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Stigmatization of Persons With HIV/AIDS in Saudi Arabia

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Abstract

Data about the stigmatization of persons living with HIV/AIDS in Saudi Arabia are scarce. Recent statistics from Saudi Ministry of Health showed that 77% of HIV-positive Saudis were males. The present study analyzed data from 162 Saudi male college students. The findings suggest that students who knew less about HIV/AIDS were more likely to stigmatize persons living with HIV/AIDS than those who knew more. Neither degree of religiosity nor worry about HIV infection was related to AIDS stigma. However, AIDS-related shame was the best predictor of AIDS stigma. The findings of this study point to important suggestions for AIDS prevention programs in Saudi Arabia.

Keywords

AIDS, Arabic culture, Saudi Arabia, stigma

Our understanding of the social aspects of HIV/AIDS in the Middle Eastern and North African (MENA) region is insufficient compared with other regions in the world (Jenkins & Robalino, 2003; Obermeyer, 2006). In 2007, the Joint United Nations Programme on HIV/AIDS estimated that 35,000 individuals were infected with HIV in MENA, bringing the total number of people living with HIV to 380,000. Available research on HIV/AIDS from this region has shown that persons living with HIV/AIDS (PLWHA) are stigmatized, marginalized, and considered a source of shame (Roudi-Fahimi, 2007). The goal of this article is to assess the role AIDS-related shame, knowledge about HIV/AIDS, worry about HIV infection, and religiosity in predicting the stigmatization of individuals with HIV/AIDS in Saudi Arabia.

AIDS-related stigma refers to unfavorable evaluation and treatment of PLWHA. Discrimination against PLWHA is one of the most troubling features of the AIDS epidemic. Reports from countries with both high and low HIV seroprevalence have documented the widespread discrimination against PLWHA and the people who are associated with them (Bogart et al., 2008; L. Li et al., 2007; Parker & Aggleton, 2003). The mistreatment of PLWHA takes different forms, which range from verbal insults to avoidance and isolation. AIDS-related stigma, whether at the personal or institutional level, has a tremendous impact on the well-being of PLWHA.

In 2007, around 40% of all new cases of HIV infection worldwide were reported among young people aged 15 to 24 years (United Nations Children's Fund, 2008). Youth's susceptibility to HIV infection is influenced by factors such as peer pressure, erroneous beliefs about invulnerability, and early experimentation with sex, alcohol, and drugs. Thus, examining young people's knowledge of HIV/AIDS and their perceptions of PLWHA is critical in the fight against AIDS. In Saudi Arabia, 14% of HIV/AIDS cases were found in young people between the ages of 15 and 24 (Al-Mazrou, Al-Jeffri, Fidail, Al-Huzaim, & El-Gizouli, 2005), who represent 19% of the Saudi population (United Nations Population Fund, 2005).

AIDS in Saudi Arabia

Saudi Arabia occupies more than 80% of the Arabian Peninsula and covers an area of 2.25 million square kilometers. The population of Saudi Arabia is estimated to be around 28 million, of which 20% are expatriates. On the human development index (which consists of three dimensions: living a long healthy life, being educated, and having a decent standard of living) Saudi Arabia ranked the 59th out of 182 countries (United Nations Development Programme, 2009).

Recent data on HIV/AIDS indicate that during the span of 19 years (1984-2003), 7,807 HIV/AIDS cases were reported to the Saudi Ministry of Health. Most infected individuals (6,064) were expatriates, whereas the remaining 1,743 individuals were Saudi citizens (Al-Mazrou et al., 2005). Seventy-seven percent of the HIV-positive Saudis were males. Most of the HIV/AIDS patients resided in three major Saudi cities. Jeddah, in the western province of Saudi Arabia, had the

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highest number of HIV/AIDS patients (40%), followed by Riyadh (the capital in the central province), which accounted for 15% of the cases. Dammam, which is located in eastern province, had the next-highest number of HIV/AIDS patients, 12%. In 2006, the Saudi Ministry of Health announced that there were around 10,000 individuals with HIV/AIDS in Saudi Arabia (Fattah, 2006). The predominant mode of infection in Saudi Arabia is heterosexual sex, with almost all Saudi women contracting the HIV virus from their husbands, whereas an overwhelming number of men had contracted it from commercial sex workers (Alrajhi, Halim, & Al-Abdely, 2004).

Compared with other Muslim countries, Saudi Arabia is a very conservative state that adheres to a strict interpretation of Islam. AIDS in Saudi Arabia as well as other countries in the MENA region is perceived as a moral disease, and people with HIV/AIDS are perceived as deviant and as deserving the disease for having violated social and religious rules (Hasnain, 2004; Musso, Fanget, & Cherabi, 2002). For example, a population-based study from Iran found that 79% of the participants believed that lack of religious and moral commitments could cause AIDS infection (Montazeri, 2005).

As is the case for many countries in the MENA region, the existing literature on the social aspects of HIV/AIDS in Saudi Arabia is meager (Abdelmoneim, Khan, Daffalla, Al-Ghamdi, & Al-Gamal, 2002; Al-Almaie, 2005; Badahdah, 2005a, 2005b). One study, for example, examined Saudis' knowledge about HIV/AIDS and attitudes toward PLWHA and the factors that influenced their attitudes. The study found that college students harbored negative attitudes toward PLWHA, which were predicted by participants' religious commitment and misconceptions about HIV transmission (Badahdah, 2005b). Another study examined the knowledge and attitudes of 500 individuals who attended primary health care facilities in Riyadh and found that 52% of the participants would terminate their relationship with an HIV-positive friend (Al-Ghanim, 2005). Studies from countries around the world have suggested that negative attitudes toward PLWHA play a role in hindering the efforts of persons at risk and PLWHA from communicating their health status to others, seeking medical care, and adhering to antiretroviral therapy.

Study Purpose

None of the studies on AIDS from Saudi Arabia and other countries in the MENA region investigated the contribution of shame as a cultural value to the stigmatization of PLWHA. Thus, the importance of the present study comes from its focus on AIDS-related shame as an essential element in the stigmatization of PLWHA. Shame, as an integral component of stigma (Goffman, 1964), is conceptualized as a strong negative emotion that "results from a person experiencing failure in relation to personal or other people's standards, feeling responsible for that failure, and believing that the failure reflects an inadequate self" (Cunningham, Tschann, Gurvey, Fortenberry, & Ellen, 2002, p. 334). There are several reasons for choosing AIDS-related shame as an independent variable in this article. First, the emotional aspects of stigma (e.g., shame, guilt, and anger) have been understudied and widely ignored in the stigma literature (Link & Phelan, 2001). Next, shame has been considered one of the most influential emotions in the lives of Arabs (Glidden, 1972). Third, several studies on AIDS have found the emotion of shame to be relevant to the experience of the stigmatized, their families, and people who are associated with them (Bogart et al., 2008; Kalichman & Simbayi, 2003). Therefore, shame was expected to play a significant role in shaping participants' perceptions of PLWHA in this study. In addition to AIDS-related shame, the study examined how knowledge about HIV/AIDS, worry about HIV infection, and degree of religiosity contribute to students' perceptions of PLWHA.

Research Design

Sample

A total of 162 Saudi male college students who attended a public university in Riyadh, Saudi Arabia, took part in this study. Approval to conduct the study was obtained from the university's research ethics committee. None of the approached students refused to participate in the study. Participation in the research was voluntary, and no credit was given for participation. Students were informed about the purpose of the study and the obtained approval to collect the data. They were assured of confidentiality and anonymity and were asked not write their name on the questionnaire.

The respondents' median age was 22 years, and the vast majority (91%) indicated that they were single. Most students (82%) reported that they had grown up in a middle-income family, whereas the rest had been raised in either a low- or high-income family (11% and 7%, respectively).

Method

The data were collected via a self-administered questionnaire, which contained several background questions, the dependent variable, attitudes toward PLWHA, and four independent variables: knowledge of HIV/AIDS, HIV-related worry, religiosity, and AIDS-related shame.

The first independent variable was a 12-item index that tapped students' knowledge of HIV/AIDS. It assessed students' knowledge of HIV transmission (e.g., sexual intercourse, semen, and contaminated needles), nontransmission routes (e.g., kissing and touching HIV-infected individuals), effective risk reduction (e.g., condoms), misconceptions (e.g., only homosexuals get AIDS), and basic facts (e.g., there is a cure for AIDS). Participants reported their knowledge using three response categories: "correct," "wrong," and "do not know." Both incorrect and "do not know" answers were

Table 1. Saudi College Students' Knowledge About AIDS

Item	Correct Response	Correct Answer	
		N	Percentage
Sexual intercourse with an HIV-positive woman	True	157	96.9
You can tell if someone has AIDS by looking at him or her	False	76	46.9
Only homosexuals get AIDS	False	92	56.8
One can get AIDS by kissing someone on the check	False	81	50.3
HIV may live in human body for years without symptoms	True	104	64.2
There is a cure for AIDS	False	75	46.3
One can get HIV by touching someone with AIDS	False	85	52.5
The AIDS virus can be transmitted through breast-feeding	True	74	45.7
A mosquito's bite can transmit the AIDS virus	False	51	31.5
One can get HIV by sharing contaminated needles	True	139	85.8
Condoms reduce the probability of getting the AIDS virus	True	73	45.1
The AIDS virus can be found in men's semen	True	35	21.6

treated as wrong answers. Items were summed to yield a total possible score ranging theoretically from 0 to 12, with higher scores indicating more accurate knowledge about HIV/AIDS. Worry about HIV infection tapped respondents' personal assessment of their own personal risk and worry about HIV infection (Badahdah, 2005b). The scale consisted of five items: "I get frightened every time I heard about HIV/AIDS," "I am afraid of getting HIV," "I might have been exposed to HIV because of my behavior in the past," "I feel uncomfortable talking about HIV/AIDS," and "I tend to avoid reading about HIV/AIDS." Participants used a 5-point response format, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Higher scores mean greater worry about HIV infection.

The third independent variable is the degree of religiosity. The conceptualization of religiosity in Islam is complex, and the measures that exist tend to be long or culture specific (e.g., Chang-Ho & Ibrahim, 2007; Ghorbani, Watson, Ghramaleki, Morris, & Hood, 2000). In the present study, two items that have been used in previous studies (Badahdah, 2005b) were employed to assess students' degree of religiosity. The first item was about participants' self-assessment of the impact of Islamic teaching on their daily life, whereas the second asked participants about frequency of worship, a very important indicator of religiosity in Islam. A high score is indicative of a higher degree of religiosity.

The last independent variable is AIDS-related shame. In the AIDS literature, shame has been examined from the perspective of HIV-seropositive patients, their family and associates, and HIV-seronegative individuals. This study focused on vicarious shame, which refers to situations in which a person who is not the proximal agent of a wrongdoing experiences shame (Lickel, Schmader, Curtis, Scarnier, & Ames, 2005). Two items were used to measure this concept. One item asked participants whether they would experience shame for having a relative with HIV/AIDS. The second item asked participants if they would be ashamed for having PLWHA in Saudi Arabia. Students rated their responses on a 5-point scale (1 = *strongly disagree*, 5 = *strongly agree*). High scores indicate a greater sense of shame.

The dependent variable, stigmatization of PLWHA, was defined as prejudice and discrimination directed toward PLWHA and the individuals, groups, and communities with which they are associated (Herek, 1999). An extensive search of the AIDS literature revealed that standardized Arabic measures of AIDS-related stigma do not exist. Because of the lack of such measures, the present study used a scale that was written in Arabic and employed in a previous study in Saudi Arabia (Badahdah, 2005b). For example, students were asked about their degree of agreement with statements such as "People with AIDS should be fired from jobs" and "If a friend of mine got AIDS I would continue our friendship." Participants responded to each statement on a scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). The items were summed and averaged to create a composite scale, with high scores signifying unfavorable attitudes toward PLWHA.

Results

Overall, students' knowledge about the HIV/AIDS (Table 1) was unsatisfactory ($M = 6.45$, $SD = 2.32$). More than 50% of the participants were unable to identify the correct answer for six out of 12 statements about HIV transmission. For example, more than half of the students thought they could recognize people with AIDS from their appearance (53%) and that a person can be infected by kissing an HIV-positive person on the cheek (50%). Similarly, 55% of the students erroneously believed that there is a cure for AIDS, that HIV cannot be transmitted via breast-feeding, and that condoms are ineffective in reducing the probability of HIV infection. A large number of students (84%) either did not know the correct answer (52%) or believed (32%) that HIV can be contracted

Table 2. Regression Analysis Predicting Stigma Attached to People With AIDS in Saudi Arabia

Predictor	B	*SE* B	β
Knowledge of AIDS	−0.06	0.02	−.18*
Fear of AIDS	−0.03	0.07	−.03
Religiosity	−0.01	0.09	−.01
AIDS-related shame	0.26	0.05	.38**

Note: $R^2 = .19$.
*$p < .05$. **$p < .01$.

via mosquito bites. Surprisingly, 78% of the respondents either did not know or gave the wrong answer to the item that quizzed them about the existence of HIV in semen.

The five items measuring worry about HIV infection showed an acceptable level of reliability (α = .63). Students had a low level of personal worry about HIV infection (M = 2.77, SD = 0.84). There was no significant relation between worry about HIV infection and the knowledge of HIV/AIDS index ($r = -.12$, $p = 12$).

Cronbach's alpha showed that the seven-item attitudes toward people with HIV/AIDS had a good level of reliability (α = .70). Saudi male students' perception of PLWHA was negative (M = 3.72, SD = .76). For example, more than two thirds of the participants agreed that people with HIV/AIDS should be isolated from the public (76.3%) and would not entertain the idea of marrying into a family that had a member with HIV/AIDS (70.2%). Students also endorsed similar negative statements, for example, that they would not feel comfortable being touched by someone with HIV/AIDS (65.4%) and that people with HIV/AIDS should be fired from their jobs (59.4%). Thirty-nine percent of the students said they would sever their relationship with a friend if he contracted HIV.

To identify the variables that contributed to students' stigmatization of PLWHA, a multiple regression analysis was performed (Table 2). The results of the regression analysis showed that worry about HIV infection and religiosity were not significant predictors of AIDS-related stigma. However, knowledge of HIV/AIDS, albeit weak, was significantly and negatively related to the stigmatization of PLWHA (β = −.18, $p < .05$). That is, students who knew more about HIV/AIDS expressed more positive attitudes toward PLWHA. As anticipated, the best predictor of AIDS stigma was AIDS-related shame (β = .38, $p < .001$). The two items about AIDS-related shame explained 19% of the variance in the stigma attached to individuals with HIV/AIDS ($R^2 = .19$, adjusted $R^2 = .17$).

Discussion

This study explored how knowledge of HIV/AIDS, worry about HIV infection, degree of religiosity, and AIDS-related shame influence Saudi college students' perception of PLWHA. This research is very important because it focused on Saudi males, who represent 77% of the HIV-positive patients in Saudi Arabia. In addition, it investigated the role of AIDS-related shame as an important ingredient in the stigma attached to person with HIV/AIDS in Saudi Arabia. Overall, students' knowledge of HIV/AIDS was inadequate, as indicated by the fact that the majority were unable to identify the correct answers to half of the statements on the HIV/AIDS knowledge index. Similar misconceptions about HIV/AIDS have been reported among students from other countries in the Arab region (Badahdah, 2005b; El-Gadi, Abudher, & Sammud, 2008; Petro-Nustas, Kulwicki, & Zumout, 2002; Tebourski & Ben Alaya, 2004). The majority of the participants in this study, for example, thought that they could recognize HIV seropositive individuals from their appearance. A similar inaccuracy was observed in other countries such as United Arab Emirates (Gańczak et al., 2007) and Iran (Tavoosi, Zaferani, Enzevaei, Tajik, & Ahmadinezhad, 2004). Furthermore, the findings of the present study indicate that many students were ill-informed about condoms as a valuable HIV preventive measure. This result is consistent with studies from other MENA countries (e.g., Huang, Bova, Fennie, Rogers, & Williams, 2005; X. Li et al., 2004). For example, a study of high school students from Tunisia found 69% did not know that condoms can protect from HIV infection (Tebourski & Ben Alaya, 2004).

Students' lack of knowledge about the importance of condoms in controlling the spread of HIV is probably the product of a conservative ideology that equates condom promotion with encouraging people to engage in unlawful sexual activities. As Madani, Al-Mazrou, Al-Jeffri, and Al Huzaim (2004) observed, "The concept of 'Safe Sex' basically promotes the use of condoms for non-marital sexual relations. . . . [I]n Islamic countries [this is considered] a way of promoting non-marital sex which is absolutely prohibited in Islam" (p. 7). This misperception is common among the general public and health care providers. For example, a recent study reported that 90% of family physicians in Kuwait objected to promoting condom use as a protective measure against HIV transmission (Fido & Al Kazemi, 2002). Another serious misconception about HIV/AIDS found in the present study was indicated by the fact that most participants thought that HIV cannot be found in semen. A similar misconception was reported in a study from Taiwan (Tung, Ding, & Farmer, 2008), which showed that only 49% of the participants were aware that HIV could be spread through infected semen.

The presence of these and other counterfactual beliefs about HIV/AIDS increase young people's risk of exposure to infection, fuel exaggerated fears of AIDS, and perpetuate the stigmatization of PLWHA (Herek & Capitanio, 2002). Consistent with other studies (Shapiro, 2005; Tavoosi et al., 2004), there was an inverse relation between knowledge of HIV/AIDS and stigmatization of PLWHA in the present study. That is, respondents who knew less about HIV/AIDS

were more stigmatizing of PLWHA than the more knowledgeable ones.

Saudi male students displayed unfavorable attitudes toward PLWHA that were in accordance with findings from other studies conducted in Saudi Arabia. For example, a Saudi study found that 79% of the participants agreed that testing for HIV should be required for prospective marriage partners (Al-Ghanim, 2005). In the United Arab Emirates, a study found that 94% of the students favored implementing such a measure (Gańczak et al., 2007). In the present study, 90% of the respondents embraced such a statement. Isolating people from the rest of society and terminating their employment received high levels of support from Saudi students, 59% and 76%, respectively.

Although knowledge of AIDS was valuable in predicting students' stigmatization of PLWHA, shame associated with AIDS, which had not been examined previously in this cultural context, was the best predictor of AIDS stigma. More than half of the participants believed that people with HIV/AIDS ought to be ashamed of themselves. An even larger percentage of students endorsed the other two statements on shame. Specifically, at the personal level, 72.3% of the students said that they would be ashamed if a relative was diagnosed with HIV. Vicarious shame, which was measured by an item that read, "It is shameful to have people with HIV/AIDS in Saudi Arabia," was supported by 68.4% of participants. These findings demonstrate that shame, a master emotion for Arabs that guides and colors their perspectives and behaviors (Kulwicki, Miller, & Schim, 2000), influenced Saudi students' reactions to individuals with HIV/AIDS. Saudi students might associate AIDS with shame because they perceive AIDS more as a moral-religious issue than as a health condition. This might explain why more than half of the students in this study believed that PLWHA were responsible for their infection, and 75% believed that AIDS is a punishment from God.

Saudi AIDS prevention programs might be responsible for generating the beliefs among Saudis that PLWHA are morally inferior and a source of shame. As an Islamic, conservative state, Saudi Arabia has implemented moral-religious preventive measures in the fight against AIDS that has focused on abstinence and faithfulness to one's spouse. This myopic orientation, some have argued, is caused by the Saudi government that is reluctant to accept other preventive methods that are perceived to be in conflict with Islamic teaching, such as safer sex or needle exchange programs (Madani et al., 2004).

The current study's findings demonstrate the benefit of providing students with accurate information about HIV/AIDS as a strategy to eliminate the stigma attached to PLWHA. This strategy likely would be very effective if educational campaigns in Saudi could present HIV/AIDS as a health issue rather than a moral failure. The Saudi moral-religious approach to AIDS prevention could be accused of encouraging and maintaining the marginalization of PLWHA.

Several limitations of the current research warrant discussion. One limitation pertains to the nature of the sample. The findings cannot be generalized because the sample was small, convenient, and consisted exclusively of male college students. Future research should examine knowledge about HIV/AIDS and attitudes toward PLWHA among other segments of the Saudi population that we do not know anything about, such as Saudi female college students, men who have sex with men, and drug users. Notwithstanding these considerations, the results of the current study show the importance of HIV/AIDS knowledge and shame as a cultural value in the stigma attached to people with HIV/AIDS in Saudi Arabia.

Implications for Practice

This study explored Saudi male college students' perceptions of persons with HIV/AIDS. Because of the widespread misconception about HIV/AIDS, the findings suggest that the Saudi AIDS national program needs to embrace a comprehensive AIDS strategy that promotes safer sex among young Saudis. Despite the fact that most HIV-positive persons in Saudi Arabia are males, the Saudi AIDS strategy that exclusively focuses on abstinence and faithfulness offers little protection to Saudi women, who lack control over their bodies and sexuality. The findings also have an implication for nursing practice in Saudi Arabia, where 58% of nurses are Saudis. Nurses who deal with HIV-positive patients should pay attention to the importance of shame in the stigmatization of persons with HIV/AIDS. I would expect that shame plays an even more powerful role in the lives of PLWHA. With this in mind, health care providers in Saudi Arabia should strive to create and maintain a shame-free health care environment.

Declaration of Conflicting Interests

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