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**The impact of HIV-related stigma on the lives of HIV-positive women: An
integrated literature review**

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Abstract

Aims and objectives. To critically explore how HIV-related stigma impacts the lives of HIV-positive women through an integrative review of the literature.

Background. Throughout history Human Immunodeficiency Virus (HIV) infection has been associated with the sex trade, injecting drug use and other deviant behaviours within society. These historic associations can lead to the generation of negative perceptions of women with HIV infection. As such, women who contract HIV infection can be susceptible to societal stigma.

Design. An integrative literature review

Methods. To identify the publications on the impact of HIV-related stigma among women, a search was performed using the following databases: CINAHL, Medline, PsycINFO, EMBASE, and Applied Social Sciences Index and Abstract (ASSIA) covering the period from 2000 to 2014. The following key words were included in the search: “women”, “HIV”, and “stigma”.

Results. Twenty-six articles were retrieved and reviewed. From the results, four key themes merged in relation to HIV infection related to stigma among women: the individual, relationships, work and the community.

Conclusions. Despite great advances in the management and treatment of those who are HIV positive, it appears the lives of many women with HIV infection remain greatly affected by their HIV infection with gender-specific stigma and stereotypes. Having a holistic understanding of this impact offers the potential for those responsible for the funding and draws the attention of researchers and policy makers on promoting medical services specifically for women with HIV

infection, minimising social stigmatisation towards this client group, and optimising their health outcomes.

Relevance to clinical practice. In an attempt to amplify HIV-positive women's ability to resist social injustice, obtain support, and optimise their health outcomes, nurses should expand their roles and work with professionals from different sectors to ensure the provision of comprehensive care to women with HIV infection.

What does this paper contribute to the wider clinical global clinical community?

- This paper helps to recognize the extent to which stigma impacts on HIV-positive women.
- This paper highlights the need for minimizing social stigmatization towards HIV-affected women.
- This paper helps to promote attention on HIV-affected women's needs and provide care according to their needs in an attempt to optimise their health outcomes.

Keywords: stigma, HIV, women, female

Introduction

For the past few decades, with the introduction of antiretroviral therapy, Human Immunodeficiency Virus (HIV) has been transformed from an acute and fatal disease to a chronic and more manageable disease (Hogg *et al.* 2008). Despite the advancing treatment, the prevalence of HIV infection remains a serious and challenging issue. The Joint United Nations Programme on HIV and AIDS (UNAIDS 2011) reports that there were approximately 34 million people living with HIV infection worldwide at the end of 2010 with women making up more than half of the global total (51%).

Women often face challenges in adapting as they live in a society where HIV infection related stigma is prevalent, making it increasingly difficult to cope with their illness (Lawless *et al.* 1996, Lekas *et al.* 2006, Logie *et al.* 2011). Stigma is defined by Goffman (1963) as discrediting and undesirable attribute that an individual possesses. In the case of HIV infection, it is commonly associated with discrediting behaviours or characteristics that are deviant from social norm, such as illicit drug use and sex work (Carr & Gramling 2004, Logie *et al.* 2011). These associations have led to society forming a negative impression and prejudice towards people living with HIV infection (Carr & Gramling 2004). Apart from that, people may also reject HIV-positive individuals, as they fear being infected with HIV itself (Herek *et al.* 2002).

Given that HIV-related stigma relies heavily on the existing social representation, stigma cannot be simply explained as negative meanings associated with HIV disease itself only (Herek *et al.* 1998, Lekas *et al.* 2006, Logie *et al.* 2011). Other existing stereotypes may exacerbate the process of stigmatisation, such as gender and race (Lawless *et al.* 1996, Lekas *et al.* 2006, Logie *et al.* 2011). With regards gender, studies have shown that women who have HIV infection are

often characterised as immoral and are judged more harshly than men due to the idea that women should be a caregiver and a mother, and women having HIV infection are regarded as a failure in social roles (Lawless *et al.* 1996, Lekas *et al.* 2006, Logie *et al.* 2011). In terms of racial issues, women of African descent appear to experience higher levels of stigma than women of Caucasian descent (Lekas *et al.* 2006). As a result, the overlapping stigmas pose multiple burdens on HIV-positive women, which can significantly affect their psychological well-being, safe sex practice, support systems, employment opportunities, and crucially hamper engagement with treatment (Lawless *et al.* 1996, Peterson 2010).

To date, there is a paucity of review articles focusing on the impact of HIV-related stigma in women's lives. To further understand the impact of stigma in women's lives, both qualitative and quantitative studies that meet this review article's aims were accessed. Through the synthesis of the relevant studies, a more complete and current picture of how HIV-related stigma influences women's lives is captured. With such insight, it is hoped that specific recommendations as part of nursing practice guidelines can be considered.

Aims

The aims of this paper are to 1) present an integrative review of the published literature to explore how HIV infection-related stigma impacts the lives of HIV-positive women and 2) identify the contextual differences of HIV infection-related stigma for HIV-positive women.

Methods

Search Strategy

To identify the publications on the impact of HIV infection-related stigma among women living with HIV infection, a search was performed using the databases of CINAHL, Medline, PsycINFO, EMBASE, and Applied Social Sciences Index and Abstract (ASSIA) covering the period from 1990 to 2014. Herek et al. (2002) indicated that the level of HIV-related stigma has declined over the 1990s; hence, in an attempt to assess the impact of HIV-related stigma in most recent years, the period was restricted to 2000 onwards. The following key words were included in the search: “women”, “female”, “HIV”, and “stigma”. In addition to searching electronic databases, general search engine results (via Google Scholar), and the reference lists of relevant studies, were scanned for grey literature.

Inclusion and exclusion criteria

Studies were eligible for inclusion in this literature review if they met the following criteria: 1) studies that involved HIV-positive women; 2) studies that focused on the impact of HIV-related stigma on women’s lives; 3) articles published from 2000 to 2014; 4) studies published in English; 5) journal articles with full text; 6) study information: study site, study period and sample clearly reported; 7) research articles (quantitative/qualitative studies); 8) systematic review or meta-synthesis articles

The exclusion criteria were: 1) studies that involved men/gay men/transgenders with HIV infection; 2) studies that did not involve HIV-positive women; 3) studies that did not focus on

the impact of HIV-related stigma; 4) non-empirical papers; 5) duplicates; 6) not English language; 7) pre-1990; 8) literature review articles.

Study selection

During the initial literature search, titles and abstracts were screened based upon inclusion and exclusion criteria. The full texts of the remaining studies were retrieved and screened. Through the search strategy, 485 articles were identified from the databases (**Figure 1**). Titles and abstracts were reviewed and 456 excluded, leaving 29 studies relating to stigma, HIV infection, and women. Full text screening eliminated a further five articles, and two additional articles were added through the search of reference lists of retrieved articles and Google Scholar. As a result, there were 26 articles for review (**Table 1**). The study selection process and the rationale for exclusion are shown in **Figure 1**.

Results

Based upon these included studies, four themes were identified as factors relevant to the lives of women with HIV-related stigma, including individual, relationships, work, and community.

Within these four categories, this paper will provide an integrated exploration of the factors that influence the lives of women with HIV infection.

Individual– *Unprotected sexual behaviours and psychological distress*

For HIV-positive women in the studies by Teti *et al.* (2010) in the United States of America (USA) and Logie *et al.* (2011) in Canada, receiving a diagnosis of HIV infection was a life-changing and distressing experience. Many of them discussed feeling ashamed of having HIV

infection due to the historic associations with promiscuity or injecting drug use (Logie *et al.* 2011, Teti *et al.* 2010). The majority of HIV-positive women in a study by Wingood *et al.* (2007) in the USA also reported having experienced discrimination in their lives. Fear of stigmatisation from family and friends can present women with a number of challenges that may overwhelm their coping ability (Rouleau *et al.* 2012, Teti *et al.* 2010). The women in Teti *et al.* study (2010) described that the disease instilled fear when deciding to disclose their HIV status to their family, friends, or sexual partners. Having hidden their HIV status to sexual partners, women often found it difficult to refuse using condoms, which in turn increases the potential spread of HIV infection (Teti *et al.* 2010).

The results are consistent with quantitative studies by Clark *et al.* (2003) in the USA, Wingood *et al.* (2007) in the USA and Wingood *et al.* (2008) in South Africa. These studies indicate that perceiving a higher level of stigma makes women less likely to disclose their HIV status (Clark *et al.* 2003, Wingood *et al.* 2008) and more likely to have unprotected sex (Wingood *et al.* 2007). On those accounts, HIV-affected women's concerns about rejection and stigma may shape the way they manage risk behaviours. This may imply that nurses and other health care providers should take account of HIV-related stigma and discuss unprotected sex in credible and informative ways while providing HIV care.

Apart from risky sexual behaviours, the overwhelming sense of fear about living with HIV infection and rejection by family and friends may impair women's psychological functioning (Teti *et al.* 2010). A greater proportion of the women in the studies by Teti *et al.* (2010) and Logie *et al.* (2011) have linked suicidal ideation related to knowing about their HIV status, as living with HIV was perceived by them as unbearable. Similarly, several quantitative studies

from the USA, Canada, Peru and South Africa elucidate that the higher levels of stigmatisation experienced by HIV-infected women, the more likely their psychological functioning decreased (Clark *et al.* 2003, Logie *et al.* 2013, Murphy *et al.* 2006, Vyavaharkar *et al.* 2010, Wagner *et al.* 2010, Wingood *et al.* 2007, Wingood *et al.* 2008, Wu *et al.* 2008). As such, it highlights the needs to incorporate mental health services as an integral component of HIV care. Additionally, encouraging and actively engaging affected women in women support groups may potentially alleviate their emotional distress and increase their support networks.

It has also been reported that African American women appear to experience more adverse psychological distress as a result of HIV-related discrimination, compared to Caucasian women (Wingood *et al.* 2007). This may imply that the cumulative effects of HIV infection-related stigma and pre-existing prejudices in relation to gender and race could collectively increase women's psychological burden. To tackle such issue, targeting HIV services towards specific ethnicities can be crucial to the success.

Relationships– *Family and friends*

Family and friends play an important part in providing support to women with HIV infection (Peterson 2010). However, for some women who disclose their HIV status, their family and friends are not always supportive (Brickley *et al.* 2009, Rouleau *et al.* 2012).

In several qualitative studies from the USA, Canada, South Africa, the United Kingdom (UK), Vietnam and India, women have described that after revealing their HIV status to family, friends, or loved ones, they were devastated by their negative reactions (Anderson & Doyal 2004, Brickley *et al.* 2009, Carr & Gramling 2004, Kako & Dubrosky 2013, Lekganyane & du Plessis

2012, Logie *et al.* 2011, Ndirangu & Evans 2009, Okoror *et al.* 2012, Rahangdale *et al.* 2010, Rouleau *et al.* 2012). These negative reactions include forcing them to stay away from children, stopping them from having any physical contact, separating eating utensils, ending relationships, and not being allowed to stay with their family members (Anderson & Doyal 2004, Brickley *et al.* 2009, Carr & Gramling 2004, Kako & Dubrosky 2013, Lekganyane & du Plessis 2012, Logie *et al.* 2011, Ndirangu & Evans 2009, Okoror *et al.* 2012, Rahangdale *et al.* 2010, Rouleau *et al.* 2012). Moreover, for women who play a mothering role, HIV-related stigma has been purported to pose a moral and social threat to their children as well (Murphy *et al.* 2006). This may reflect that HIV-related stigma impacts on the lives of not only affected individuals but their close relationships as a whole, such as children. Hence, it is inevitable to include affected women's family into the plan of HIV care.

Women's experiences of HIV-related stigmatisation by family and friends appear to vary across cultures. In Africa, for example, once African women were known to be infected with HIV, they are inclined to be stigmatised by not being allowed to cook and share food with family members and their children (Okoror *et al.* 2007). As food is symbolic of love and status, the participation in sharing food reinforces the sense of belonging to a family (Okoror *et al.* 2007). In that sense, living in a context where HIV-infected women are not allowed to involve in family activities due to the stigma related to HIV infection, their caregiving roles and status will be devalued within families.

In addition, in India, a number of women with HIV infection appear to experience stigmatisation by their family due to physicians' violation of patients' confidentiality without permission (Rahangdale *et al.* 2010). Once women were diagnosed with HIV infection, their family

members were the first to be informed by health professionals due to the cultural belief that HIV infection is closely linked to immoral behaviours (Rahangdale *et al.* 2010). Consequently, such cultural belief has made women with HIV infection more vulnerable and likely to encounter HIV-related stigmatisation by their family (Rahangdale *et al.* 2010).

In brief, stigma related to HIV infection is socially constructed (Herek *et al.* 1998), which can negatively affect how HIV-infected women and their family and friends perceive HIV disease within a social context. With such influence, women's experiences of stigmatisation by their family and friends may further impair their ability to combat social stigma and to manage their HIV illness. Thus, health professionals should be in position to treat women with respect and dignity, and their professional judgement should not be interfered by HIV-related stigma.

Work

In spite of women's traditional role as care-givers, many women, nowadays, play double roles as care-givers and working women, which allow women to supplement their family incomes.

However, for HIV-positive women, HIV-related stigma posed by society can have a pervasive impact on their employment status and vocational development (Carr & Gramling 2004, Kako & Dubrosky 2013, Liamputtong *et al.* 2009, Poindexter 2013).

When knowing women's HIV infection status, some employers and co-workers appear to be supportive (Carr & Gramling 2004), whereas a number of women in the studies from the USA, New Zealand, Thailand and Kenya have reported that their employers' first reactions involved firing them or encouraging them to leave their jobs (Carr & Gramling 2004, Kako & Dubrosky 2013, Liamputtong *et al.* 2009, Poindexter 2013). Such stigmatisation also persists in the work

environment of medical settings. It is exemplified by Poindexter's study (2013) in New Zealand, illustrating that some young nurses have had a job offer withdrawn following disclosure on a medical questionnaire due to their HIV infection status. As such, this raises a concern of whether affected women are aware of workplace protection acts implemented by a national government. These rights should be addressed and provided by legislation. Health care providers also need to include this aspect of women's lives into their assessment plan and provide relevant information and support resources as needed.

Although the selected qualitative studies reveal that HIV-infection-related stigma can significantly affect how employers and colleagues treat HIV-positive women, the quantitative studies by Wingood et al. (2008) and Hattingh et al. (2009) in South Africa indicate that HIV-related discrimination is not directly associated with employment loss. Hattingh and his colleagues (2009) further point out that such disassociation is due to the fact that the majority of women in Africa are economically dependent on their partners. Therefore, in Africa, unemployment was the general tendency across the female population, and not only relevant to HIV-infected women (Hattingh *et al.* 2009).

In the workplace, employers play a prominent role in supporting their employees, whereas results from the aforementioned studies indicate that they often hold misconceptions about HIV infection. This may imply the importance of improving current HIV education and the need for establishing a safe and supportive work environment in which HIV-related stigmatisation and discrimination are not tolerated.

Community-Healthcare

Access to and regular utilisation of healthcare services is pivotal to ensure that women with HIV infection benefit from the advancing treatment (Schler *et al.* 2009). Having experienced and feared social rejection or isolation, it could make HIV-positive women especially dependent on health professionals. However, based upon the findings from the selected studies, HIV-related stigma appear to hinder the success of HIV treatment (Abel & Painter 2003, Carr & Gramling 2004, Liamputtong *et al.* 2009, Logie *et al.* 2011, Okoror *et al.* 2014, Rahangdale *et al.* 2010, Rouleau *et al.* 2012, Theilgaard *et al.* 2011, Wagner *et al.* 2010, Wingood *et al.* 2007).

One quantitative study from the USA indicates that women who experienced HIV-related discrimination were less likely to seek medical care (Wingood *et al.* 2007). Congruent with it, emerging evidence, including Carr and Gramling (2004) in the USA, Liamputtong *et al.* (2009) in Thailand, Okoror *et al.* (2014) in South Africa, Theilgaard *et al.* (2011) in Tanzania, Abel and Painter (2003) in the USA, Rahangdale *et al.* (2010) in India, Rouleau *et al.* (2012) and Logie *et al.* (2011) in Canada, reveals that HIV-positive women have experienced subtle or overt discrimination in the form of pressure from their health providers due to social stigma related to HIV infection. For instance, health care providers could appear to overuse universal precaution or react with disdain and fear, saying “*wearing three pairs of gloves and it was not a problem related to HIV* (Logie *et al.* 2011, p.6)” and “*there is no reason to risk our normal patients by taking you in* (Carr & Gramling 2004, p.35).” Such stigmatisation experienced by women led to losing trust in medical professionals and resulted in delayed treatment (Okoror *et al.* 2014).

Aside from this, the accounts of HIV-positive women also reveal the difficulty in adhering to antiretroviral therapy due to fear of being discovered their HIV infection status (Abel & Painter

2003). The evidence presented confirms the importance of ensuring that all health care providers have the necessary competencies and knowledge to avoid stigmatising behaviours and provide competent, safe and ethical care to HIV-positive women. The principles underlying the use of universal precaution should also be reiterated in the plan of HIV care. In turn, it will allow affected women to have the confidence and competence to facilitate health behaviours.

While the negative encounters experienced by women due to HIV infection-related stigma are fundamentally the same across the included international studies, there is a particular concern over lack of confidentiality in developing countries, such as African countries and India (Okoror *et al.* 2014, Rahangdale *et al.* 2010, Theilgaard *et al.* 2011). In these countries, the way in which women's HIV infection diagnosis is filed or expressed by health professionals appears to easily expose their HIV infection status to the public or to the women's family (Okoror *et al.* 2014, Rahangdale *et al.* 2010, Theilgaard *et al.* 2011). Concerned about the likelihood of being found their HIV infection status, women's access to HIV care is negatively influenced (Rahangdale *et al.* 2010, Theilgaard *et al.* 2011). By contrast, HIV-positive women's statements in the qualitative studies by Anderson and Doyal (2004) and Ndirangu and Evans (2009) in the UK illustrate that while having experienced negative reactions by their friends or family, the UK healthcare services were not negatively influenced by HIV infection-related stigma and instead provided them with a sense of belonging. The results reflects that national policies in health care play a fundamental role in reinforcing and ensuring quality of HIV care, and thus health policies tailored to meet HIV-positive women's needs should be clearly delineated and applied.

Discussion

This paper explored a broad spectrum of stigma-related impact on HIV-infected women's lives. Experiencing stigma can negatively affect individuals' psychological well-being, safe sexual practice, relationships with family and friends, employment status, and access to healthcare.

The impairment of HIV-infected women's psychological functioning can be the ultimate outcome of HIV-related stigma. In other words, women who face the challenges of gaining support from family, friends, and community or face financial struggles due to employment loss are more likely to experience psychological distress (Serovich *et al.* 2001, Teti *et al.* 2010).

These stressors create additional burdens to women who already have to manage stressful and lifelong illness.

The challenges of seeking or gaining support from significant others and having safe sex practice faced by these HIV-affected women are related to their decisions on disclosure or non-disclosure (Peterson 2010, Rouleau *et al.* 2012). Although some may prefer self-imposed social isolation in an attempt to avoid HIV-related stigma, the choice of disclosing women's HIV infection status has the implication for support (Lekganyane & du Plessis 2012, Serovich *et al.* 2001). It is exemplified by Lekganyane and du Plessis's (2012) and Serovich *et al.* (2001) studies, indicating that selective disclosure of individual HIV illness can serve as a strategy for managing support and safe sex practice.

Healthcare is another important support resources for women with HIV infection. Nevertheless, women's negative experiences with healthcare services pose a negative impact on their access to care and ultimately affect treatment outcomes. While some negative encounters could be

context-specific, such as the violation of patient's confidentiality in Africa and India, women's experiences of health professionals' stigmatising attitudes or reactions have been reported in both developed and developing countries (Abel & Painter 2003, Carr & Gramling 2004, Okoror *et al.* 2014, Rahangdale *et al.* 2010, Theilgaard *et al.* 2011). Health professionals' stigmatising behaviours towards HIV-affected women could present in either a subtle or obvious manner (e.g. overuse of universal precaution or direct rejection for treatment) (Carr & Gramling 2004, Lekas *et al.* 2006, Logie *et al.* 2011, Rahangdale *et al.* 2010, Rouleau *et al.* 2012). Such reactions appear to be greatly influenced by personal beliefs and perceptions of HIV infection instead of inadequate knowledge (Lekas *et al.* 2006, Logie *et al.* 2011). This may imply the gap between the actual knowledge and subjective feeling towards HIV illness. This is echoed with the study by Lew-Ting and Hsu (2002), indicating that people who are anxious about HIV disease are more likely to demonstrate prejudice and negative reactions towards affected individuals, compared to those with limited HIV knowledge.

Although similar encounters associated with HIV-related stigma have been documented throughout the world, the extent of its impact could vary depending upon social context and cultural beliefs (Herek *et al.* 1998). In that respect, HIV-related stigma shaped by cultural beliefs determines the severity of its influences. Aside from HIV disease itself, the pre-existing prejudices of gender and racial may also exacerbate HIV infection-related stigma (Logie *et al.* 2011). Taken together, how a society defines HIV illness and the roles of being women or women of colour can form collective interpretations of women living with HIV infection through individual perceptions and subsequent reactions. Therefore, HIV-related stigma that is profoundly engrained into social beliefs and values is an important factor that impedes women

with HIV infection to seek or receive support from close family and friends, employers and other community services.

Conclusion

This paper aims to critically explore the impact of HIV-related stigma on women's lives. Many women living with HIV infection experience significant levels of stigma that negatively affect their psychological well-being, social networks, and the utilisation of healthcare. These encounters can even be exacerbated further when considering the impact of gender and racial stereotypes posed by society. Therefore, it is imperative to take steps to address the severity of stigmatisation toward women with HIV infection. In addition, health care providers and political leaders must make a strong commitment in establishing sociocultural and political environment that enables HIV-positive women to facilitate their health behaviours and resist social inequalities. As the conceptual basis of the impact of HIV infection-related stigma remains poorly understood, this review paper can serve as a heuristic tool for understanding the impact of stigma on women living with HIV infection.

Relevance to clinical practice

The results of this paper reveal implications relevant to clinical practice. Firstly, as it is not uncommon to see health care providers made moral judgement while taking care of HIV-affected women, maintaining professional judgements and improving communication skills are inevitable for nurses and other health professionals. Even subtle actions, such as overuse of universal precaution, can potentially hurt the feelings of HIV-positive women. Hence, temperance is necessary for balancing professionalism and personal values and perceptions. By treating HIV-

positive women with respect and dignity, it helps to establish and enhance the trusting relationships between nurses and affected women, subsequently facilitating women's health behaviours. Secondly, since HIV infection-related stigma broadly affects women's lives, nurses should incorporate an assessment of HIV-related stigma into nursing care plans, specifically addressing the socio-cultural contexts in which the affected women live, their psychological well-being, support system, work-related issues, and issues in relation to access and adherence to treatment. As family is often the first support source for HIV-positive women, nurses should act as bridges to involve patients' family and friends into individualised care, and provide correct information about HIV illness. Thirdly, nurses should expand their roles and work on various levels, such as the effective mobilization of various community support groups, psychologists, social workers, career services and other professionals. Working with professionals from different sectors can ensure the provision of comprehensive care to HIV-positive women.

Fourthly, as HIV infection-related stigma is deeply engrained into social values and cultural beliefs, it may take years to diminish the heightened level of stigma. We, as nurses, should provide HIV-infected women with the strategies to combat stigma and further raise their awareness of support services and other opportunities within the community, in which they can meet other women living with HIV infection. Thereby, HIV-affected women can share their experiences and coping strategies. The involvement in support groups can help to encourage women to get involved in HIV care, build their confidence, and amplify their ability to resist and challenge the socially-constructed HIV-related stigma and other social injustice.

Fifthly, revealing or concealing HIV status to their family and friends appears to be a difficult decision for HIV-positive women, and this decision heavily affects their management of HIV

illness and ultimately clinical outcomes. Thus, nurses should play an active role in assessing and understanding the concerns of women with HIV infection and provide interventions based on their needs. Last but not least, HIV-infected women's confidentiality should be reinforced in healthcare settings to ensure their privacy is protected and respected.

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Conflict of interest

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Figure 1 Flow chart of study selection process

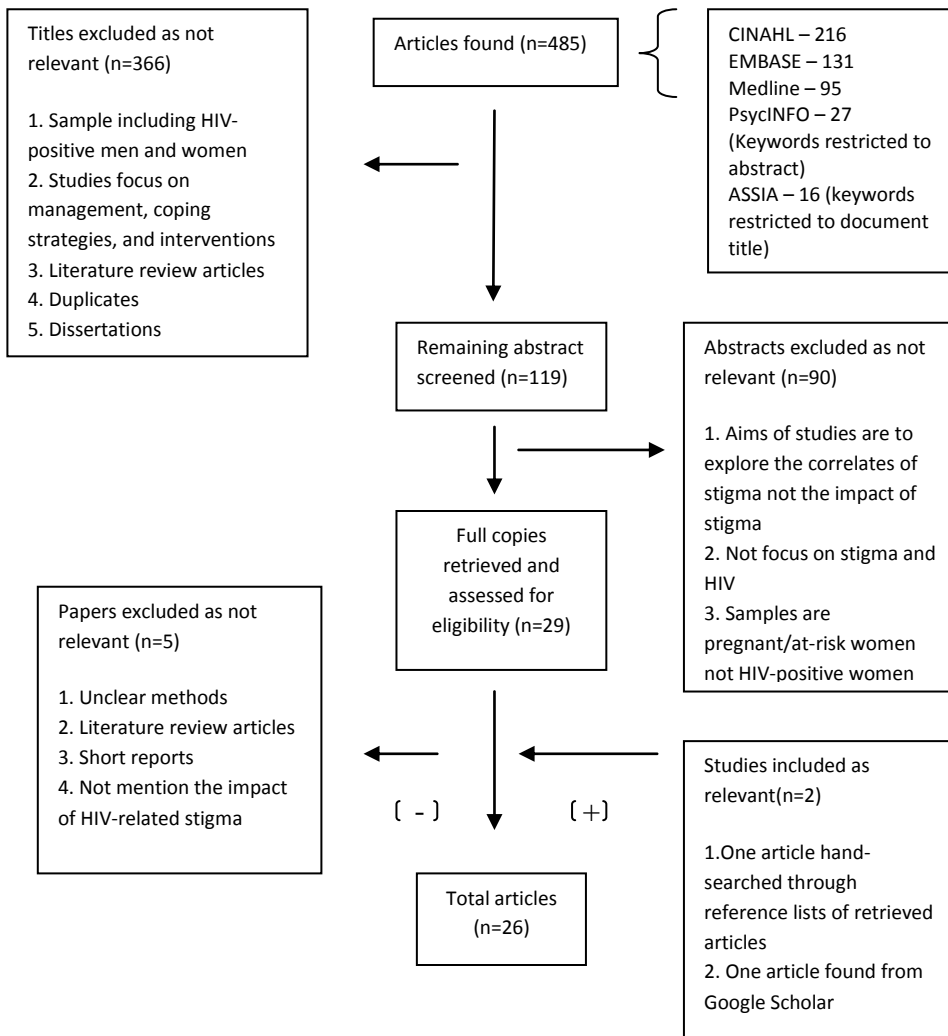


Table 1: Summary of the selected articles

	Author (year)	Country	Title	Research design	Participants	Sample size	Impact area of stigma
1	Peterson (2010)	US	The challenges of seeking and receiving support for women living with HIV	Qualitative study	HIV-positive women	N=45	Relationships
2	Teti et al. (2010)	US	'pain on top of pain , hurtness on top of hurtness': Social discrimination, Psychological well-being, and sexual risk among women living with HIV/AIDS	Qualitative study	HIV-positive women	N=26	Psychological distress, unprotected sex
3	Vyavaharkar et al. (2010)	US	Relationships between stigma, social support, and depression in HIV-infected African American women living in the rural southeastern United States	Quantitative study	HIV-infected African American women	N=340	Psychological distress
4	Wingood et al. (2007)	US	HIV discrimination and the health of women living with HIV	Quantitative study	HIV-positive women	N=366	Psychological distress, ↓seeking medical care, unprotected sex
5	Murphy et al. (2006)	US	Correlates of HIV-related stigma among HIV-positive mother and their uninfected adolescent children	Quantitative study	HIV-positive women/their children	N=118	Psychological distress,
6	Carr & Gramling (2004)	US	Stigma: A health barrier for women with HIV/AIDS	Qualitative study	European American women with HIV	N=9	Relationships, employment, healthcare
7	Abel & Painter (2003)	US	Factors that influence adherence to HIV medications: perceptions of women and health care providers	Qualitative study	HIV-positive women v.s. health care professionals	Two focus groups 6 women with HIV; 5 health care professionals	↓medication adherence
8	Clark et al. (2003)	US	Stigma, disclosure, and psychological functioning among HIV-infected and Non-infected African-American women	Quantitative study	HIV-infected and Non-infected African-American women	98 HIV-infected and 146 non-infected women	Psychological distress
9	Logie et al. (2013)	Canada	Associations between HIV-related stigma, racial discrimination, and depression among HIV-positive African, Caribbean, and black women in Ontario, Canada	Quantitative study	HIV-positive African, Caribbean, and black women	N=173	Psychological distress
10	Logie et al.	Canada	HIV, gender, race, sexual	Qualitative	HIV-	15 focus	Relationships,

	Author (year)	Country	Title	Research design	Participants	Sample size	Impact area of stigma
	(2011)		orientation, and sex work: A qualitative study of intersectional stigma experienced by HIV-positive women in Ontario, Canada	study	positive women	groups across five cities (n=104)	healthcare
11	Wagner et al. (2010)	Canada	Correlates of HIV stigma in HIV-positive women	Quantitative study	HIV-positive women	N=159	Psychological distress
12	Rouleau et al. (2012)	Canada	Disclosure experience in a convenience sample of Quebec-born women living with HIV: a phenomenological study	Qualitative study	HIV-positive women	N=8	Relationships, healthcare
13	Ndirangu & Evans (2009)	UK	Experiences of African immigrant women living with HIV in the UK: Implications for Health Professionals	Qualitative study	HIV-positive women	N=8	Relationships, healthcare
14	Anderson & Doyal (2004)	UK	Women from Africa living with HIV in London: A descriptive study	Qualitative study	African immigrant women with HIV	N=62	Relationships, healthcare
15	Okoror et al. (2014)	South Africa	HIV positive women's perceptions of stigma in health care settings in Western Cape, South Africa	Qualitative study	HIV-positive women	N=51	Healthcare
16	Lekganyane & du Plessis (2012)	South Africa	Dealing with HIV-related stigma: A qualitative study of women outpatients from the Chris Hani Baragwanath Hospital	Qualitative study	HIV-positive women	N=6	Relationships
17	Hattingh et al. (2009)	Free State, South Africa	Socio-demographic risk factors for HIV infection in women living in Manguang, Free State	Quantitative study	HIV-infected women and HIV-uninfected women	N=249 HIV-infected women; N=239 HIV-uninfected women	Employment
18	Wingood et al. (2008)	South Africa	HIV stigma and mental health status among women living with HIV in the Western Cape, South Africa	Quantitative study	HIV-positive women	N=120	Psychological distress, employment
19	Okoror et al. (2007)	South Africa	"My mother told me I must not cook anytime" – Food, culture, and the context of HIV- and AIDS-related stigma in three communities in South Africa	Qualitative study	HIV-positive women	N=195	Relationships
20	Theilgaard et al. (2011)	Tanzania	Addressing the fear and consequences of stigmatization – a necessary step towards making HAART accessible to women in Tanzania: a qualitative study	Qualitative study	HIV-positive women v.s. healthcare providers	Four focus groups 40 women with HIV; 6 healthcare providers	↓seeking medical care, relationships
21	Wu et al. (2008)	Peru	Burden of depression among impoverished HIV-positive women in Peru	Case series	HIV-positive women	N=78	Psychological distress
22	Brickley et al.	Vietnam	Community, family, and	Qualitative	HIV-	Interviews:	Relationships

	Author (year)	Country	Title	Research design	Participants	Sample size	Impact area of stigma
	(2009)		partner-related stigma experienced by pregnant and postpartum women with HIV in Ho Chi Minh City, Vietnam	study	positive women	N=20 Focus groups: N=14	
23	Kako and Dubrosky (2013)	Kenya	“You comfort yourself and believe in yourself”: Exploring lived experiences of stigma in HIV-positive Kenyan women	Longitudinal qualitative study	HIV-positive women	N=54	Relationships, affecting their own business
24	Poindexter (2013)	New Zealand	HIV stigma and Discrimination in medical settings: stories from African women in New Zealand	Qualitative study	African immigrant women with HIV	N=4	Employment
25	Liamputtong et al. (2009)	Thailand	HIV and AIDS, stigma and AIDS support groups: Perspectives from women living with HIV and AIDS in central Thailand	Qualitative study	HIV-positive women	N=26	Employment, healthcare
26	Rahangdale et al. (2010)	India	Stigma as experienced by women accessing prevention of parent-to-child transmission of HIV services in Karnataka, India	Qualitative study	HIV-positive women	N=14	Relationships, healthcare