

People with TB and HIV in South Africa face a double stigma

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People who have both tuberculosis (TB) and human immunodeficiency virus (HIV) infection experience 'a unique and overlapping double stigma,' according to research published in the May issue of *Social Science and Medicine*. Having TB sends a signal that the person also has HIV. As a consequence, identities associated with TB are now strongly influenced by HIV stigma. Some co-infected individuals distance themselves from others with HIV and foreground their TB infection to minimise stigma. This finding may have implications for the uptake of services which integrate TB and HIV care.

Background

Stigma can be defined as 'the shame or disgrace attached to something regarded as socially unacceptable.'

Sociologists argue that ideas about unacceptability are not innate, but socially produced. Moreover, some people use such ideas to assert dominance over other people, especially people who are already marginalised for reasons linked to gender, sexuality, poverty or other reasons.

Some of the key drivers of HIV stigma are its association with sexual promiscuity, the high prevalence in marginalised communities and its association with premature death.

In the past, TB stigma was primarily driven by TB's transmissibility, but it appears that since the 1960s, access to effective treatments has led to a reduction in TB stigma in many parts of the world.

For this study, Dr Amrita Daftary of Columbia University conducted semi-structured interviews, of an average of 40 minutes' duration, with 40 patients recruited at three public health clinics in KwaZulu-Natal, South Africa. The burden of HIV and TB is extremely high here and

three-quarters of people with TB also have HIV.

All participants were co-infected with active TB and HIV. Average age was 34, half were unemployed and most lived in unstable accommodation in townships and informal settlements.

The researcher purposively recruited individuals with a wide variety of characteristics that could affect their experience of illness, including gender, marital status, employment, site of TB infection, stage in treatment and whether they were diagnosed with TB or HIV first.

Findings

Participants described TB and HIV in quite different terms. TB was considered 'natural' and 'usual', an infection that affected people indiscriminately. A person could not be held responsible for having TB. On the other hand, HIV was seen to reflect an individual's behaviour and morality, making them fit for judgment.

Furthermore, the permanence of HIV infection was contrasted with the temporary period of TB infection. TB treatment was understood to offer a cure, whereas HIV – despite antiretrovirals – was seen to be a fatal illness that 'finishes' people.

One woman commented on other people's attitudes to the two infections:

'They take it [TB] a usual thing because they say it's usual, it's in everyone. It means it's a thing which doesn't select. [HIV,] there it's difficult for them to take easy. They tell themselves that as you have HIV-positive, you are the thing which will leave the world.'

But despite the infections having distinct identities, they became inextricably linked, as people who developed TB were assumed to have HIV too. The stigma usually associated with HIV was transferred to people with TB. TB became as undesirable and stigmatised as HIV.

'For TB, they think the person with TB is with HIV and she is dying. We mustn't come close to her.'

At the same time, the physical symptoms of TB often made HIV more visible, therefore deepening the stigma of HIV. Whereas individuals without symptoms were often able to keep their HIV status hidden, weight loss or persistent coughing could expose a person's health problems, leading to gossip.

One woman said that she had previously been able to cope with pulmonary TB as she did not have visible symptoms. In contrast, she currently had glandular TB which caused nodular protrusions to become clearly noticeable on her face and neck.

'If you've got lungs TB, I think it's better because nobody knows what's going on... You're sick... Glands TB you're so ill and embarrassed because everybody knows what's going on because some other peoples, if they see you, you've got glands, they think you got HIV because HIV is a confidential disease, you can't tell anybody. So if you have got glands, everybody knows what's going on.'

Some co-infected respondents tried to fight public perceptions of the link between the two infections. But by distancing themselves from other people with HIV, they probably

contributed to the stigmatisation and 'othering' of HIV.

'Many say, they say, "You got TB, you got AIDS" But it's not true. If you got TB, you've got TB... All depends on what you did in your life.'

Similarly, respondents attempted to manage the way that people perceived them by being selective in the health information they shared with others. Almost all spoke about TB more often and more easily than about HIV.

'I don't think about I'm going to tell my mum I'm taking this [antiretrovirals] now. Because TB, people don't worry about TB, because

TB they know that you have to get tablets, it's finished. But HIV, you must know that, I think you know, once you get HIV, people start to run away from you. That's what makes us scared to tell that much.'

Conclusion

Amrita Daftary says that her respondents experienced a unique form of stigmatisation created by their dual diagnosis. The links between the two illnesses led to identities associated with TB becoming even more undesirable and stigmatised. HIV was the driving factor behind co-infected people's experiences of disease-related stigma and discrimination. 'Not only did they have HIV, the primary stigmatising attribute, they also

developed TB, which revealed their HIV status, reinforced the stigma of having HIV, and consequently perpetuated and renewed stigma against TB,' she says.

She says that the manner in which a number of respondents attempted to separate TB from HIV raises questions about policy efforts to integrate TB and HIV care. Integrated services may reinforce negative public perceptions and could impact on the uptake of TB care.

Daftary A. HIV and tuberculosis: The construction and management of double stigma. *Social Science & Medicine* 2012;74:1512-1519.

Article courtesy of www.aidsmap.com.

SINGLE SUTURE

Imaging HIV in infected cells reveals viral tactics

The tactics that HIV uses to infect cells have been visualised in greater detail than ever before, thanks to a microscopy technique that allows even structures within viruses to be seen.

Conventional light microscopes cannot resolve structures that are smaller than about 200 nanometres because they are limited by the wavelength of visible light. Viruses, which typically measure 25 - 300 nm, are just too small to see.

One way around this has been to tag proteins with fluorescent markers, activate them one at a time, and then map the locations of all these markers into a composite image. Markers can interfere with protein function, though, making it difficult to study proteins in action.

Nathalie Arhel at the Pasteur Institute in Paris and her colleagues have modified this technique and inserted a 6-amino-acid motif into the enzyme that HIV uses to integrate its DNA into its host's genome. The motif is too short to affect the enzyme's function, but long enough to bind to a fluorescent marker molecule.

They used the technique to take a closer look at HIV. Previously, it was unclear whether the virus's genetic material is released into the cytoplasm of the host cell, or whether it remains in a container called a capsid until reaching the cell's nucleus. The technique has revealed that it remains in the capsid - information that may provide opportunities for targeting the virus before it integrates its DNA.

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