HIV positive men had higher mean scores on QoL and its sub-domains.

Discussion

The study sought to determine how stigmatization affected patients' perceptions of social support and quality of life and gender-based analysis.

The study's initial hypothesis was that male patients would score higher on stigmatization than female patients. According to statistical analysis of the data, there are no appreciable variations in the stigmatization scores between HIV-positive male and female patients (see table 1). Although male HIV patients experienced a somewhat higher stigma than female HIV patients, the results did not corroborate the hypothesis. The hypothesis is not supported since the mean difference between male and female, 1.52, is not statistically significant at p >.05. (t=.57, p>.58, Cohen'SD=.07)

However, in the sub-domain of HIV stigma, Disclosure Concern (DC) is statistically significant (p.05). However, the mean difference between male and female HIV and AIDS patients is not statistically significant in the other three sub-domains. According to a study by Mercy Pindani et al., stigma and prejudice are experienced by all people living with HIV and AIDS (2014). Due to negative beliefs associated with the illness, the most pervasive of which are prostitution and promiscuity, people are stigmatized when they learn about HIV or interact with HIV patients.

Although the degree and intensity of people's reactions to HIV/AIDS vary from society to society around the world, it is nevertheless stigmatized in almost all of them. It is viewed from a religious standpoint as a result of sinful behavior and breaking Islamic norms, such as homosexuality and extramarital sex (Muhammad, 2007).

Numerous factors, including misunderstandings about the sickness and how it spreads, contribute to the stigmatization of the condition (Gilmore & Somerville, 1994; Volinn, 1989). Because of predetermined beliefs, both men and women are equally stigmatized in the case of HIV/AIDS. Stigma is a social construct that develops from society's belief system. Due to the nature of the disease, people develop unfavorable beliefs about HIV. Symptoms worsen over time and impact a person's physical, mental, and social health. Second, they hold individuals accountable for their reckless behavior because they believe HIV is a result of specific maladaptive behavior patterns. Additionally, HIV patients are especially vulnerable to prejudice and discrimination because HIV is commonly linked to immoral and deviant behavior (Kegeles et al., 1989; Warwick et al., 1998).

Despite the stigma that persons with HIV and AIDS face from their loved ones, friends, and the general public, they are still highly hesitant to disclose information about their condition, which is thought to be the reason why they won't even tell their family members in dire situations. On the other hand, patients dealing with HIV and AIDS must make their HIV status known to important people in their lives. One of the most effective ways to support patients facing stigma is by disclosing HIV illnesses. Because telling loved ones about one's HIV status makes it easier for them to understand the patient's condition and better able to offer love, care, and other forms of practical support. It also lessens the strain of keeping the information a secret. It has been observed that most individuals react favorably when they learn about a person's HIV status (National AIDS Manual, 2012). According to a poll done in the United States in 2010, more than two-thirds of those who told their family members they were HIV positive did not end their relationship with them and continued to live with them. Their family turned into a vital source of mental and practical assistance. It inspired others to provide the patient support and bravery to battle prejudice and discrimination in larger society.

Most people disclose their HIV status to at least some of their connections, finds a research by Kalichman et al. When HIV patient tells their loved ones they are HIV positive, they report experiencing a sense of social support. For instance, they confided in friends more often than family because they felt that friends understood them better. Likewise, within the family, they confessed to the mother and sisters more frequently than the father and brothers.

There are a number of reasons to tell loved ones, close friends, and medical professionals about your HIV status. In order to prevent sickness and aid in adopting preventative measures, information is shared with medical professionals. On the other hand, telling friends and family is more self-centered in an effort to uphold an honest relationship. Additionally, it makes obtaining assistance from them and reducing stress easier (Jeffe et al., 2000; Schnell et al.,1992).

The study's second hypothesis looked at whether female patients would score lower on measures of perceived social support than their male counterparts. Our findings indicate that there is no significant difference between HIV males and HIV women's MPSS scores, indicating that HIV affects both groups' social support systems equally (t=.78, p>.43, Cohen's d=.11, see table 2). Numerous studies have shown how important social support is for those dealing with any sickness. Along with their coping mechanisms and initial medical care, the person receiving social support also reported fewer physical symptoms associated with HIV/AIDS, which strongly predicts health outcomes (Ashton et al., 2005). A study by Udobong Regina (2015) found that social support is viewed as a crucial institution for the effective management of HIV and AIDS because it benefits those who are living with the disease by fostering better relationships and communication among caregivers as well as providing support and a positive attitude from society. The study also found that among HIV patients, particularly women, there was a significant relationship between social support and effective coping mechanisms. As a result, the social surroundings in which HIV/AIDS patients live greatly impact them. They might, for instance, encounter social rejection or judgments from their loved ones, acquaintances, or even coworkers. HIV has an impact on a patient's social interactions because society typically avoids maintaining relationships or interactions with them. They are not permitted to engage in social activities, yet they would love to do so (Holzemer et al., 2007; Kalichman et al., 2009; Sayles et al., 2008; Visser et al., 2008). Stigmatization is a typical cause of HIV patients' social networks being disrupted because people identify the disease with immorality and view those who have it as having certain discreditable traits, which leads to the breakdown of social ties (Schmitz & Crytal, 2000).

The third theory states that female patients would experience a lower level of quality of life than male patients. On the total scale of quality of life and its sub-domains, men and women with HIV significantly differed from one another, according to the statistical analysis (t= 2.49, p.05, Cohen's d=.32, see table III). HIV positive men had higher median scores on QoL, and its subscales than HIV positive women did. These results support earlier research by Tesfay et al. (2015), Rajeev et al. (2012), Chandra et al. (2009), Casado (2005), and Kohli et al. (2005) that indicated female HIV and AIDS patients have poorer health quality scores than male patients. The marital status and gender of HIV patients also significantly affect their quality of life, according to a 2017 study by Wani and Sankar. According to a study, male HIV-positive individuals enjoy a better quality of life than their female counterparts. Additionally, patients who were married scored better on the quality of life scale than those who were single or divorced, emphasizing the value of a robust support network.

Female patients score lower than male patients across all dimensions, according to a study by Amanuel Tesfay et al. (2015) on gender differences in health-related quality of life and associated factors among HIV patients who are taking highly active antiretroviral therapy. According to Claes Cederfjäll et al., women with HIV/AIDS also have a pessimistic outlook on life, a weaker sense of reason, and little social interaction (2004). These problems have a negative effect on their quality of life.

Women are also underprivileged from a cultural perspective because of the prevalent norms and values in a specific community. Men are typically viewed as superior in most cultures; they hold more power and authority than women and make all of the decisions, while women are devalued and even discouraged from doing so, impacting their general quality of life. In the event of HIV/AIDS and the stigma associated with the condition, women also tend to the needs of the entire family and carry out all domestic duties, negatively affecting their physical and emotional health (UNAIDS, 2001).

limitations

The current study's findings indicate the effect of stigmatization on perceived social support and quality of life among HIV patients. However, the following limitations were drawn from this study.

There are a number of factors other than stigma which may strongly influence the quality of life of people living with HIV, such as psychiatric disorders, unemployment, availability, and accessibility of people living with HIV to the treatment. In the current study, only those people who were under medication were considered, and their physiological health is comparatively stable with no serious diseases. Therefore, it is the limitation of the current study which should be considered by future researchers, such as those HIV patients who are not taking medication and its comparison with those who have a consultation on regular bases.

implications and recommendations

- The current study, which exclusively included HIV/AIDS patients, discovered a link between social support, stigma, and quality of life. This study can be replicated by future scholars utilizing different approaches and techniques. To spot differences in the findings of social support and quality of life, they may compare the HIV group to the general population or people with other chronic diseases like cancer or diabetes.
- Stigma negatively impacts the patient's social network and exposes them to rejection, disapproval, and criticism from family, friends, and the broader community, which worsens their physical health. Setting up an educational program for families is advised, as is teaching them various stress-reduction techniques like relaxation exercises, deep breathing, and meditation.

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