Background
AIDS stigma inflicts hardship and suffering on people with HIV and has been found to reduce the likelihood of seeking HIV counseling and testing, using PMTCT and disclosing one’s HIV-positive status, which can lead to sexual risk taking.

Stigma can deter infected individuals from seeking timely medical treatment for HIV-related problem, accessing local health care facilities. It can also reduce HAART adherence, which increases the risk of treatment failure and the development and transmission of drug resistant virus.

The present study was designed to examine prevalence of AIDS stigma and discrimination and their underlying factors in two urban Indian settings.

Methods
We recruited 1,076 adult participants, who were seeking non-HIV-related health care services from hospital and clinic waiting areas in Bangalore (n=530) and Mumbai (n=546).

Endorsement of coercive policies and intent to discriminate against People Living with HIV (PLHA), HIV-related knowledge, perceived impact of personal values, and feelings toward PLHA and other marginalized groups were assessed in face-to-face interviews.

Results
Demographics

<table>
<thead>
<tr>
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<th>Mumbai</th>
<th>Bangalore</th>
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<tbody>
<tr>
<td>Mean age (range)</td>
<td>32.1 (18-66)</td>
<td>32.3 (18-70)</td>
</tr>
<tr>
<td>Education (10 yrs)</td>
<td>86.2 %</td>
<td>39.2 % **</td>
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<tr>
<td>Monthly income</td>
<td>Rs.18,023</td>
<td>Rs.12,652 **</td>
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*p < 0.05

As shown in Table 1, the vast majority of participants supported coercive testing policies for marginalized groups at high risk for HIV/AIDS as well as coercive family policies, and tended to blame PLHA for their own infections.

Self-reported intent to discriminate varied depending on the type of situation presented, with the majority reporting that they would not want to be treated in the same clinic as a PLHA (56%) and 52% stating that they would refuse to eat from the same plate as an infected individual.

The mean percent correct knowledge were 77% in Bangalore and 71% in Mumbai (p<0.01). Misconceptions regarding casual transmission routes were common at both sites, but were held by a significantly larger proportion of participants in Bangalore (47%) than in Mumbai (38%, p<0.01).

As shown in Table 3, both endorsement of coercive policies and intent to discriminate against PLHA was associated with:

- the belief that people who become infected deserve their infections,
- having negative feelings toward PLHA,
- misconceptions re: causal transmission,
- HIV-related worry, and
- perceiving that one’s opinions about HIV are influenced by one’s moral beliefs.

Summary/Conclusions
The results reveal a high prevalence of stigma attitudes and intent to discriminate in both cities, suggesting that AIDS stigma is not a region-specific phenomenon in India.

The results also show that basic HIV education is still needed in urban Indian settings. Programs may benefit from involving PLHA to humanize the epidemic.

The regression analyses show that AIDS stigma attitudes and intent to discriminate against PLHA are driven primarily by misconceptions, blame and negative feelings towards people living with HIV/AIDS, highlighting the importance of addressing these factors in future stigma reduction interventions.