

Stigma, discrimination and HIV or AIDS: an empirical investigation of Asian immigrants and refugees in Canada

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Abstract

Purpose – HIV or AIDS remains invisible and dismissed by most South Asians living in Canada as HIV or AIDS issues are perceived as an offshoot of Western lifestyle linked with drug use and promiscuity. This paper aims to look into how people living with HIV or AIDS (PLWHA) cope with prejudice and stigma.

Design/methodology/approach – To guide this research, a constructivist grounded theory approach was adopted as the theoretical and methodological framework. The authors reached the participants through a Toronto-based group that works with PLWHA. The authors chose their respondents in a snowball method and interviewed them both in person and online.

Findings – This paper identifies how South Asian immigrants and refugees/refugees with HIV or AIDS claimants are vulnerable to discrimination in Canada due to the following factors, which include but are not limited to: a lack of information about HIV and AIDS incidence in the community; and the Canadian health system's inability to respond appropriately to the lack of information.

Practical implications – HIV service engagements should take place within the context of a constellation of local traditions, or standardized expectations of patient engagement with HIV services can be counterproductive.

Originality/value – It is critical that governmental action prioritizes increasing public understanding of stigma. To minimize the consequences of HIV-related discrimination and stigma, misconceptions about HIV transmission must be debunked.

Keywords Stigma, Canada, Asia, Discrimination, HIV or AIDS, Serostatus

Paper type Research paper

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Background

Under the Refugee Convention, Canada welcomes around 25,000 refugees and 250,000 immigrants each year (CIC, 2011). Asia accounts for roughly half of all newcomers. India alone sends 35,000 immigrants to Canada each year (CIC, 2020). Refugees and immigrants are permitted to enter Canada even with HIV and AIDS. As a result, the number of people living with HIV (PLWH) arriving in Canada from South Asia could be substantial. The Government of Canada estimates that 63,000 people will be living with HIV in Canada in 2022 (Serebrin Jacob, 2022). In 2002/2003, around 700 people living with HIV or AIDS (PLWHA) [refugees] landed in Canada; since 2000, 172 PLWHA have come to British Columbia alone (Haag and Gilbert, 2007; Kiffer, 2020). This has alarmed public health professionals and policymakers in Canada, as it threatens to strain already overburdened public health facilities while also increasing the risk of HIV transmission within the country. Immigrants living with HIV in Canada face additional stress as a result of their HIV condition, making them even more vulnerable. HIV or AIDS stigma and prejudice continue to be significant barriers to accessing care and treatment.

Multiple challenges confront South Asian immigrants and refugees, particularly women, including socio-economic inequity, systematic marginalization, gender inequality and cultural and language barriers. Inequality refers to the state of being unequal, and it usually pertains to numerical values. At the same time, inequity is a near synonym for injustice and unfairness, and it usually refers to more qualitative issues. These people may face many forms of prejudice, putting their health and the health of others in jeopardy. However, at this time, nothing is known regarding the degree of this risk and its influence on health, either experimentally or anecdotally. South Asia is home to around 10% of the world's PLWH (UNAIDS, 2010) and approximately 93% of individuals affected in South Asia live in India (Hasman and Noble, 2016).

AIDS appears to be regarded as someone else's problem. Hence, AIDS stigma has become deeply entrenched in the attitudes of health-care practitioners. Several violent attacks against PLWHA have happened in the recent decade, including one in Bangladesh, where a man was set ablaze and burned. The same happened to a teacher living with HIV in India. Logie *et al.* (2016) focused heavily on the third phase (of his three phases: the HIV epidemic, the AIDS epidemic and the stigma, prejudice and denial epidemic), which is currently one of the least explored aspects of HIV or AIDS. Stigmatization, prejudice and discrimination all have similar effects in terms of severity. The hardship they impose on an individual's life is exacerbated by their gender, ethnic identity, origin and cultural background. Migrants, in general, and refugees in particular, endure more discrimination in destination nations than native-born inhabitants.

Stigma is the product of prejudiced attitudes that lead to discrimination. One of the most apparent consequences of stigma is the isolation of those who are stigmatized by family, friends, co-workers and even health-care professionals who are charged for providing treatment and support. HIV transmission may be viewed as the outcome of "immoral" behaviour, which is the most critical factor in the degree of prejudice (Jun, 2020; Lu *et al.*, 2019). People believe that PLWHA deserves to be punished for their depravity (Bharat *et al.*, 2001, p. 8). There has been little published research on HIV prevalence and treatment among South Asians in Canada. Anecdotal information suggests that many South Asian women in Canada are unaware of their HIV status until they begin prenatal care and are tested for HIV as part of routine procedures in the early stages of pregnancy (Yoshioka and Schustack, 2001). Disclosing one's HIV status can be a depleting emotional experience for anyone (Nishanth *et al.*, 2021). A study conducted in the USA discovered that 73% of all known South Asian HIV or AIDS cases started in India, 19% in Pakistan, 6% in Bangladesh and 2% in Sri Lanka (CDC, 1998). Approximately 1.2 million people in the USA have HIV. About 13% of them do not know it and need testing. Asians, who make up 6% of the population, accounted for about 2% of HIV diagnoses in 2018 in the USA (CDC, 2019). It is fair to expect a similar distribution in Canada (Zaidi, 2005).

The purpose of this research is to learn how South Asian immigrants, refugees and asylum seekers living with HIV in Canada are coping with the obstacles of living with HIV or AIDS. The study's specific goals are to discover:

- To what extent do refugees and immigrants living with HIV or AIDS face prejudice from their own ethnic communities, gender groups, and the general Canadian population?
- How does discrimination affect health outcomes (morbidity and mortality, social isolation, mental health and general well-being)?

Methods

We considered Snedden's (2016) definition of South Asia in this study. Bangladesh, Bhutan, India, Pakistan, Nepal and Sri Lanka are all part of South Asia; Afghanistan and the Maldives may also be included. The term "Indian subcontinent" is commonly used

interchangeably with the former; however, the latter word is reserved for Bangladesh, India and Pakistan (Snedden, 2016). We used immigrants/refugees (as our participants) primarily because some refugees became immigrants and citizens at a point in time. Refugees are the most likely of all sorts of immigrants to apply for citizenship. For refugees to become Canadian citizens, they must spend at least three years in Canada, pay a fee and pass a test on their knowledge of Canadian history, geography, economics, government, laws and symbols. All of our participants were either refugees or immigrants, but during the study, many became citizens, some immigrants and some remained refugees.

Participant selection, ethical approval and consent to participate

One of the strategies used was observation (both participatory and non-participatory), and great care was taken to ensure work ethics, timeliness and clear communication with participants. McMaster University Research Ethics Board approved this study. The vast majority of the interviews were conducted in person. To recruit individuals, snowball and purposive selection techniques were used. Some of the interviews were performed online using the PLWHA's dedicated chat rooms. Sex and sexuality are taboo themes in many Asian cultures, and they are rarely discussed openly. Given the sensitivity of these themes, particularly those involving sexuality and sexual practices, developing rapport with interviewees is critical in allowing participants to reveal these matters without feeling embarrassed or criticized. Respect and civility, acceptance and understanding, privacy, integrity and individualization were all primary values in all of the interviews.

Study design

To guide this research, a constructivist grounded theory (GT) approach was adopted as the theoretical and methodological framework. GT is a standard qualitative research tool for investigating social processes and elucidating how people anticipate and respond to life events. This technique is crucial for this study because it seeks to analyse the life experiences of the researched. Developing a theory is an iterative process when using GT. Further data is collected and analysed for every new hypothesis until it does not yield any new information. We use GT when existing theories do not effectively describe a phenomenon.

Rather than starting with a pre-existing theory, a constructivist GT approach attempts to build a theory based on data that has been systematically obtained and scrutinized (Diesel *et al.*, 2016). This method is appropriate for the study, especially given the scarcity of data on South Asians living with HIV and AIDS in Canada.

The research team and reflexivity

This project was carried out as part of a post-doctoral research fellowship (funded by CIHR, Canada). The researchers are/were both males with extensive and long research experience in Asia, Africa, Europe and North America.

Relationship with participants

We reached the participants through a Toronto-based group that works with PLWHA. Through this organization, we established rapport with the participants. Participants were properly informed [according to the ethics protocol] that the interview would be conducted purely for academic and research purposes. The participants clearly spelled out that the interviewer is a researcher.

Data collection

Participants were given a checklist that included necessary guides. Repeated interviews were conducted when some questions required more in-depth and clearer replies. Repeated interviews were scheduled and conducted according to the convenience of the participants. We used an audio recorder with their permission while interviewing them. There were no interviews that lasted longer than 45 min. To make sure that the participants were comfortable with the answers they provided, transcripts were given to participants for their comments or edits, if any.

Analysis

The data was coded and entered by the first and second authors. We used Nvivo to manage interview transcripts, web content and audio. The findings were presented to the participants. Some quotations from the participants were presented to illustrate the findings. We anonymized the participants while quoting them.

Results

We interviewed 28 participants on the organization's premise, where they get consultation services in Toronto. All of them happily participated in the interview. Participants in the study came from a diverse spectrum of socio-economic and cultural backgrounds. Education, present and previous employment, and financial condition all have a role in one's social standing. The vast majority (57%) were unemployed (either voluntarily or forcibly). In comparison, 29% volunteered in medical care and service groups, 18% worked in fast-food restaurants such as McDonald's and Tim Horton's and a few worked as sex workers. The majority of persons were living with HIV or AIDS through unprotected heterosexual sex; seven of them were infected through homosexual sex; five were infected through sharing injection equipment; and a few others were infected through blood transfusions. Of the 28 participants, six self-identified as transgender or inter-sexed. Two of the six transgender individuals were transwomen. The remaining 22 were grouped by male (13) and female (9). The mean age of the participants was 39.

Sentiments about HIV and AIDS

HIV status concealment has ramifications for both individuals and the community. The psychological toll of concealment is the most significant. "Carrying this news in secret is the heaviest burden in the world," said one participant who delayed almost six months to reveal his status. I was on the verge of going insane because I thought it needed to be shared with someone. Not admitting it cost me a couple of years of my life in those six months. It is preferable to confront whatever occurs due to the disclosure; the internal conflict over disclosure can lead to loneliness, isolation and melancholy (Chesney and Smith, 1999, p. 1165; Nishanth *et al.*, 2021). Infected people experience worries and irritation as a result of the secrecy. Furthermore, they are scared that obtaining treatment would lead to unintended and undesired disclosure, putting them in a humiliating situation.

Another highly detrimental of secrecy can be noticed in sexual relationships. The risk of transferring the virus to loved ones via sexual contact is particularly frightening. Because their partner is uninformed of the justification, PLWHA loses the bravery to negotiate safe sex in such instances. "It's the most difficult time in a relationship," one participant stated. This was ethically repugnant to me. I have been asked a few times why I've suddenly become more conservative about our sexual relationship. I tried to justify myself, but I felt like I was lying'.

There could be a variety of causes for the delay in disclosure. Some people put off treatment because they cannot accept the fact that they have been infected, do not

understand how it happened to them or do not trust the test results. “I reasoned that it would be easier for me to bear the sorrow alone. What is the point of telling people about this? Bad news breeds more bad news.” Specific risk groups, such as MSM, are particularly vulnerable to stigma. This, in turn, expresses the fear of being stigmatized simply for seeking HIV testing ([Chesney and Smith, 1999](#), p. 1164). This means that certain groups bear the double sigma burden, which has a double impact. Working directly with PLWH can cause additional delays in care; for example, treating PLWHA may limit their career options, making it harder to transition from HIV therapy to another field of medicine.

When questioned about their initial reactions to learning of their HIV status, the majority of respondents said the same thing: it was a heart-breaking experience, a significant burden and virtually indescribable: “[...] I wish there were languages for expressing emotions. I wish there were something or someone who could comprehend my emotions. I wish I could describe how I felt at the time. I suppose I still carry a feeling almost identical to the initial one. There is no difference. Of course, first impressions were the starting point”.

Many of the participants were sceptical of the diagnosis’s outcome at first. They raced to get examined several times, with some seeking six or seven opinions in the hopes of receiving a negative diagnosis:

It is difficult to accept that one has been diagnosed with a critical condition. I would like to believe that HIV never existed. By accident, scientists came to this conclusion. They have come up with some new ideas lately. Alternatively, I would like to know if this is a fever-like illness. We contract the ailment, buy some over-the-counter medication and recover.

A particular way of life emerges as the prevailing one. Only a few activities are allowed inside this framework: medication, food and movement (3M). Some individuals who told their relatives about their situation received comfort, collaboration and assurances of future help. However, as time passes, PLWHA’s focus shifts to other concerns, and they become despondent:

A few days ago, I was an average person. I used to go to work, stores, the bank, and meet with pals for coffee. Friends’ calls became less frequent than they had been previously. When I make phone calls, they go unanswered. The discussion time has significantly decreased even if they pick up the phone. These changes happened so quickly! It is excruciating! These, I suppose, are pushing me toward my final breath [...] Can you fathom what would happen if the world were to change?

The widespread belief worsens the devastating stigma that HIV is spread by indiscriminate, dangerous intercourse with sex workers ([Abad et al., 2015](#)) and men:

I pray to God regularly. I inquire as to what major crime I committed warranted such a punishment. I am not sure what I can do to get rid of this. So, what exactly do you want me to do? I have never worked in the sex industry or been a client. How can I inform the rest of society that I have joined this group? I am afraid I cannot.

The opinions offered by the participants about their feelings paint a different image. Interestingly, some respondents expressed relief after receiving a positive diagnosis, stating that they now had evidence of why they had been experiencing multiple symptoms for months and why no treatment had been able to alleviate those symptoms. In some ways, they felt relieved, at least because they know how to proceed with their treatment plan.

Most respondents had to wait two to three months after learning that they were living with HIV before seeing an infectious disease specialist. Many acknowledged being hesitant to take medication because they had lost hope in life. However, according to participants, some clinicians assisted them in changing their outlook on life. “[...] surprisingly, doctors discuss saving lives! I am curious how current medical technology has failed terribly to provide hope to persons experiencing this disease.”

Participant A, a 37-year-old Bangladeshi man, was tested for HIV following unprotected sexual contact. He was the fourth kid in a four-child family. His entire family in Canada, as well as a percentage of his relatives in his home nation, relied on his salary. His HIV test confirmed that he was afflicted with the virus.

I jumped out of my chair and started screaming, wailing, and slapping myself. I sobbed on the floor in the clinic's corner; my knees squeezed against my chest. I realized I could not share my tremendous agony with anyone else. I began to feel despondent and unhappy, believing that I was unique among my peers. I would continue to think and act differently than before.

"I cry tears of despair and misery as I reflect on the unfair circumstance," remarked Participant A. However, as I learned from reading and counselling sessions, "I have got the virus, but I am not the virus".

The concept of "stigma contagion" is presented here to explain how stigma can influence people's lives regardless of whether they are "guilty" or "innocent." As one person put it:

It was given to me by my parents. Fortunately, thanks to HAART, I have been able to stay alive. This is not to say that I am not in pain. This is not just physical pain; it is also continuous psychological distress. It is a terribly unpleasant scenario. Some of my family members and I are well aware that I am not to blame. But how could I persuade the entire society that I am not guilty? Is not being accused of a crime you did not commit the most excruciating experience? What makes matters worse is that I cannot ask my folks what I did wrong. They were not alive anymore.

According to several types of research, disclosing information to children might have major consequences, including increased family issues, deteriorated family relationships, poor self-esteem and traumatic memories (Ullah, 2011):

My parents invited several of my relatives because it had been long since they had seen them. We, too, wished to have a wonderful time with them. They declined the invitation at the last minute, stating that they had some pressing tasks to complete. My parents eventually told us that they turned us down since they were aware of our sero statuses.

Discrimination and stigma experienced

People not living with HIV in the community criticize PLWHA for stigmatizing them in the general public; as one HIV negative individual put it:

[...] we, as a community, have been vilified as a result of a tiny number of dumb people who became sick. We are not liable for the suffering of others. Even though we are not optimistic, people perceive us to be so. Then who is to blame? So, how do we deal with the positive? We already have a horrible reputation. We are both gay. Ok. We are aware that we are frequently looked down upon. However, we cannot accept that people think of us in a favourable light [...]. (Interview)

When this group interacts with the general population, they usually endure discrimination on both sides. Refugees and immigrants who are already exposed to xenophobic prejudice and discrimination based on their sexual orientation and HIV status.

The level of stigmatization and discrimination varies depending on the conditions. Natives, for example, face less prejudice than non-natives, while PLWHA faces less stigma than those who have fully developed AIDS. As a result, HIV-positive individuals with higher CD4 counts face more discrimination than those with lower CD4 counts. In general, three types of stigmas have been described in the literature: performed stigma, felt stigma, and internalized stigma.

Individuals who experience illnesses may not always face the same level of stigma; stigma is determined by social identity, public opinion and other factors. It is widely accepted that

stigma represents the creation of deviation from expectation. According to [Goffman \(1963\)](#), stigmatization is a powerful disparaging social term that radically modifies people's ideas of themselves. Stigma, as a social construct, has an impact on the lives of those who are infected, as well as their partners, family and friends. Many academics interpreted Goffman's idea to include a wide range of negative attributes, such as how society rejects people based on their psychological and physical characteristics when they deviate from widely accepted normative norms. As a result, stigma hinders people from interacting socially.

When diagnosed with cancer, they must accept that their life expectancy will be considerably reduced. Their mental health may endure as a result of their loss of hope. This has occurred in the early stages, but the sickness is manageable and not outwardly disruptive. The duration of this phase is predicted to be four years. Individuals can deny their HIV status because there may be no apparent signs of it. Concealability becomes a defence against enforced stigma, and people try to hide their status as much as they can. Some people assume that hiding their true feelings will safeguard their self-esteem. However, this comes at the expense of social support. Individuals begin to develop evident clinical manifestations associated with the condition after the latent period of the disease ([Alonzo and Reynolds, 1995](#); [Rongfeng et al., 2020](#)), which results in noticeable changes in their behaviour and those in the community.

"I wish I had cancer instead of this disease." I might be able to die peacefully. I have already died before I have even begun to die. Cancer or other diseases may have aroused sympathy from me, but the consequence has been wrath, shame, and solitude". (One of the participants)

Despite the fact that PLWHA in Canada is not considered a threat to public health or safety, they are expected to place a high demand on public health and social services ([Aids Law, 2006](#)). Regulations limiting resident applicants due to public health concerns include two exceptions: one for people applying for permanent residence as a refugee or as a person "in need of protection," and another for "family class" applicants ([CIC, 2011](#)). Many theories concerning identification, bias, stereotyping, group dynamics and social movements make use of the idea of stigma. Simultaneously, historical and cross-cultural settings must be examined, as stigmas that are important in one culture or period may be relatively insignificant in another society or period ([MacIntosh, 2007](#)).

Disclosure

Many factors can have an impact on disclosure decisions. On the other hand, the number and severity of the factors are determined by one's society and family. The conventional wisdom holds that people will immediately disclose their sexual orientation to their partners. However, what happens to people who do not have partners? How do people who are single initially talk about their situation? The effect of disclosure varies according to the level of knowledge and awareness ([Proscovia et al., 2021](#)). In the health-care system, confidentiality, which is linked to disclosure, is a significant concern. Serostatus, on the other hand, should be known by those who need to know, such as doctors, nurses, caregivers and psychosocial counsellors, due to its practical implications ([Greeff, 2008](#); [Roberts et al. \(2016\)](#); [Fennel et al., 1994](#)).

Rejection in relationships

One of PLWHA's main fears is the possibility of being marginalized and rejected by their group. The most common barrier to disclosure is rejection by sexual partners, family members, classmates, friends and co-workers. One person said,

I did not want to be apart from my family and friends. I expected them to abandon me. My wife questioned whether I had tested positive after noticing my persistent drop in her desire to

engage in sex. I gave the nod. I could see how fast her heart was beating. She went through several days and nights without eating, sleeping, or showering. In a month, she looked to have recovered[...] She did, however, build a relationship with another man in a year, I believe. She started arriving home late. I used to check in with her to see if anything was wrong. She said, sobbing, that everything in her life had gone wrong. It was clear that she was referring to my current situation. I was powerless. While I understand her anguish, I suppose being useless is even worse. She has options, whereas I do not.

Potential sexual partners turned down almost every participant because of their HIV status. This has long-term consequences for their self-esteem and confidence. Some men claimed to have been socially and sexually isolated from other HIV-positive men, whom they frequently considered morally inferior. In general, people refuse to accept meals prepared by PLWHAs. This, too, is based on the individual's HIV or AIDS knowledge, comprehension and information ([Proscovia et al., 2021](#)).

[...] one of my friends and I split a can of coke. He might have been hesitant to turn down my offer. It was excruciatingly unpleasant when I learned afterwards that he had gone to the laboratory to be tested.

Is it possible to be stigma-free? Human rights violations, epidemic fuelling, and care attempts are all hampered by stigma. This has long-term societal implications: "AIDS is no longer killing people. The stigma is what is killing us. We are killed by the way we are looked upon" (one respondent).

Adherence to antiretroviral therapy

It is critical to stick to HIV treatment for the drug to lower the viral load effectively. If you miss a dose of your medication, even if it is only once in a while, HIV has a reasonable probability of multiplying quickly. The level of stigma associated with HIV can have a direct impact on drug adherence. People who disclose their HIV status to a wide range of social contacts are more likely to face stigma and the difficulties that come with it ([Mao et al., 2009](#)). People with HIV-related physical symptoms have lower treatment adherence rates ([Mao et al., 2009](#); [Venable et al., 2006](#)). According to Rintamak et al. (2006), there is a direct link between adherence and social stigma. One person said,

The sum is excessive. This makes me feel relatively weak. I have never been one for sticking to a schedule. I have always been a free thinker and a free person. Getting my medicine feels like a major hassle. Some of my family members appear to be distressed at times. I am not sure if I should keep going. So, if I die soon, what is the point?

There is no doubt that complicated therapy regimens burden patients. It is usual to forget to take medication from time to time. In many circumstances, people cannot ask anyone to remind them to take their prescription, and family members or partners may be reluctant to do so. The way they are reminded may have a stigma attached to it.

Social isolation and cultural sensitivity

The fact that most Asians want to protect their families from disgrace influences their disclosure. Only 2% of appropriately polled identified the primary risk behaviours for HIV transmission (unprotected anal and vaginal intercourse, having numerous sex partners and using non-sterile drug injection equipment). One Bangladeshi participant put it this way:

After learning about it, I decided not to tell anyone in my family about my serostatus. For a few months, I was in that position. I concluded that carrying this responsibility was too much for me. I felt compelled to share, even though I knew it would cause my family and me more pain. I was pretty aware that not only I but the entire family would be labelled – like, "Oh, this family has HIV."

Stigma is applied in a more harmful manner on an individual level:

I called an old friend and offered him coffee. While profanely swearing, he declined. He stated that he was not one of my contemporaries. Another participant reported that a buddy called him a “prostitute” in public. Maybe I am, but I knew she was alluding to my HIV status. This is considered verbal abuse. That treatment struck me as a little abrupt. Those who tend rejection can show it gradually. Then we are not as surprised as we may be.

Harassment is a by-product of stigmatization. It can take many forms, including sharing offensive jokes, sending provocative emails or texts, exhibiting or showing pornographic photos, taunting about religion and race and inquiring about personal life. Abuse arising from stigma in the workplace can range from verbal to physical, including yelling and using harsh words; isolating; intimidating; assigning more complicated assignments than before; purposely modifying work rosters; and undermining performance. One participant explained how she lost her job in the following way:

My supervisor called me after the second month. He was, in my opinion, a good person with a good heart. Like others in the office, he claimed that he was aware of my status and that certain complications were associated with it. The company would like to extend your contract for another month and would appreciate it if you resigned. That month, I did not take it. That was my last day at work on that particular day. How could I return to where I was asked to leave because of my serostatus? It was humiliating, shameful, and excruciatingly painful. I recall going two days without eating. I wanted to sob uncontrollably. Nevertheless, there was no strength left to scream. I considered killing myself several times while I was there. I reconsidered my decision. I knew PLWHA had an extended life span.

This participant spoke about a variety of difficulties, one of which was her financial status. She went without a job for a few months because she had no savings. She was recruited by a community service organization that was fully aware of her situation. Prior to reaching this position, however, the detailed participant internalization of the stigma she had been exposed to:

You are well aware of the high cost of living in this city. My family and friends were already aware of my situation. One of my pals came to get some money from me. She was in desperate need of cash. I believe she rushed because she feared I might die before I could repay the money. I opened my freezer one morning. It was completely devoid of people. I was starving. I was apprehensive about going out to get groceries. I did not go out till it was completely dark.

According to studies, disclosure frequently leads to violence against PLWHA, which often increases due to gender. In most Asian cultures, women are at the bottom of the family structure. As a result, male dominance over them is a common occurrence, making it feasible to commit violence against them:

It hit me like a ton of bricks. My husband, I assumed, was the person closest to me on the planet. I felt the distance between us widen as soon as he learned of my serostatus. He simply pushed me back and exclaimed, “What?” What? What exactly did you say? This is not the first time he has been rude to me. I have always believed that your partner is your best friend, the person with whom you can share anything. Now I realize he is only interested in hearing positive news [...] but that is life. My life belongs to me, and he belongs to him. I need to live a long life.

Discussions

The south Asian community in Canada faces double or multiple discrimination because they are a visible minority and have HIV. Stigma promotes prejudices based on sexual orientation, gender, race, socio-economic position and HIV status. Respondents endured more stigma among South Asians than in other Canadian populations. Furthermore, women living with HIV were shown to be particularly vulnerable and stigmatized. Because of stigma, many PLWH concealed their status and avoided HIV-related services.

Principal findings

The main finding in this article is that South Asian immigrants, refugees and asylum seekers who test positive for HIV face discrimination in Canada. This is due to factors such as a lack of knowledge about HIV and AIDS in the community and the Canadian health-care system's inability to address the lack of knowledge appropriately.

Today, the HIV or AIDS pandemic is a human reality. People used to count their days after being diagnosed with HIV. This has altered as a result of medical advances. If PLWHA is detected early and put on medicine, they can expect to live longer than they thought. On the other hand, medical progress appears ineffective when discrimination and stigma associated with the disease contribute to the burden. Stigmatization and discrimination can happen to anybody, anyplace; abusers do not pick a convenient location to practice stigmatization or discrimination. For the stigmatized, however, the location of stigmatization or discrimination – for example, schools or workplaces – is extremely important. Stigmatization and prejudice had devastating implications for Asians in Canada. According to this assessment, workplace discrimination is the most harmful because it results in job loss and other direct consequences for the respondents. Discrimination in the workplace happens throughout the hiring process when different terms and conditions and benefits packages are offered to different employees. The transfer, promotion or dismissal of the respondents impacted. From hostility to pity, various sentiments from family members, friends and employers were conveyed in various ways. Extreme astonishment, nervousness, despair and depression were the most common reactions; a few people received the news well and conveyed that they were treated the same as everyone else. Some of the respondents were reassured that their friends and family would always be there for them.

Strengths and weaknesses

This research has led to significant findings about risk and protective factors at the population level. However, it has also sometimes pushed the idea that HIV risk and protective factors work and can be changed irrespective of the social-cultural context (Cahilland and Valadez, 2013). One of the most critical parts of this research is isolating variables to figure out how they affect HIV risk without other factors that could confuse, hide or change their link. This study aimed to learn more about how different social situations and sexual cultures affect HIV risk (Jones *et al.*, 2016). This study would have been richer if more respondents could have been added. This was, however, not possible due to resource and logistical constraints. This study has the potential to help researchers learn more about the cultural meanings of health, sexuality, resilience and other things related to HIV and AIDS (Chen *et al.*, 2020). It made it possible for people to offer detailed accounts of their own experiences that drew attention to socio-contextual, political and structural factors (Wilson *et al.*, 2016; Peyre *et al.*, 2018).

The dispute over whether concealment or disclosure protects children afflicted by vertical transmission and the benefits of concealment or disclosure warrants further exploration. How do you think youngsters will handle their serostatus? It could ruin their upbringing and education opportunities and inflict long-term mental stress if they find out.

Unanswered questions and future research

Research efforts should focus heavily on removing the obstacles that people face when trying to obtain medical care. Even though Canada is a bilingual country, the French-speaking minority in Anglophone regions sometimes receives inferior medical care because of the lack of services offered in their language (Djiadeu *et al.*, 2020). Furthermore, PLWH in rural areas face unique challenges that may harm their HIV care outcomes (MacKenzie *et al.*, 2017).

The results of this study cannot be extrapolated to include all of Canada's immigrants living with HIV. Internalized and enacted HIV stigma may have an impact on long-term participation in the HIV care chain during the process of migration and settling in Canada. Examine the connections between the present required HIV screening process, migration, settlement, culture, stigma and involvement in HIV care in Canada during the Canadian immigration process.

A person's capacity to receive health and social care, stable housing, meaningful employment and movement throughout society were all negatively impacted by a person's HIV status in Canada. It is critical to look at the experiences of racialized immigrants and the HIV screening procedure from an intersectional perspective. Immigration status, legal status, institutional rules and structures, gender, culture, trauma and intergenerational contexts must be taken into account by health and social care professionals when delivering adequate and appropriate health and social care to this population. Future research may delve into how the cultural and gendered aspects of language and communication in HIV prevention help minimize the level of discrimination and stigma. This will help health workers to treat HIV and AIDS in the real world and with the most vulnerable people.

Conclusions

The bottom line should be to reduce stigma and discrimination against the PLWHA. The critical issue is that stigma and discrimination are enforced at various levels, including family, community, institutional, legal and policy. Across multiple situations, practitioners can use a shared core approach to stigma and prejudice with appropriate changes. Some people's mind-sets are imprinted with discrimination. As a result, even if policies are in place, people cannot overcome this culturally or personally. This is exemplified by widespread discriminatory practices in all sectors of life. Addressing HIV-related stigma and prejudice remains a significant concern. It is crucial that raising public understanding regarding stigma is prioritized for policy action. Misconceptions about HIV transmission must be dispelled to reduce the repercussions of HIV-related discrimination and stigma.

It is important to place HIV service engagements within a constellation of local traditions, many of which will not shift easily to accommodate what is needed to execute engagement. If not negotiated among other practices on a local and individual level, standardized expectations of patient engagement with HIV services can be counterproductive. Due to the often-inadequate match between HIV care and treatment services and PLWH's lived realities, a more comprehensive practice-oriented HIV response is crucial.

Statements and declarations

Competing interests

The authors declare that the manuscript is an original work and has not been published, nor is it under consideration elsewhere. The authors declare that there is no conflict of interest.

Authors' contribution

The first author was responsible for conceptualization, data curation, formal analysis, funding acquisition, investigation, writing up and project administration. The second author was responsible for conceptualization, formal analysis, polishing the write-up, project administration, etc.

References

- Abad, N., Baack, B.N., O'Leary, A., Mizuno, Y., Herbst, J.H. and Lyles, C.M. (2015), "A systematic review of HIV and STI behavior change interventions for female sex workers in the United States", *AIDS and Behavior*, Vol. 19 No. 9, pp. 1701-1719, doi: [10.1007/s10461-015-1013-2](https://doi.org/10.1007/s10461-015-1013-2).
- Aids Law (2006), "Recent changes to the visitor visa process affecting entry into Canada for people living with HIV/AIDS", *XVI International AIDS Conference, AIDS2006. Toronto*, 13-18 August 2006, available at: <https://i-base.info/htb/5513> (accessed 9 December 2020).
- Alonzo, A.A. and Reynolds, N.R. (1995), "Stigma, HIV and AIDS: an exploration and elaboration of a stigma trajectory", *Social Science & Medicine*, Vol. 41 No. 3, pp. 303-315.
- Bharat, S., Aggleton, P. and Tyrer, P. (2001), *India: HIV and AIDS-Related Discrimination, Stigmatization and Denial*, Joint United Nations Program on HIV/AIDS (UNAIDS), Switzerland, Geneva, pp. 1-66.
- Cahilland, S. and Valadez, R. (2013), "Growing older with HIV/AIDS: new public health challenges", *American Journal of Public Health*, Vol. 103 No. 3, pp. e7-e15.
- CATIE (2007), *The Epidemiology of HIV in Canada*, CATIE, Factsheet, Toronto.
- CDC (2019), "HIV in the USA", available at: www.cdc.gov/hiv/group/raciaethnic/asians/index.html (accessed 23 November 2019).
- Chen, D., Duan, L., Chen, X., *et al.* (2020), "Coping strategies and associated factors among older Chinese people living with HIV/AIDS", *Psychology, Health & Medicine*, Vol. 25 No. 7, pp. 898-907.
- Chesney, M.A. and Smith, A.W. (1999), "Critical delays in HIV testing and care: the potential role of stigma", *American Behavioral Scientist*, Vol. 42 No. 7, pp. 1162-1174.
- CIC (2011), "Facts and figures: immigration overview-permanent and temporary residents", Canada, available at: https://qspace.library.queensu.ca/bitstream/handle/1974/8469/2011_CIC_Facts%20and%20Figures%20-%20Immigration%20Overview%20-%20Permanent%20and%20Temporary%20Residents.pdf?sequence=15&isAllowed=y (accessed 17 July 2018).
- Diese, M., Shrestha, L., Pradhan, B., *et al.* (2016), "Bottlenecks and opportunities for delivering integrated pediatric HIV services in Nepal", *Curr Opin HIV AIDS*, Vol. 11, pp. S21-29.
- Djiaadeu, P., Yusuf, A., Ongolo-Zogo, C., Nguemo, J., Odhiambo, A.J., Mukandoli, C., Lightfoot, D., Mbuagbaw, L. and Nelson, L.E. (2020), "Barriers in accessing HIV care for francophone African, Caribbean and black people living with HIV in Canada: a scoping review", *BMJ Open*, Aug 27, Vol. 10 No. 8, p. e036885, doi: [10.1136/bmjopen-2020-036885](https://doi.org/10.1136/bmjopen-2020-036885).
- Fennell, R.S., Foulkes, L.M. and Boggs, S.R. (1994), "Family-based program to promote medication compliance in renal transplant children", *Transplantation Proceedings*, Vol. 26 No. 1, pp. 102-103.
- Goffman, E. (1963), *Stigma: notes on the Management of Spoiled Identity*, Englewood Cliffs NJ, Prentice-Hall.
- Greeff, M., Phetihu, R., Makoe, L.N., Diamini, P.S., Holzemer, W.L., Naidoo, J.R. and Chirwa, M. (2008), "Disclosure of HIV status: experience and perceptions of persons living with HIV/AIDS and nurses involved in their care in Africa", *Qualitative Health Research*, Vol. 18 No. 3, pp. 311-324.
- Haag, D. and Gilbert, M. (2007), Trends in HIV positive immigrants and reporting by Citizenship and Immigration Canada (CIC) 2000 – 2007. Center for Disease Control. CDC, December.
- Hasman, A. and Noble, D.J. (2016), "Childhood immunisation in South Asia – overcoming the hurdles to progress", *Perspectives in Public Health*, Vol. 136 No. 5, pp. 273-7.
- Jones, B.L., Nagin, D.S. and Roeder, K. (2016), "A SAS procedure based on mixture models for estimating development trajectories", *Sociological Methods & Research*, Vol. 29 No. 3, pp. 374-393.
- Jun, Y., Eric, J.N., Van, P.D., *et al.* (2020), "Vietnamese female sex workers in rural cross-border areas of Guangxi, China: migration and HIV/STI risk behaviors", *AIDS Care*, Vol. 32 No. 12, pp. 1515-1523, doi: [10.1080/09540121.2020.1719968](https://doi.org/10.1080/09540121.2020.1719968).
- Kiffer, G.C., Anabelle, B.F., Fournier, J.T., *et al.* (2020), "Substance use patterns and awareness of biomedical HIV prevention strategies among sexual and gender minority men in Canada", *AIDS Care*, Vol. 32 No. 12, pp. 1506-1514, doi: [10.1080/09540121.2020.1719026](https://doi.org/10.1080/09540121.2020.1719026).
- Logie, C.H., Newman, P.A., Weaver, J., *et al.* (2016), "HIV-related stigma and HIV prevention uptake among young men who have sex with men and transgender women in Thailand", *AIDS Patient Care and STDs*, Vol. 30 No. 2, pp. 92-100.

Lu, N., Zixin, W., Yuan, F., Mary, I. and Lau, J.T. (2019), "Behavior intention to use routine opt-out HIV testing in primary care settings among men who have sex with men in China", *AIDS Care*, Vol. 31 No. 12, pp. 1565-1573, doi: [10.1080/09540121.2019.1612003](https://doi.org/10.1080/09540121.2019.1612003).

MacIntosh, J.M. (2007), "HIV/AIDS stigma and discrimination: a Canadian perspective and call to action", *Inter-American Journal of Psychology*, Vol. 41 No. 1, pp. 93-102.

MacKenzie, L.J., Hull, M.W., Samji, H., Lima, V.D., Yip, B., Zhang, W., Lourenço, L., Colley, G., Hogg, R.S. and Montaner, J.S.G. (2017), "Is there a rural/urban gap in the quality of HIV care for treatment-naïve HIV-positive individuals initiating antiretroviral therapy in British Columbia? ", *AIDS Care*, Vol. 29 No. 10, pp. 1218-1226, Epub 2017 May 4. PMID: 28472896, doi: [10.1080/09540121.2017.1322678](https://doi.org/10.1080/09540121.2017.1322678).

Mao, L., Kidd, M.R., Rogers, G., Andrews, G., *et al.* (2009), "Social factors associated with major depressive disorder in homosexually active, gay men attending general practices in urban Australia", *Australian and New Zealand Journal of Public Health*, Vol. 33 No. 1, pp. 83-86.

Nishanth, K.K., Sanjeev, B.B., Sunil, K.D., *et al.* (2021), "Determinants of HIV status disclosure to children living with HIV in coastal Karnataka, India", *AIDS Care*, Vol. 33 No. 8, pp. 1052-1058, doi: [10.1080/09540121.2020.1851018](https://doi.org/10.1080/09540121.2020.1851018).

Peyre, M., Gauchet, A. and Bissueletal, F. (2018), "Satisfaction with sexual life in people living with HIV/AIDS: the persistent weight of the fear of transmission", *AIDS Care*, Vol. 31 No. 6, pp. 681-686.

Proscovia, N., William, B., Joelynn, M., *et al.* (2021), "Gender, HIV knowledge and prevention attitudes among adolescents living with HIV participating in an economic empowerment intervention in Uganda", *AIDS Care*, Vol. 33 No. 7, pp. 888-896, doi: [10.1080/09540121.2020.1844860](https://doi.org/10.1080/09540121.2020.1844860).

Roberts, T., Cohn, J., Bonner, K. and Hargreaves, S. (2016), "Scale-up of routine viral load testing in resource-poor settings: current and future implementation challenges", *Clinical Infectious Diseases*, Vol. 62 No. 8, pp. 1043-1048.

Serebrin Jacob (2022), "Federal government announces \$18M for HIV testing", available at: www.ctvnews.ca/health/montreal-aids-conference-federal-government-announces-18m-for-hiv

Snedden, C. (2016), *Shifting Geo-Politics in the Greater South Asia Region*, Daniel K. Inouye Asia-Pacific Center for Security Studies, Honolulu, HI.

Ullah AKMA (2011), "HIV/AIDS-related stigma and discrimination: a study of health care providers in Bangladesh", *Journal of the International Association of Physicians in AIDS Care*, Vol. 10 No. 2, pp. 97-104.

UNAIDS (2010), *Global Report: UNAIDS Report on the Global AIDS Epidemic*, UNAIDS, Geneva.

Vanable, P.A., Carey, M.P., Blair, D.C. and Littlewood, R.A. (2006), "Impact of HIV-related stigma on health behaviors and psychological adjustment among HIV-positive men and women", *AIDS and Behavior*, Vol. 10 No. 5, pp. 473-82.

Wilson, P.A., Valera, P., Martos, A.J., Wittlin, N.M., Muñoz-Laboy, M.A. and Parker, R.G. (2016), "Contributions of qualitative research in informing HIV/AIDS interventions targeting black MSM in the United States", *The Journal of Sex Research*, Vol. 53 No. 6, pp. 642-54, doi: [10.1080/00224499.2015.1016139](https://doi.org/10.1080/00224499.2015.1016139).

Yoshioka, M.R. and Schustack, A. (2001), "Disclosure of HIV status: cultural issues of Asian patients", *AIDS Patient Care and STDs*, Vol. 15 No. 2, pp. 77-82.

Zaidi, I.F., Crepaz, N., Song, R., Wan, C.K., Lin, L.S., Hu, D.J. and Sy, F.S. (2005), "Epidemiology of HIV/AIDS among Asians and pacific islanders in the United States", *AIDS Education and Prevention*, Vol. 17 No. 5, pp. 405-417.

Further reading

Brouard, P. (2006), "A closer look: the internalization of stigma related to HIV", *United States Agency for International Development (USAID)*, Center for the Study of AIDS/University of Pretoria, and Caroline Wills, Policy/South Africa.

Care India (2011), "Vulnerability to HIV & AIDS: a social research on cross border mobile populations from Nepal to India", p. 1, October.

Castells, M. (1996), *The Network Society*, Blackwell Publishers Inc, Oxford.

- Charmaz, K. (2000), "Grounded theory: objectivist and constructivist methods", in Denzin N.K. and Lincoln Y. S. (Eds), *Handbook of Qualitative Research*, Sage Publications, Thousand Oaks CA, pp. 509-535.
- Clay, S., Bond, V. and Nyblade, L. (2003), "We can tell them: AIDS is not spread by being together" children's experiences of HIV-related stigma and discrimination in Zambia", Working report, Lusaka, Zambia: Associated Press.
- Dorais, L.-J. (2003), "From refugees to transmigrants: the Vietnamese in Canada", Paper presented at the 8th International Metropolis Conference, Vienna, September, Université Laval, Québec, Canada.
- Fernandes, A.P., Sanches, R.S., Mill, J., Lucy, D., Palha, P.F. and Dalri, M.C. (2007), "Lipodystrophy syndrome associated with antiretroviral therapy in HIV patients: considerations for psychosocial aspects", *Revista Latino-Americana de Enfermagem*, Vol. 15 No. 5, pp. 1041-1045.
- International Center for Research on Women (ICRW) (2002), *Addressing HIV-Related Stigma and Resulting Discrimination in Africa: A Three-Country Study in Ethiopia, Tanzania, and Zambia*, ICRW, Washington, DC.
- Parker, R. and Aggleton, P. (2003), "HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action", *Social Science & Medicine*, Vol. 57 No. 1, pp. 13-24.
- Persson, A. (2005), "Facing HIV: body shape changes and the (in)visibility of illness", *Medical Anthropology*, Vol. 24 No. 3, pp. 237-64.
- Public Health Agency of Canada (PHAC) (2015), *Ministerial Advisory Council on the Federal Initiative to Address HIV/AIDS in Canada*, Public Health Agency of Canada.
- Smit, P.J., Brady, M., Carter, M., *et al.* (2012), "HIV-related stigma within communities of gay men: a literature review", *AIDS Care*, Vol. 24 No. 4, pp. 405-412.

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