BRATISLAVA INTERNATIONAL SCHOOL OF LIBEAL ARTS

# Social Inclusion and Stigmatization of People Living with HIV: Case Study of Slovakia

**Bachelor Thesis**

**Bratislava 2016** **Tomáš Mališka**

**BRATISLAVA INTERNATIONAL SCHOOL OF LIBEAL ARTS**

# Social Inclusion and Stigmatization of People Living with HIV: Case Study of Slovakia

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# Declaration of Originality

I declare that this bachelor thesis is my own work and has not been published in part or in whole elsewhere. All used literature and other sources are attributed and cited in references.

Bratislava, 22 February 2016

Tomáš Mališka,

Signed: ……………………..

# Social Inclusion and Stigmatization of People Living with HIV: Case Study of Slovakia

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## Abstract

The purpose of this case study is to investigate the effects of the social stigma of HIV infection on living conditions of people living with HIV (PLWHIV) in Slovak society. The study will also examine the related discrimination, prejudices, social barriers and their psychological consequences. Theoretical research is supplemented by qualitative and quantitative field research of public opinion and interviews with PLWHIV as well as professionals from relevant fields. The goal of this research is to provide an insight and an analysis of the problematics, in order to create a basis for recommendations for change and improvement in specific areas. The study also aims to investigate the consequences of HIV stigma on the prevention efforts to stop the infection.

The first part of the study examines and summarizes the theoretical context of the HIV-related stigma through constructivist analysis of the core sociological theories of health and illness and deviance, with a special focus on the concept of stigma. Application of these theories on STI's and HIV itself provides an explanation of their presence in the society, their social interpretation, and impact on individuals, and the society. The second part focuses on the empirical results of the research while it analyzes and summarizes the state of the HIV-related stigma in Slovakia, which is then followed by an analysis of the state from the human rights and legal perspectives in the third part. The last part includes the implications and possible issues with which the PLWHIV in Slovakia have to deal with, and how it could be improved.

In conclusion, the study provides a clear evidence of the strong negative effect of HIV-related stigma has on people's lives while it all leads to deepening of negative social stereotypes, and the threat of dissemination of this infection based on the stigma, and its denial. The study argues that the socially constructed stigma of STI's and HIV has serious social and psychological impact on people's lives.

# Sociálna inklúzia a stigmatizácia ľudí žijúcich s HIV: Prípadová štúdia Slovenska

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## Abstrakt

Účelom tejto prípadovej štúdie je skúmať vplyv sociálneho stigmy HIV infekcie na životné podmienky ľudí žijúcich s HIV (PLWHIV) v Slovenskej spoločnosti. Štúdia skúma súvisiacu diskrimináciu, predsudky, sociálne bariéry a ich psychologické dôsledky. Teoretický výskum je doplnený kvalitatívnym a kvantitatívnym terénnym výskumu spoločenských postojov a rozhovormi s PLWHIV, ako aj odborníkmi z príslušných odborov. Cieľom tohto výskumu je poskytnúť náhľad a analýzu problematiky, s cieľom ponúknuť základy pre odporúčania na zmeny a zlepšenia v špecifických oblastiach. Štúdia má tiež za cieľ skúmať dôsledky HIV stigmy na preventívne snahy zastaviť infekciu.

Prvá časť štúdie skúma a sumarizuje teoretický kontext súvisiaci s HIV stigmou cez konštruktivistické analýzy základných sociologických teórií zdravia a choroby a deviácie, s osobitným zameraním na koncepciu stigmy. Použitie týchto teórií na sexuálne prenosné infekcie aj samotné HIV poskytuje vysvetlenie ich prítomnosti v spoločnosti, ich sociálne interpretácie, a vplyvu na jednotlivca a spoločnosť. Druhá časť je zameraná na empirické výsledky výskumu a zároveň analyzuje a sumarizuje stav súvisiaci s HIV stigmou na Slovensku, ktorý nasleduje analýza stavu z oblasti ľudských práv a právnych aspektov v tretej časti. Posledná časť zahŕňa dôsledky a

možné problémy, s ktorými PLWHIV na Slovensku budú musieť vysporiadať a ako by mohla byť situácia zlepšená.

V závere štúdia poskytuje jasný dôkaz o silnému negatívnom vplyve súvisiacom s HIV stigmou na životy ľudí, zatiaľ čo to všetko vedie k prehlbovaniu negatívnych spoločenských stereotypov a hrozbe šírenia tejto infekcie na základe stigmy a jeho popieraní. Štúdia tvrdí, že sociálne konštruovaná stigma pohlavne prenosných infekcií a HIV má vážne sociálne a psychologické dopad na životy ľudí.

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# Table of contents

Declaration of Originality II
Abstract III
Abstrakt V
Acknowledgement VII
List of abbreviations 9
Introduction 10
    Research design and methodology 12
1. Health and Illness, Social Stigma and HIV/AIDS 15
    1.1 Sociology of health and illness and the role of sick roles 16
    1.2 HIV/AIDS medical information, treatment, prevention - a factsheet 19
    1.3 HIV-related stigma 22
    1.4 Condom use and testing stigma 31
2. Law, rights and legal constraints of PLWHIV 36
    2.1 Human rights of PLWHIV 36
    2.2 Slovak legislation concerning PLWHIV 37
    2.3 The issue of criminalization 44
3. HIV/AIDS in Slovakia 47
    3.1 HIV/AIDS in numbers - World and Slovakia 47
    3.2 Perception of HIV and People Living with HIV by Slovakians 49
        3.2.1 Basic education about HIV/AIDS 50
        3.2.2 HIV awareness and opinions on living conditions of PLWHIV 51
        3.2.3 Questions of personal attitudes in interaction with PLWHIV 55
4. Conclusion 60
    4.1. Recommendations for further research 64
    4.2 Personal note 64
Resumé 66
Bibliography 69

# List of abbreviations

HIV - Human Immunodeficiency Virus

AIDS - Acquired Immunodeficiency Syndrome

UNAIDS - Joint United Nations Programme on HIV/AIDS

PLWHIV - people living with HIV

STI - sexually transmitted infection

ARV - antiretroviral

HAART - Highly Active Anti-Retroviral Therapy

MSM - men having sex with men

# Introduction

When the HIV virus was first diagnosed in Los Angeles in 1981 and the HIV/ AIDS epidemic started in the U.S. around 1982 and thousands of healthy people got infected, it brought to light several major closely related problems, since the research of the virus, its nature, and medical consequences were still not enough medically examined and the development of HIV/AIDS treatment was in its infancy. HIV/AIDS brought in that time millions of people to death and as a result, a whole social movement emerged that lead to the formation of the famous advocacy group named ACT UP. Since then, the treatment has been developed, today we are able to stop HIV/AIDS from killing people and we are still progressing in the field of treatment research. But simultaneously with the epidemic continued and another big problem of a non-medical character continues - the one of social stigma. Today, we can successfully stop HIV from breaking out to AIDS, stop it from killing and even infecting other people, but we are still “killing” people living with HIV on the social basis. We discredit them, demonize them, ignore them, exclude them. And by that we not only hurt people on an individual level, we also block the results of the medical progress. People living with HIV with access to the treatment are able to live a full, high-quality lives like everyone else, but we treat them differently than non-infected people. Thousands of stories carry the testimony about stigma and we are just closing our eyes as if they did not exist.

Imagine a man diagnosed as HIV-positive. Before the diagnosis he worked in a company since its beginning, enjoyed work a good working team and good relations with his boss as well as his colleagues. After he got diagnosed with HIV and his boss got informed from the sick note from the AIDS center, he was immediately fired. And not only that, his boss sent and email to all his colleagues with his personal data, photo and a map where he worked with marked which toilets and kitchen he used. The boss required all his colleagues to be tested for HIV and submit evidence that their tests are negative, otherwise, they would be fired too. Our man went to police which had, shockingly similar approach as his boss and after three months of doing nothing, they informed him that his case was postponed. After that, he moved to another country. Since then he had no job-related problems. (HIV Práce, 2014, April 2a) Or another short story of a construction worker who got diagnosed during a standard preventive examination at a general practitioner. After he got informed about his diagnosis, he got drunk and told his colleagues that he was HIV positive. On the next day, they started to complain to their boss that they do not want to share accommodation use the same shower or share the same machinery or tools with such a dangerously ill person. Their boss sent them all a leaflet with information about HIV and the ways in which infection can be transferred, but they still refused to work with him. After a few days, the man committed suicide. (HIV Práce, 2014, April 2b) We do not have to imagine these stories, they are true stories. The first man is happy now, the second could be too, with proper treatment, he could live a full life. Instead, the HIV stigma killed him only a few days after he got diagnosed. And that is only the beginning.

HIV stigma is closely related with several negative social phenomena and violations of human right and laws. Myths, stereotypes, prejudices, taboos, inadequate education, misinformation and many other factors that will be further described in more detail are leading our lives towards ignorance, discrimination or other potential ways of harming of other innocent people that unjustifiably personalize out fear of death. We stigmatize them and combine various forms of stigma, maintain the taboo and spread the negative prejudice. And that constitutes another key problem - in these ways, we are unknowingly blocking the positive impact of the medical development in the area of HIV prevention and treatment by creating social obstacles. HIV stigma causes damage on the individual basis as well as on the social basis. Research, deconstruction, and elimination of HIV stigma is necessary for the good of all.

Thanks to the modern medicine, people living with HIV got a second chance to live a good life, thanks to our society their lives can lose their sense, and they can lose their rights. That is contrary to the principles of liberal democracy as well as humanity. This case study of Slovak environment will not only analyze the social stigma related to HIV and its roots and recommend systematic changes to improve the current situation in Slovakia but it will also aim to become a part of the series of studies of the HIV-related stigma around the world as it will attempt to contribute to the field by a case study from a country, where the field itself is still unexplored.

**Research design and methodology**

In this work, we will study the state of living conditions and stigmatization of people living with HIV in Slovakia, and the consequent obstacles, trying to prove the hypothesis stated according to current sociological theses. For this purpose, we examined the object of study through sociological theory of health and illness, deviance and stigma based on the constructivist theory from the core basis of these individual theories through more specific focus on STI's (sexually transmitted infections), and relation to social stigma, to HIV itself and the various kinds of social stigma and its combinations, examining it from its essence, its sources and the ways of spreading. Secondary literature consisted of academic articles on the issue of HIV stigma and psychological consequences from social sciences journals, methodologies for work with people living with HIV and international, and national legal documents focused primarily on human rights principles or legislation connected with direct or indirect policies influencing the behavior towards people living with HIV or their duties.

Theoretical background of our hypothesis is supported and deeply interconnected by further qualitative and also quantitative research divided into several subsections described below. Independent results of the survey conducted at several levels were further processed by a comparative method and evaluated through the background provided by theoretical research. Since there is no known research on this phenomena in Slovak conditions, it was carried out as a part of this study, complemented by incomplete occasional data in a form of interviews, stories and testimonies collected from the environment of social and medical institutions working with people living with HIV in Slovakia, Czech Republic or others.

Theoretical research further includes empirical analysis of legislation, inclusiveness, and provision of social security, later compared with practice, insight on education and prevention programs, culture, HIV/AIDS activism, and religion. Field research is divided into two primary sections - quantitative and qualitative, according to the purpose of the data collection and character of data itself.

The quantitative part of the research survey consists of survey/probe of opinions and attitudes towards HIV and PLWHIV in Slovakia. Survey was conducted through specific questions related to the education about the HIV infection and perceptions, and attitudes towards people living with HIV related to different parts of social life. The aim of this survey was primary to conclude major perception of HIV, people with positive status and stigma related to the issue through the possible appearance of negative social phenomena, prejudices, myths, and stereotypes. Survey was carried out during December 2015 and January 2016 in a form of an online anonymous questionnaire through the web and social media, with 500 random volunteer respondents from Slovakia. Specific shortcomings and weaknesses of the survey will be specified in the chapter focused on the results.

The qualitative part of the research includes primarily five interviews with people living with HIV about their perceptions of the society they are living in with this particular aspect of identity, life experience, feelings within their identity inwardly and also outwardly to smaller communities, groups, and society. Interviews were conducted during December 2015 and January 2016 with informed consent and anonymously. Audio records of interviews were made, but due to conditions of informed consent about privacy and anonymity, records will remain non-public. All interviewed respondents got due to the sensitivity of the issue of HIV stigma a chance to choose an alias, change name or gender to protect their identity, therefore, names to which thy study refers do not have to match real names of interviewed PLWHIV. The study will refer to them according to the alias or name they have chosen, namely as to: “John”, “Tomáš”, “Roman”, “Pius” and”Jaro”.

Another 2 interviews provided us with an insight on the whole issue from different point of view, not right from the perspective of the people personally involved in the issue, but from professionals in the areas of medicine and religion. One interviewed person from the field of medicine requested to stay for understandable reasons anonymous and study will refer to her as to “Medical student”. Second interviewed person from the field of theology was Miroslav Kocúr, ThDr., PhD. and study will refer to him as “Kocúr”.

All interviews were conducted during personal meetings with respondents in a place they perceived as a safe space, completely anonymous and no specific personal data including names were used, with an exception of Kocúr. Respondents that were not able or willing to meet personally have responded on questions in written form. Interviews with the people living with HIV and their comparison with the public opinion research are the core point of this study and provide us a measurable source of data applicable on the theory proving the hypotheses of the study with possible direct or indirect recommendations for improvement of current situation.

# 1. Health and Illness, Social Stigma and HIV/AIDS

Our health is in our lives often unconscious state. We are generally not aware of the fact that we are healthy human beings until we are confronted with our own or someone else's illness, which makes us realize our health condition. This awareness comes from certain social concepts of perception of health and illness. under which the society, and individual interactions function to define and assess our social status within the society we are living in. Sociology of health and illness, based on the precondition that the state of health and illness are defined by the social and cultural background we are living in (Giddens, 2009), is examining and analyzing these conceptions to deconstruct them and analyze what it really means to be healthy or "normal", which might mean different things across different cultures. In this framework, sociology focuses mainly on the experience of illness of individuals in the context of the social perceptions of their illness and its influence on them in the interaction with their social environment.

In the past, illnesses were often viewed as a presence of demons or consequences of sins (Giddens, 2009) and had spiritual dimensions, today we regard them as objects of science and modern medicine for both good condition of the individual as well as the public health, which is necessary for a good functioning society without pathologies. Medicine became, according to Giddens, a tool used to reshape the deviant condition and to "fix" the body, which is perceived neutrally and differentiated from the whole individual, back to the state perceived as normal.

Such a state of the perception of health and illness, when the illness depends not only on the neutral review of the medicine but also on the social and cultural interpretation brings to the society also certain negative social phenomenas connected with the physical or psychical capacities of the bearers of the label of sick, and their social status within the society.

### 1.1 Sociology of health and illness and the role of sick roles

Health and illness have according to sociologists clearly not only individual dimension and consequences but also social. When we are ill, we do not only adapt to the conditions prescribed by the doctor to get better or keep our health condition in a good way to live a salubrious life, but we also adapt to certain social conditions and rules applied in interaction. As described by Goffman in his theater theory of dramaturgy, throughout our lives, in certain situations within social interactions, we adapt and play certain roles which include certain patterns of behavior. (Goffman, 1959).

In the context of Goffman's theory, sociology of health and illness works with another conception first introduced by Parsons, called a "sick role" (Parsons, 1952). This conception of role describes behavior patterns for sick people in order to eliminate the negative impact of the illness in the society. this role is according to Parsons acquired through socialization and activated every time when the person is sick to minimize further possible damage in the functioning of the society. "Illness is therefore potentially dysfunctional as it could disrupt the smooth functioning of the society." (Giddens, 2009), and it has to be repressed. But a problem arises when the illness is untreatable. In the past, such cases were solved e.g. by segregation on islands, which is, of course, today unacceptable and only the most serious and infectious diseases are solved in quarantine.

Parsons's conception of the sick role was later refined and developed by later sociologists, which improved its meaning. Freidson (1970) differentiated the sick role on three more specific levels of the sick role according to the interaction of the bearer of the sick role and his/her environment.

According to Freidson, the different sick roles differ on the basis of the expectations of the society and the perception of the specific sickness of certain type and degree, and on the basis of the rights, privileges and benefits which the bearer of the sick role receives from the environment to fulfill the expectations. According to these criteria, he identifies “the conditional sick role, the unconditionally legitimate sick role and the illegitimate sick role” (Freidson, 1970). The first one refers mainly to the temporary illnesses from which the bearers of the role will recover and for that purpose, they receive rights and privileges to be able to do so, for example, time off from work or school, fewer obligations, more rest. The unconditionally legitimate sick role refers to the bearers of the sick role suffering from untreatable illnesses, which leads to kind of long-term permission to occupy this role with its rights and privileges, and less or nearly none duties, or at least acknowledgment that the individual is not responsible for the illness in case in less serious illnesses.

The third, and for us most important sick role in this case study is the illegitimate sick role, which according to Freidson refers to the illnesses and health conditions, which are socially stigmatized and there is an assumption that the bearer of this sick role is somehow responsible for his illness, which means that the rights and privileges guaranteed in cases of previous sick roles are in this kind of sick role not granted.

This stigmatized illegitimate sick role is often the one which is assigned to people living with HIV, based on several misconceptions about certain already stigmatized groups of people, lifestyle, sexual behavior, religion etc. HIV has been since the beginning of the epidemic socially interconnected with irresponsible and immoral behavior, mainly irresponsible sexual behavior by having unprotected sex, having homosexual sex or being promiscuous, working as a sex worker, or intravenous drug use. Both of these interconnections with HIV have been already socially stigmatized as wrong, immoral, sinful, deviant and socially unacceptable and, therefore, have multiple stigmas. The first sign of multiple stigmas of gay people and HIV, sincerest of the victims of HIV epidemic were gay people was the original name for HIV/AIDS which was previously stated as “gay cancer” or GRID - gay-related immune disorder (Giddens, 2009, p. 401).

Especially sexuality has been and probably still is a taboo in the society because a discussion about sexuality brings the private and intimate sphere to the public sphere, where it is considered as obscene, inappropriate due to strong social norms and morals. Basically, according to Foucault, in the past 2 centuries, sexuality without the purpose of procreation was perceived as phenomena that should be repressed and controlled, while strong and strict social norms and morals about acceptable sexuality has been set. This put "perversions" as e.g. homosexuality outside the society as socially condemned and unacceptable. (Foucault, 1990, Giddens, 2009, p. 392). This approach to ostensibly uncontrolled sexual behavior created a taboo and simultaneously a stigma on certain groups, what is the best environment for the development of prejudices and stereotypes empowering the stigma.

The fact that HIV is categorized mainly as an STI transmitted through unprotected sexual intercourse and full of stereotypes and prejudices, it is publicly inevitably labeled as inappropriate, rejected and suppressed as wrong, "dirty", interconnected with immoral sexuality, and often creates a false impression that PLWHIV are fully responsible for their infection because of their immoral and irresponsible behavior, sometimes even viewed as a wage of sin in terms or religious beliefs.

> *"It is a kind of moral dilemma. The primary categorization of this illness is as of illness related to irresponsible sexual life, in terms of religion as of immoral life and, therefore, a sinful life bounded primarily on sexual activity. From the Church's point of view, any irresponsible sexual life is a sin… I remember when it* (HIV) *was a deadly illness since the beginning. Basically, you were just waiting. Worse than cancer - that has been popularly rumored."* (Kocúr)

This basically proves that a strong moral stigma is at least in Christian environment very present. According to data from 2011 census in Slovakia, 65,3% of Slovakians claim their identity as Catholic. (Statistical Office of Slovak Republic, 2011)

Another very important popular interconnection of HIV/AIDS is death, since HIV/AIDS used to be a deadly disease, and without proper treatment still can be. Basically, PLWHIV are often perceived as like they have done something wrong and often got labelled by the second stigma, e.g. men are labeled as gays, women as sex workers while both can be also simultaneously perceived as well as drug users. (Koka, Ahorlu, Agyeman, 2013, p. 232) and that they are going to die, maybe even very soon. Untreatable deadly disease, something like a death penalty. This is caused because, in the beginning of the HIV/AIDS epidemic true, many people were dying. Hundreds of thousands, millions of dead until medicine did not find the treatment suppressing the development of the virus. Medicine developed, PLWHIV are a living healthy life but the interconnection with death remained present all can also play an important role in stigma and barriers to prevention efforts. HIV-related stigma provides according to Deacon "evidence of the complex relationship between stigma and existing forms of prejudice and disadvantage, discrimination and the variety of different responses stigma and discrimination by people living with HIV and AIDS". (Deacon, 2006, p. 419)

### 1.2 HIV/AIDS medical information, treatment, prevention - a factsheet

Human Immunodeficiency Virus (HIV) is a virus which weakens human's immune system and the CD4 cells (T cells) which fight diseases and infections in the human body. As the HIV develops, it makes the individual unable to fight off infections and diseases and more likely to get them and infection-related cancers. HIV can further lead to the acquired immunodeficiency syndrome (AIDS), which is the final stage of HIV infection. This stage does not have to be ever developed, but once it develops, it means that the immune system is seriously damaged and vulnerable to infections leading to death. The life expectancy of people diagnosed with AIDS is about 3 years, if combined with serious illness developed as a result of AIDS, the life expectancy lowers to about 1 year of life. HIV/AIDS are not curable yet, so once one acquires them, it is for entire life. However, they can be controlled by antiretroviral therapy which can dramatically prolong life and keep one healthy and even non-infectious and has a baby that will be HIV-negative. Live expectancy can with the help of treatment become near to normal live expectancy of HIV-negative people but it varies according to several factors as e.g. gender, race, lifestyle or access to treatment. (Samji, Cescon, Hogg, 2013)

There are only 3 possible ways to acquire HIV - through unprotected sexual activity, blood, or from mother to child. The only transmitters of HIV are specific body fluids, namely blood, semen, pre-seminal fluid, rectal fluids, vaginal fluids and breast milk, and these must come to a contact with mucous membrane in vagina, penis, rectum ,and mouth; to a contact with a damaged tissue, or be injected into the bloodstream. No other way of acquiring HIV is possible. Kissing, using same toilets, sharing cutlery or food, touching, shaking hands, being in the same room - none of these activities is a risk and standard social contact with PLWHIV is not in any way considered as a risky behavior that could possibly lead to transmission of infection. The probability of HIV transmission has been according to medical studies in specific ways of transmission detected in percentage values for blood transfusion in 92,5% of exposures, needle-haring during intravenous drug use in 0,63% of exposures, receptive anal intercourse in 1,36% of exposures, insertive anal intercourse in 0,11% of exposure, receptive penile-vaginal intercourse in 0,8% of exposures, receptive penile-vaginal intercourse in 0,4% of exposures and very low in oral intercourse. (Patel, Borkowf, Brooks, Et al. , 2014). Of course, several factors as e.g. acute or late-stage HIV infection or high viral load may increase the risk, as well as condom use or antiretroviral therapy in case of HIV positive partner decrease the risk.

HIV testing is performed from blood tests and it is focused on the anti-HIV antibody which is figuring whether are these antibodies present in the blood count. If the test is reactive, which means that the HIV antibodies are present, the second test is performed, because these antibodies can be present also in the case of other health problems. Therefore, a reactive anti-HIV test does not necessarily mean that the person is HIV positive. Second test if focused directly on the presence of HIV. If this one is positive, it is followed by edification from the doctor and further medical examinations, consultation of treatment etc. Opinions on treatment differ, some doctors claim that the treatment is needed only for certain viral load and number of

CD4 cells, others claim that the best solution is to start treatment right after diagnosing HIV.

The treatment of HIV consists of combination (so-called “cocktail”) of antiretroviral (ARV) drugs also called HAART - Highly Active Anti-Retroviral Therapy, that basically surprise the virus so the immune system can intensify and the body is able to protect itself against external influences. Important is during ARV the measurement of a number of CD4 cells and viral load, to have more CD4 cells and lower viral load, otherwise, can the HIV virus cause AIDS. The ultimate goal of HAART is to lover individuals viral load to the level when the viral load becomes undetectable and the health risk of the patient with HIV is minimized. Undetectable viral load of HIV also minimizes the probability of HIV transmission onto HIV negative partner through sexual intercourse, and research shows that no transmission of HIV from an undetectable partner has been proven (Rodger, Bruun, Cambiano, Et. al., 2014). However, condom use is regardless of undetectable viral load still recommended.

In the field of prevention of HIV transmission are known two basic methods - the “CNN” method standing for condoms, needles, and negotiation, and the “ABC” method standing for abstinence, being faithful and condom use. Condom use is in both method an essential part of HIV prevention since their high efficiency against HIV and other STI’s, since its protection is 90 to 95% effective (Pinkerton, & Abramson, 1997) and therefore “condoms should not be seen as distinct from other strategies but as an integral part of comprehensive strategies that also counsel abstinence and reducing the number of sexual partners.” (Sinding, 2005). Similarly, needles in the meaning of needle exchange and usage of sterilized needles in so-called “harm-reduction” programs lower the risk of HIV transmission (Sinding, 2005) and together with systematic efforts for rehabilitation and detoxication of intravenous drug usage, needles exchange should be a mandatory part of HIV prevention in endangered groups. Programs built on the basis of abstinence or being faithful as the only aspects of HIV are quite problematic and disputable, since definition of abstinence does not exist and this method itself does not prove its functionality (Sinding, 2005), but e.g. in

South India, 80% of women infected with HIV were monogamous (Newman, 2000), or in Cambodia in 2002, 50% of women were infected by their husbands (Nakamura, 2002). Of course, responsible sex life - reduction of sexual partners and faithfulness in relationships are a positive contribution to prevention of HIV or other STI's as e.g. gonorrhea or syphilis, but these factor of prevention alone are not proven to be highly efficient tools for stopping HIV since sexuality is a primary human instinct which cannot be stopped, but can be complemented with condom use which provides high enough protection against transmission of HIV. The best option is, therefore, a combination of all preventive approaches in the combination of the work with awareness and reduction of risky behavior and promotion of condom use and needle exchange. Otherwise, the only 100% prevention of STI's is not to have sex, otherwise, HIV/AIDS affects us all without any differences. Most of the HIV transmission happens by having unprotected sex with people that do not know their status, therefore, testing and condom use is the basis of all prevention.

### 1.3 HIV-related stigma

Social stigma is a phenomenon, which is present in social relations probably since the beginning of any society based on certain rules, norms and concepts of "normal". Stigma in Greek means a sign, or in a figurative sense a label, and literally refers to a certain sign of differentiation based on social norms or preferences, which deepens a gap between people in interactions. The fight against HIV/AIDS-related stigma and its consequences (discrimination, prejudices, the stigma of testing) is currently in international society perceived as one of the major goals enabling us to challenge the spread of HIV. (Ugarte, Högberg, Valladares, & Essén, 2013, p. 165; Earnshaw, & Chaudior, 2009, p. 1160; Misir, 2015, p. 328; Deacon, 2006, p. 418)

Stigmatizing attitudes towards PLWHIV can be basically described in terms of a psychological process of kind of dehumanization in which people are alienated from their human identity in order to make them look less human, 2nd. class citizens. Dehumanization means "demonizing the enemy, making them seem less than human and hence not worthy of humane treatment. This can lead to increased violence, human rights violations….” (Maiese, 2003). It also, according to Maiese, includes deindividuation, which correlates that PLWHIV are often falsely labeled by minority group labels as gays, sex workers or drug users, what also makes them seem less than fully human, what results in moral exclusion (Maiese, 2003). All these signs of dehumanization are in our society and in lives of PLWHIV present.

Currently, we know many more or less different definitions of stigma concepts which vary in methodological approach to the phenomena itself. The “father” of the concept of stigma from which builds probably every scholar was sociologist Erving Goffman in his work *Stigma: Notes on the Management of Spoiled Identity*. The definition of social stigma refers, according to Goffman, to an “attribute that is deeply discrediting” (Goffman, 1963, p. 3) using the stigmatized attribute to create the discrediting gap between our “actual social identity” (Goffman, 1963, p. 2) - as we are in our individual personality and identity, and our “virtual social identity” (Goffman, 1963, p. 2) - as we (in our real identity) are perceived by the others. It is a social process - mechanism of devaluation of stigmatized individual leading to one's discrediting in purpose of his disqualification from chance of acquiring social acceptance (Goffman, 1963; Giddens, 2009, p 400), and therefore, it leads to setting of social inequality (Earnshaw, & Chaudoir, 2009, p. 1161). The whole process is basically used for the acquisition of social control over the stigmatized individual and his/her behavior (Goffman, 1963). However, “stigma is not solely a product of the ‘mark’ itself, but rather of a social interactions and relationships in which the ‘mark' is constructed as a reflection of its possessor's tarnished character” (Earnshaw, & Chaudoir, 2009, p. 1161) judged according to certain morals and social norms.

Another aspect important for this study is being aware of dealing also with multiple stigmas, which occurs when two or more stigmatizing attributes appear in individuals identity, which is in our case primarily the illness stigma of HIV, but also social stigma of homosexual people and drug users. These two already stigmatized groups are often popularly stereotypically closely interconnected with HIV through social associations with HIV based on prejudices and stereotypes about it, but it might be in some cases based on homophobia as the irrational fear, hatred and judgements towards people with homosexual orientation (Weinberg, 1972), or perception of them as deviant from the point of view of the stigmatizing one which may come from various social environments influencing his perception of social norms and deviance as breaking the social norms according to which he/she lives. Multiple stigmas, perceived or real, is a real issue that may occur in live of every individual living with HIV. Tomáš provides us a great example of how can multiple stigmas look like and affect the life of individual:

> "*Given the fact that I'm homosexual, I'm already on the margins of society and the fact that I'm also infectious and can endanger someone, that segregates me even on the very edge of that already marginalized minority. I can actually endanger even the healthy minority so we* (gay PLWHIV) *are doing the worst. Honestly, me for myself, I do not have a desire to fight with it"* (Tomáš)

According to Becker, the perception of PLWHIV with multiple stigmas through deviance is rather a relative than accurate evaluation, since the norms do differ across cultures and social groups and the deviants do not necessarily view the world through the norms used to perceive them as deviant. Models of deviance might be also based on the medical aspects of health and illness (Becker, 1963, p. 7), through which PLWHIV might be as bearers of the of the illegitimate sick role perceived as deviant and dangerous for society and public health. Another aspect interconnected with deviation might be in perception that HIV itself is not an aspect deviating the individual, but the fact that person is HIV positive can in eyes of HIV-negative people lead them to false assumptions which refer to some label/deviation that led the specific person to certain (assigned to be own to the anticipated label/deviation) behavior followed by acquiring of HIV.

The concept of HIV-related stigma according to Link & Phelan describes stigma through power structure as a social process which is applicable when following aspects converge - stereotyping, labeling, status loss, separation, and discrimination. (Link, & Phelan, 2001, p 367). However, Deacon stressed that researchers often include discrimination right into the concept of stigma and use it to refer to “both the stigmatizing beliefs themselves and the effects of these stigmatization processes” (Deacon, 2006, p. 419), but opposes that it discrimination is not a necessary result of stigma to cause negative consequences, but it also includes status loss or internalization (Deacon, 2006, p. 424)

Earnshaw and Chaudoir differentiate the mechanisms of HIV-related stigma according to the ways of one’s reaction to the possession of stigmatizing attribute onto two basic levels - infected and uninfected, where the HIV-uninfected reaction is a psychological response to the fact that someone may threaten their life, and the HIV-infected reaction reflects negative inner feeling (shame, fear, anxiety, lower self-esteem, etc.) that they have violated social norms and may experience the negative consequences of HIV-related stigma. (Earnshaw, & Chaudoir, 2009, p. 1162).

Also, they divide the negative feelings of the HIV uninfected into 3 categories:

- prejudice: emotions and feelings, e.g. disgust, anger, fear (Allport, 1963;)
- stereotypes: group-based beliefs referring to certain groups of people blamed for HIV applied on individual (Kanahra, 2006)
- discrimination: practically expressed prejudices (Allport, 1963)

Experiencing HIV-related stigma can subject to three different kinds of social stigma according to the way of experiencing it - enacted stigma, anticipated stigma and internalized stigma which differ on the level perception of stigma. Enacted HIV-related stigma basically describes already experienced prejudices and discrimination (Scambler, Hopkins, 1986) so it represents the real living situation of PLWHIV in their environment, while anticipated HIV stigma describes the assumptions of PLWHIV that in case of disclosure of their HIV status, they will experience stigma and discrimination (Markovitz, 1998)), what may more describe the psychological state of the individual than the situation in society as such, which is of course quite understandable since their main emotions with which they perceive status disclosure is fear and anxiety of social exclusion. Internalized HIV stigma refers to the psychological process of internalization in which PLWHIV accept all the negative feelings and attitudes towards HIV/AIDS and apply them to themselves (Link, 1987) what is a standard phenomenon in probably every stigmatized identity. All these kind of stigma can be also mutually combined or connected and multiplied with other stigmatizing identities in these three versions as e.g. internalized homophobia.

Goffman further developed his stigma theory and made an important distinction between two primary social statuses of stigmatized people according to their situation on a discredited one, and discreditable one (Goffman, 1963. p. 42). The discredited status appears when the stigma is visible as e.g. in a case of people who happened to live with a physical disability, or when one already disclosed his stigma, in our case, when the individual living with HIV informs people about his/her HIV positive status. PLWHIV which are already discredited have to, at first, learn to cope with the fact that their HIV status is disclosed (stigma management), their family, friends and their environment knows about it what immediately creates a possibility of being exposed to the negative consequences of stigma, as e.g. negative reactions, status loss, rejection, strained social interactions, social isolation and even discrimination causing stress, depressions, negative impact on self-esteem, anxiety, etc (Stutterheim, Bos, Pryor, 2011, p. 393). However, disclosure of HIV status can also generate social support for the individual which would otherwise not be possible, since obviously, nobody would know that they can need their support, or even institutional support, therefore, it is recommended that “PLWHIV must take the risk of being met with stigmatizing reactions in order to gain the support necessary to deal with the stigmatizing reactions” (Stutterheim, Bos, Pryor, 2011, p. 393). According to interviews with PLWHIV, nearly each of interviewed PLWHIV mentioned that he/she got the social support of his/her closest environment (family, friends), what provided them with enough support to manage the stigma. However, they have also reported several negative reactions and rejections - manifestations of enacted stigma.

> *“When I talked about it with my friends, everyone had the first phase of fear, but we were talking about it and they calmed down and stopped to be scared. But I’ve also experienced that one close friend of mine suddenly stopped to drink from the same bottle as me, but I have confronted him that this is not a way of HIV transmission and he got over that fear, because, it is obviously only irrational fear. But one friend stopped to meet me after I disclosed my HIV-positive status to him. And he was a very close friend with which I have spent a lot of time. And suddenly he even stopped to answer the phone. From day to day. Bye. One friend told me that I deserve it and it hurt me, that he told me such thing. It did not contest me, because, you do not tell such things to people with cancer that they deserve it, so it was amoral from him, I did not make anything amoral… I explain to everyone that I’m not radioactive, you do not catch it by walking through a room or touching something, it does not function like that”* (Roman)

Studies have proven that, according to contact hypothesis, which claims that contact between groups, in our case mainly between HIV negative and PLWHIV which disclose their status, helps to eliminate negative opinions, prejudices, etc. (Allport, 1954), therefore, one of the main problems of HIV-related stigma might be that PLWHIV remain in discreditable status what prevent social contact between the majority and PLWHIV and creates an ideal environment for maintaining and strengthening the negative attitudes, prejudices and stereotypes and allows discrimination. It basically creates a vicious circle where PLWHIV conceal their stigma because of anticipated stigma, and as a result, society is not able to de-stigmatize identity of HIV positive people due to lack of social contact, awareness, and information. Exactly the same is happening in the case of discrimination of PLWHIV since they are not willing to disclose discrimination based on their HIV-positive status because it can discredit them, society is not able to solve these problems, or the process of solving of these problems is considerably slowed.

The discreditable stigma status appears when the stigma is not visible or when the individual did not reveal it to his/her environment, or, at least, thinks that they do not know (Goffman, 1963, p. 42). In such case “the issue is not that of managing tension generated during social contacts, but rather that of managing information about his failing. To display or not to display; to tell or not to tell; to let on or not to let on; to lie or not to lie; and in each case to whom, how, when, and where” (Goffman, 1963, p. 42). One of the most important negative factors influencing life quality in case of  the discreditable individual living with HIV is the endless fear and anxiety of the stigma disclosure and its possible social consequences.

> *“I do not tell anyone that I’m HIV positive, only a minimum of people knows that and honestly, I have a terrible fear and panic that it would be publicly disclosed, that people would know that and I would not be able to control it. I fear how would people react. I do not talk about it and that is also the thing that I mind the most…I’m convinced that this infection is not so much about health problems, but rather about the social problems. It would be wonderful if people would not have to feel ashamed and hide because actually there is no reason to do that. No-one with leukemia or cancer or anything else is ashamed and no one looks at him through his fingers, so why should we?”* (HIV Práca, 2014, April 2c)

The consequences of HIV-related stigma, regardless of whether it was disclosed or not, lead necessarily to symptoms of minority stress describing the creation of stressful environment in which PLWHIV as a minority ( and sometimes even minority in minority) which can have without social support very negative impacts on mental health what resolves in mental health problems triggered through stress processes, expectation of rejection, hiding and concealing, internalization of prejudices, depressions, anxiety, or feelings of shame (Meyer, 2003).

Another consequence of HIV and its relation to death can be in the case of PLWHIV stronger feelings of  existential death anxiety, according to their reports, mainly after the diagnosis of HIV, causing stress and fear for their lives, what can result in negative mental health and pathogenic behavior, e.g. self-destructive behavior. This effect can be even increased by anticipated stigma, therefore, social and psychological support are in addition to treatment the most important aspects for their well-being But the best placed to talk about this death anxiety are PLWHIV themselves:

> *"When I got it, I was scared of how much life has left me and I saw myself dead. I was choosing a song for my funeral. I was in my early 20's when I found out I'm HIV positive and I think that I was at that time the youngest one in Slovakia. It frightened me a lot. That was a start for such period of my life when I have had depression for half a year, then came such initiative to use drugs until it will kill me, like, when I have only a year of life left, at least, I'm gonna enjoy it. Of course, that completely destroyed m health and I started to attend a psychologist and then it got better. The one thing that helped me a lot was that I went to the doctor, and now I live with it for 11th. year."* (Tomáš)

Also, Roman reports similar feelings and experience with death anxiety together with anticipated and also internalized stigma and indications of feeling of social death:

> *"The first moment was a horror, one gets very scared.Your first idea is that you will die in a half year. That is the first thing. A large darkness. Such a contact with death which each one has to face. The worst thing is that exactly this is what destroys many HIV positive people, that they cannot deal with it, they believe it and will succumb to it. It is that feeling of such a dirty dirt. You are living somewhere in the social ranking and suddenly, you are a total waste because you have the worst thing on Earth in you. In one moment you know you have it and when you tell someone, he/she will not even shake hands with you. And you have it. It is a feeling of dirtiness, guilt. HIV positive people have this feeling very often, because you know it is forever. And this is the key thing that kills them,*

> *that they start to believe in that fear of death and feeling of dirtiness, and they let it devour them. They conceal it, they are terrified of the moment when someone will find out, they fear of social exclusion. And this will kill them. But I told myself that I will be dying only when I will be really dying, now I'm alive so I will live… I still tell myself that if I will stay alive for next 50 year, it will be great….And that solved me many things, it purified the topics I deal with in my life."* (Roman)

John was talking about the same experience after diagnosis proving that the perception of diagnosis of HIV is a very strong psychological harm, however, social support can make a very important improvement of mental health after the harm, but a sign of compensations and change in existential thinking may be, as well as in Roman's case, present:

> *"Since I did not have enough of information about HIV, only that one will die, my first feelings were that I do not even end school, buy my own flat, I will not reach my career and everything you dream up as a child is from minute to minute gone… I was in shock, thinking that I will immediately die, but the help of the doctors and my social environment helped me to start again. Now I'm more ambitious, I'm working harder to achieve my goals and I care about my health more… Now I live for today and the closest future, that means max. 5 years."* (John)

To become and to be a minority with discreditable or already discredited stigma status can also mean to experience social death, which means that the individual is by the society not fully accepted as human being, he/she faces discrimination, prejudices, social rejection and isolation, he/she might be demonized or even criminalized  as a manifestation of social control and suppression. This can happen simultaneously with kind of social denial and ignorance towards their existence, but social death might be also caused by the  anticipated stigma where PLWHIV assume that they are socially dead., however, "due to the reactions of others as well as the internalized self-feelings stigmatized persons' life chances and opportunities are lessened, they are set apart from others." (Koka, Ahorlu, Agyeman, 2013, p. 235). But the consequences do not end in affecting only PLWHIV, they do harm also the majority because social death in case of PLWHIV also lowers the awareness of HIV-negative people, both because they may ignore the phenomena as if it does not apply to them, or they can fear the stigma due to the anticipated stigma and, therefore, they can experience mental health problems as e.g. anxiety or fear, or do not undergo HIV testing (Starks, Rendina, Breslow, et. al, 2013), what is a direct threat to the prevention efforts.

HIV-related stigma and its mechanism in the social environment affects not only PLWHIV, their living conditions and mental health, but HIV stigma also significantly affects the area of HIV/AIDS prevention through taboo, fear and anticipated stigma of HIV negative people that are at risk of acquiring HIV. Stigma in this issue creates a great psychological barrier of HIV-negative people towards the prevention efforts and slows down the worldwide movement fighting HIV/AIDS both on the side of PLWHIV and prevention of further spreading of this virus which is making not only the immune system helpless against other illnesses, but also the people feeling helpless in fighting the stigma, which consequences appear mainly in the society, healthcare and criminalization by the legal system. These aspects will be examined further within the results of quantitative and qualitative research.

### 1.4 Condom use and testing stigma

One of the critical issues of STI's prevention is definitely condom use, which people despite his numerous positive functions as protection from unintentional pregnancy, transmission of STI's or even hygiene do not use and even have prejudice toward it (e.g. condoms reduce the sensitivity of penis). Problem is, that condoms were in the past and still partially are stigmatized as something that is not completely correct to use during sexual intercourse. One of the main sources comes from the theological paradigm telling us, that condom use prevents the birth of a new life which should be, according to the most conservative interpretations, the only function of sexual intercourse, and preventing it is a sin.

> *"With HIV is connected an important chapter in which has Catholic Church a long term static approach - usage of contraceptive devices, in this meaning specifically physical protection…which are per se in Catholic Church forbidden and not permissible is even the view that one should use protection to not infect another, because it is interconnected with conceiving. Conceiving should be possible anytime and therefore, condom use is in the spirit of the teachings of the Catholic Church absolutely unacceptable."* (Kocúr)

Therefore, condom use became in the society quite taboo and even during the hardest times of HIV/AIDS epidemic, the catholic church in the U.S. preached that people should not use condoms because it is a sin, what still continues and may psychologically affect people by suppositions that condom use is not an important practice. Taboo in the society can often cause that even people that maybe would like to use condom are simply ashamed to buy it and use it (Sinding, 2005, p. 38) because it explicitly says about them that they are going to have sex, what is also a taboo, and people can have tendency to hide their sexuality.

The second source of problems with condom use can be in education, which is the crucial aspect of prevention. In Slovakia, the sex education is still missing and is superseded by Education for matrimony and parenthood, which by the name itself reference back to the theological paradigm, and according to personal sources is in some cases even taught by theologians or nuns which refuse to talk about physical or hormonal contraception or provide inaccurate informations. That may give clues that we miss teachers qualified for such subjects. Another issue with such subject of education is in nearly exclusively heteronormative focus of subject, which is, according to the curriculum published by the Ministry of Education mentioning other than heterosexual orientation only in the last section of part of the curriculum, while other parts speak exclusively only about the relationship between man and a woman, already setting the heteronormative norms. (Ministry of Education, Science, Research and Sport of Slovak republic, p. 15). Another possible issue of this curriculum is that in the second part, point 4, "Responsible approach to sexuality" it interprets HIV/AIDS prevention in terms: "Fidelity and knowledge of sexual partner and their health status as the best prevention against HIV / AIDS and STDs" (Ministry of Education, Science, Research and Sport of Slovak republic, p. 10), which refers to approach which was already disputed above, because "sex is and undeniable reality and, in the absence of any other technology to protect sexually active people from the risk of infection, prevention message must stress correct and consistent use of condoms" (Sinding, 2005) according to what we can doubt the correctness of this curriculum. However, according to the interviews, each one PLWHIV together with medical student agreed on the fact, that sex education is in Slovakia needed and it would be helpful.

The third issue with condom use is in the decreasing tendency of condom use with increasing usage of hormonal contraceptives (Ku, Sonenstein, Pleck, 1994), or not using these protection methods at the same time (Ott, Adler, Millstein, et. al., 2002). This phenomena might be caused by several false assumptions about the function of condoms mainly as a prevention of pregnancy which is "not needed" when the female sexual partner takes hormonal contraception and not taking into account the STI's, often unfounded confidence about the health condition of sexual partner, denial of condom use or simply not having it because of reasons mentioned above, or irresponsibility. Also, strong emotional feelings towards partner during sex (and not only) make people trust partner and not to even think he/she could be a potential threat.

HIV-related stigma does constitute a barrier towards prevention efforts, and HIV testing is one of them. Early diagnosis of HIV is very important in improving the probability of effective treatment leading to suppression of virus and potentially even achievement of undetectable status. The fear and anxiety of acquiring HIV as well as the fear of being virtually identified with one of the groups associated with stereotypes about HIV (for men often e.g. fear of being identified or revealed as homosexual) creates a significant barrier to HIV testing and awareness about our HIV status not according to assumptions, but medical tests. Stereotypes about HIV, that it is a gay disease or disease of sex workers and drug users may also cause that people, who do not identify themselves as members of any of these groups may have an impression that HIV is not their problem. According to research, people  might be are aware of the benefits of testing, however, HIV-related stigma is still a deterrent aspect to testing and prevention programs should focus on stigma reduction (Maclean, 2004). Everyone who is having unprotected sex should probably get tested. The anticipated stigma of HIV plays here a major role and until people will not be scared of social rejection, exclusion, and discrimination in the society, until we do not eradicate these attitudes towards PLWHIV, stigma of testing will remain a problematic part of prevention, lowering the probability of early diagnosis of HIV and further transmission. "From both sociological and a public health perspective, the widespread popular fear of people with HIV disease is one of the most important aspects of this epidemic*"* (Weitz, 1992).

The fear of testing might be also interconnected with psychological process of death denial. People have a tendency not to think about death because such thoughts make them feel bad, they feel fear and anxiety  - very negative feelings which make people in connection with death feel weak and powerless, they feel death anxiety. People fear death and there is probably no one who does not, it is a universal and very powerful influence, whether we know about it or not. HIV reminds us death, our mortality and PLWHIV represent impersonation of this death anxiety.

> *"People do not get tested. I think that they are afraid of testing, or they subconsciously suppress. I would not get tested either if an emergency will not take to the hospital with fever… It is something like a skeleton in a closet, you put him there, hide him there or you hide him under the carpet and do not want to even think about it… I do not know many people who get tested regularly."* (Tomáš)

One of the most common ways of transmission of HIV is through sexual intercourse. Psychotherapist Irvin D. Yalom claims in a documentary movie dedicated to him and his lifework “The death anxiety is for some people countered by sexual arousal as a great vital response to death. Sexuality is the center of being alive” (Gisiger, 2014, min. 107, sec 39) what means that we might not be able to think about death during the joy of sex, we might not be able to think about sex as a threat to our health and to our lives. On the other hand, HIV testing may represent the fear of being informed that we are going to die and it might happen a bit sooner. It represents the fear and anxiety of being stigmatized and discriminated because we might be HIV positive, it is a very stressful moment to undergo testing and wait for the results for a few days or a week or two. Therefore, it contains the fear of becoming socially dead, and later on physically dead, it is almost like dying twice. Therefore, stigma should be eradicated, people should be informed about the life with HIV, that today it does not necessarily mean death and PLWHIV often die for other reasons which are not connected with HIV but from common reasons of death. Because of these significant psychological barriers, testing should not contain another obstacles which could for several reasons create an obstacle to get tested and therefore testing should be free, anonymous and easily accessible, and not only for HIV but for all STI’s.

# 2. Law, rights and legal constraints of PLWHIV

HIV/AIDS is certainly not a classical common disease like a cold or a sore throat, uncontrolled and untreated HIV/AIDS can cause serious health damage and a potential threat to public health. Every citizen has the same rights and duties guaranteed by the state, but PLWHIV are often obliged to subordinate certain specific rules and duties. Therefore, special legislation and strategies often apply to HIV/AIDS and defines specific policies and legal sanctions in order to control PLWHIV and the spread of the virus.

## 2.1 Human rights of PLWHIV

The Universal Declaration of Human Rights grants each and every human being several rights and freedoms which are imprescriptible, inalienable and irrevocable, and their observance is an essential part of every democratic country. This universal and ultimate approach to rights and freedoms are meant to protect and strengthen the social status of each and every individual, even the weakest one's. However, states ,unfortunately do not respect these principles and human rights violations are even more than 6 decades after the adoption of Declaration of Human Rights still present in our society. Slovakia signed the declaration and implemented these principles into its constitution, but human rights violations still remain an issue that needs to be solved.

We have already proved that HIV-related stigma affects the lives of PLWHIV and as a consequence, they have to face mental health problems, stereotypes, prejudices and even discrimination - the three main environments where these phenomena of stigma occur are in case of PLWHIV in healthcare (Nyblade, Stangl, Weiss, et. al, 2009) employment and their social environment in interpersonal relations, therefore, according to humanist paradigm of liberal-democratic states, it is necessary to apply human rights-based approach to prevention programs and policies on national and also international basis (Gruskina, &Tarantola, 2008). UNAIDS policy Fast-track: Ending the AIDS epidemic by 2030 refers to 3 simultaneous policies: increasing the availability of HAART, decreasing new infections among adults and zero discrimination of PLWHIV (UNAIDS, 2014), which is, as we already proved before, inevitable for the fulfillment of previous two goals. This international policy is based on the human rights principles of non-discrimination, and human dignity (United Nations, 1948) as a concept describing internal "state of peace that comes from recognition and acceptance of value and vulnerability of all living things." (Hicks, 2013).

Human rights are an essential part of theory when we want to describe, analyze and examine problems related to HIV-related stigma and its consequences on lives of PLWHIV. The basic principles which need to be protected when we want to fight HIV stigma and protect lives of PLWHIV are enshrined in Art. 1 - equality, rights, dignity; Art. 2 - a guarantee of all rights and freedoms; Art. 7 - non-discrimination; Art. 12 - the right to privacy; and Art. 25 - the right to healthcare (United Nations, 1948) which are also guaranteed by the European Convention on Human Rights and the Constitution of Slovak Republic in the Charter of Fundamental Rights and Freedoms. Right to healthcare is also guaranteed by the European Charter of Patient's Rights adopted by the Slovak Republic, which says that "Every individual has the right of access to the health services that his or her health needs require. The health services must guarantee equal access to everyone, without discriminating on the basis of financial resources, place of residence, kind of illness or time of access to services" (Ministry of Healthcare, 2008). However, access to healthcare is according to reports of PLWHIV the area in which they, paradoxically, since it should be the most competent area, experience strongest stigma and discrimination (UNAIDS, 2001; Nyblade, Pande, Mathur, et. al., 2003; Nyblade, Stangl, Weiss, et. al., 2009)

### 2.2 Slovak legislation concerning PLWHIV

As we already mentioned above, Slovakia does apply all of the international legal documents used to the protection of human rights. The Legal system of Slovak Republic also includes its own policy of HIV control and imposes PLWHIV several obligations to which they need to adapt in order to avoid a conflict with the law.

PLWHIV are after diagnosis signing and informed consent obliging them not to knowingly spread the virus and not to engage in risky behavior as e.g. having unprotected sex (without a condom) and inform their sexual partner and healthcare worker (who performs invasive procedures) about their HIV-positive status. Otherwise, they can be accused of endangering (when the virus is not transferred) or spreading off HIV according to §165 and §166 of the Criminal code of Slovak Republic No. 300/2005 in the Journal of Laws, and can be imprisoned in the mildest form for 1 - 5 years (p. 3032). According to legal practice, violation of this law in the case of healthcare workers is solved with a fine and PLWHIV are not threatened with imprisonment. However, violation of this law in the case of sexual partner is more complicated and criminalization can have negative consequences, therefore, it will be analyzed in the next sub-chapter.

Healthcare workers of course also subject to certain legislation guiding them in the performance of their work, which is also applicable to legislation relating to HIV and interaction between the healthcare worker and PLWHIV.

Healthcare is for PLWHIV granted not only by the human rights document but also specific laws developed on the basis of these human rights documents, in the case of Slovakia, it is Healthcare Act no. 576/2004 and if healthcare provider refuses to provide healthcare to PLWHIV, he/she is according to §12 obliged to prove the legitimacy of refusal (The Act on health care, healthcare-related services, and on amendments to certain laws, 576/2004). Information that one is HIV positive should not be a justification of  refusal healthcare, since The Decree on requirements for the operation of medical facilities 553/2007, §5 sets out the principles which need to be adhered by healthcare providers during providing of healthcare, which is complemented by the Journal of the Ministry of Healthcare of Slovak Republic from 2000, part 6-9, Specialized guidelines no. 17, Art. 10 which states that healthcare providers should treat “each biological material of human origin, in particular with the blood as if it contains HIV” (Journal of the Ministry of Healthcare of Slovak

Republic, 2000, p. 77) what basically means that every patient should be treated as if he is HIV positive. Therefore, patients which inform healthcare providers that they actually are HIV positive should not be refused because of their diagnose, because healthcare providers should be already protected according to previously stated laws which require certain standards of protection of patient as well as healthcare providers.

The report on the implementation of the National Programme for HIV/AIDS in the Slovak Republic for 2013 - 2016 during 2014 approved by the government of Slovak Republic states, that:

> *"Healthcare workers should treat every patient as potentially infectious… The right to receive medical care has each patient including patients with HIV / AIDS. Refusal to provide treatment to these patients is a violation of their rights and a sign of discrimination."* (Report on the implementation of the National Programme for HIV/AIDS in the Slovak Republic for 2013 - 2016, 2014, p. 13)

Despite all these legislations and report, PLWHIV report denial of medical care and HIV-related stigma is present, creating threats to the medical conditions and rights of PLWHIV as well as prevention efforts and public health, because the more will be PLWHIV refused, the more they will be hiding their HIV status. Question is, why the healthcare providers do not refuse people with other illnesses or infections, why they do not refuse people with hepatitis, which is more infectious than HIV, but still refuse PLWHIV?

> *"I had a dentist and when I had hepatitis, I informed him and he told me that it is no a problem. When I informed him after 4 years that I'm HIV positive, he refused to treat me. I called them and I was talking with the nurse who interpreted the dentist…they started to make excuses that do not have instruments for that and the nurse was interpreting doctors words but I heard him in the background as he told 'no, by no means'…*

> *Hepatitis is much more infectious and more dangerous and no one does take it so dramatically… No one cares about it but dentist will not treat you because of HIV… If you need surgery, you have to go to one clinic in Bratislava, there is the only department where you get treatment when you need surgery, nowhere else… One friend of mine, a doctor, he told me that they had HIV positive patient and it caused a commotion on the whole department. Nurses refused to go to the operating room, anesthetist refused to anesthetize him, complete nonsense"* (Roman)

Given the interviews with PLWHIV for the purpose of this study, they provided us several statements about their experiences with healthcare services:

> "I started to be aware of discrimination when I emigrated from Slovakia and started to visit a doctor in my new residence. I started to realize how terrible it is in Slovakia… The strongest feeling of discrimination was for me in healthcare, mainly in behavior towards me… I was looking for a dentist for 5 years. The reaction of the dentist I have had before was that she does not treat such cases and I have to go to infectious clinic and when we finally got to the point that she does not have proper information, she agreed to treat me, but I have stopped to go there because I did not feel good. She acted very cold and not to mention that you have never seen such an astronaut as she was fully covered with protective glass, lab coat, and multiple rubber gloves…People do not trust our healthcare and people who care about their health go to Austria because there is AIDS-Hilfe." (Jaro)

Also, Pius refers to his experience, which could be also interesting case for hygienics or Health Care Surveillance Authority:

> *"I have informed my dentist that I'm HIV positive and he told me that he does no know what to do with it. But he is a doctor so he has to know it.*

> *Later on, he admitted that he does not disinfect for economic reasons because it would rapidly increase his costs… He told me that he does not even use gloves."* (Pius)

Part of the field research for this case study included an interview with medicine student which used to work in HIV testing center which will not be, due to her request to stay anonymous, specified as well as the name of her university. She is also working in on an educational project focused on prevention of STI's. The interview with medicine student was related to her experience with studies of medicine, which educates the next generation of healthcare providers, her experience and knowledge/ opinion about the situation of PLWHIV in Slovakia in the context of access to healthcare, and opinion about HIV stigma in the context of medicine. Reference to parts of the interview with her will be indicated as "Medicine student". Her experience with her studies of medicine at university which will not be specified, she described as:

> *"I have got mostly negative experience with my university when we speak about HIV. Our professors studied medicine a long time ago so they did not study HIV during their studies since this virus appeared after their attestation, so they had to study it alone and not every of them did that in the best way. I observe that the stereotype that HIV/AIDS is a gay disease of disease of intravenous drug users. And it is also a topic which is by my classmates perceived as something that does not affect them, what is according to my opinion a big problem"* (Medicine student)

Later she is mentioning two cases which happened during lectures and reports go HIV stigma in multiple stigmas of gay people:

> "*On a lecture about hematology, lecturer expressed negative attitudes towards the policy that the questionnaire which you have to fill in before blood donation cannot contain direct questions about homosexual*

> *orientation… He himself told us that when there is a blood donor that they think is gay according to his behavior, they make some kind of mark on his blood to be more aware during testing. or something, he did not tell us directly. And he performed "homosexual behavior" according to stereotypes about gay people…it was very unpleasant. The same happened during a lecture about medical ethics, where the lecturer that was supposed to teach us about ethics was speaking about HIV positive people as about 'aids bags'[1], and he did not forget to mention that they are mostly people which are not very masculine… He not only labeled HIV positive people as 'aids bags' but also described as homosexual… But homophobia can be seen in Slovak medicine schools very, very, very, very often."* (Medicine student)

This parts of the interview show us very clearly that HIV-related stigma can be and already is present even during educating of healthcare providers, referring to the multiple stigma theory connected with HIV stigma theory. If students of medical ethic hear about PLWHIV during the lectures in such a derogative and dehumanizing way interconnected with stereotypes and prejudices, only one step remains to direct discrimination based on these aspects when they will be confronted with PLWHIV in their service.

To the problems with providing healthcare to PLWHIV in Slovakia according to her informations', because this information is in Slovakia not very publicized and publicly available since PLWHIV often do not officially report their experiences:

> "*Enough of the problems is in the area of surgery, our surgeons are very afraid of surgeries of HIV positive people and they often rather find some excuse, that is happening mainly in one big hospital in Bratislava. When they diagnose their patient as HIV positive, they often find and excuse to*

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[1] Interview was carried out in Slovak language. AIDS bag" is not a literal but contextual translation, lecturer used term "aidsáci" which does not have literal english translation. "AIDS bag" is an archaic insult towards gay people with AIDS.

> *cancel even planned surgeries. The same is with dentists. I have asked my dentist about it because aim interested in this issue and she responded that she would not treat the HIV-positive patient."* (Medicine student)

Since there is no reason why not to believe her statements, according to her experience, it seems that according to stigma theory, healthcare providers are more afraid of HIV than of violating law and rights of patients, which probably remains unsolved, since PLWHIV are due to stigma unwilling to disclose their identity and inevitably also HIV status to solve their problems on from legal viewpoint:

> *"That obstacle (disclosure of identity) is certainly there because I think that I would not be in it with another 150 HIV positive people that would go into it with me. I would end up alone as some exemplary prime example for some tabloids, media would maybe make a case for it and maybe I could win that case, but I think that in Slovakia, it would label me for my whole life. And that is quite unpleasant. I would have refused also this interview if my friend would not vouch for you and did not give me references to you* (for the interviewer). *But if someone else would come that he wants to make an interview, he can give 100 informed contents that it will protect me and my identity, I would not do this… I would be scared that I will be publicly revealed."* (Tomáš)

Most of the interviewed PLWHIV claimed, that in the case of dentists or in other cases, they have to pay for private clinics, which is very expensive, but, at least, they will treat them. John also claimed that he would appreciate at least specialized clinic only for HIV positive people which would not be private and would not cost so much money. Such clinics can be viewed in terms of segregation, but in a pragmatic view from the position of PLWHIV, it is given to their experiences with the provision of healthcare, at least, some kind of solution. In any case, all of them show that they have problems with respect for their rights what leads to direct institutional discrimination unacceptable for a democratic state granting equal rights to all people.

However, a vicious circle of HIV-related stigma is present also in the area of healthcare.

### 2.3 The issue of criminalization

Criminalization is an issue closely related to HIV-related stigma, laws about criminalizing of the threat of transferring the virus to a sexual partner during unprotected sex, preventive efforts and healthcare for PLWHIV.

Last reported case of criminalization of PLWHIV in Europe happened in neighboring Czech republic, where hygienist filed a criminal complaint against 30 PLWHIV (only gay people) that got infected by another STI after their HIV diagnose, from which hygienists deduced that they had to have unprotected sexual intercourse by what they violated the law (Tomšej, 2016). Worrisome is, that only gay people were prosecuted, what might be a sign of multiple stigmas of HIV-related stigma and homophobia (heterosexism). However, this might not be so simple, since other STI's can be transmitted also through the oral or another way in which is the transmissibility of HIV very low, as we already demonstrated, HIV is transmittable only through blood or unprotected anal or vaginal sexual intercourse. They could also have sex with another HIV positive person during which transmission of another STI happened. Any new transmission interconnected with this case was not proved. Czech AIDS Help Society considers that HIV/AIDS should not be implemented through repression but prevention and treatment of PLWHIV to help them to get to the undetectable level which significantly lowers the chance of transmission near to probability of 0%. (Tomšej, 2016)

Dangerous is, that such cases may have a completely opposite psychological effect on PLWHIV and in the a case of new infection by another STI they may feel fear to visit the doctor because it may expose them to prosecution. Cases of criminalization also empower demonizing aspect of PLWHIV as criminals what may increase the HIV - related stigma. Having sex is a matter of personal life and it should not be criminalized if HIV is not transmitted, or even if it is and it was not proven that it happened intentionally or during rape, since “There are no data indicating that broad application of criminal law to HIV transmission will achieve either criminal justice or prevent HIV transmission. Rather, such application risks undermining public health and human rights” (UNAIDS, 2008). HIV transmission should not be criminalized also in cases when the HIV positive person disclosed his/her status and the negative person even so agreed or demanded unprotected sexual intercourse. Therefore, UNAIDS recommends governments to repeal HIV-specific criminal laws and rather apply general criminal law onto cases of intentional transmissions. (UNAIDS, 2008, p. 6). Interviewed PLWHIV also reported disagreement with criminal laws against PLWHIV:

> *“Where is some equality? Where are equal rights for all people? It is set up explicitly discriminatory only on a specific infection, but id does not help to stop something? What is going to be stopped by it? It sill not be solved by scaring HIV positive people, that is not a way to go. A way to go is to teach everyone to use protection or not to have sex with a person whose status we do not know… Why it is set up that only they have the duty though you have also the duty to protect yourself... This all is about two people, not only the HIV positive one is responsible, it should be formulated that both are responsible… Another issue is when someone is HIV positive and informs partner about his status when they are going to have sex and he will thereafter say that he/she was not informed?… If he gets it and will sue me that I did not tell him, what am I supposed to do? We are perceived as some terrible social threat and we have to be eliminated and should live in celibacy. No. We have exactly the same right to have a sexual life. My behavior in this area is towards my sexual partners very fair, but sometimes I have such mental condition that I think if I should rather not have sex while I do not even endanger anyone and I do my best not to endanger anyone” (*Roman)

This clearly proves that criminalization can have a negative impact on the state of mind of PLWHIV, their self-confidence and they may feel fear and anxiety. And there is also another legal problem reported by another interviewed respondent:

> *"If I infect someone, there is automatically filed a criminal complaint against me for knowingly spreading HIV to a certain person. But when the certain person comes to police to cancel the criminal complaint, he/she just cannot cancel it."* (Jaro)

According to the UNAIDS policy brief on criminalization of PLWHIV in cases of threat of transmission or even cases of transmission of the virus, Slovak Republic has due to the §165 and §166 and even §167 - endangering by sexually transmitted disease which criminalizes even carelessness by imprisonment for 1 to 3 ears (*Criminal code of Slovak Republic, No. 300/2005)* improperly formulated legislation which does not prove any preventive implications. In the end, such legislation is according to UNAIDS and many HIV advocating NGO's opposite results and cannot improve the situation but rather exacerbate. Such legislation only empowers the HIV - related stigma and demonization of PLWHIV as potential criminals. The government should rather apply harm reduction policy, stop criminalizing of PLWHIV and potential transmissions but focus on helping them while applying the general criminal law on only serious cases of intentional transmissions of HIV. HIV is not a crime PLWHIV are not criminals and killers, they are people who happened to have a certain infection about which should be people exposed to transmission informed.

# 3. HIV/AIDS in Slovakia

## 3.1 HIV/AIDS in numbers - World and Slovakia

According to UNAIDS, in 2014 about 36,9 million people were living with HIV globally, from which about 17,1 million of people do not know they live with HIV. That is a huge number that and a threat to public health. 22 million of people needs to be reached with HAART. However, the number of new infections is decreasing, there was a decrease of 35% of new infections since 2000 and 42% decrease in AIDS-related deaths. Also, a significant increase appears in the field of access to ART, in numbers there is 84% increase in access to therapy since 2010. (UNAIDS, 2015)

Epidemiological surveillance of HIV/AIDS started in Slovakia in 1985, a few years after the beginning of the epidemic, and is provided by regional Public Health Authorities. According to the National reference centre for the prevention of HIV/AIDS, since 1985 until October 30. 2015, during 30 years, 664 Slovak citizens and 134 foreigners have been diagnosed with HIV - together 798 people, 83 of them are living with AIDS, and 43 people already died from AIDS. However, 574 of these diagnoses - nearly most of them, have been identified in last 15 years with an average number of diagnoses per year as 38. Since 2010 is the number of diagnoses per year increasing from 25 in 2010 to 46 in 2011, or 43 diagnoses in 2012 to 83 in 2013 - to this time the biggest number of diagnoses per year (Public Health Authority of SR, 2015), to 69 diagnoses of Slovak citizens and 4 foreigners in 2015.

According to the report of Public Health Authority of SR, most of the HIV diagnoses in Slovakia since 1985 until September 30. 2015 have been in a number of 664 diagnoses among Slovak citizens found among men - 578, and 86 among women. According to the way of transmission was the highest number identified in group of men having sex with men (MSM) through homosexual intercourse - 62,8%, the second most common way of transmission was through heterosexual intercourse - 22,9%, 2% of transmissions through intravenous drug use, 0,2% by transfusion and in

12,1% of diagnoses was the way of transmission unidentified. The highest cumulative incidence is in Bratislava region, (Public Health Authority of SR, 2015).

The highest number of transmissions among MSM in homosexual intercourse can easily aspire to the popular stereotypes and prejudices about HIV/AIDS, that it is a "gay disease", and it is caused by "gay promiscuity" but the highest number of transmission between MSM can be also easily interpreted through explanation that maybe the highest number of the people absolving HIV testing may be MSM and, therefore, the probability of higher number of positive diagnoses is between other groups the highest, what could be interpreted that MSM may care about their sexual health the most. Since there are no statistical records about the preferences of individuals absolving HIV testing in Slovakia, but only about preferences or ways of transmission in diagnosed individuals, this cannot be efficiently proven, but also disproved. However, in an interview for popular magazine with associate professor RNDr. Danica Staneková, CSc., the head of National Reference Centre for prevention of HIV/AIDS in Slovakia, she suggests that this argument might be true, because "Although it is indicated that homosexual men account for only four to ten percent of the male population, it must be said that they are more likely to be tested." (Život, 2012). This fact can therefore also misrepresent the final statistics of diagnosed people, especially in the relatively small number of diagnosed people like in Slovakia, where many people maybe do know their HIV status.

Targeted HIV testing is in Slovakia currently available in 10 institutions, from which one is private and others are state institutions. Not every one of these provides testing every day during the work week, but only in specific days and hours, also not every possibility of testing is free, and anonymous. Results are available in a range o 1 to 14 days, according to the place of testing. For example the NRC in Bratislava, the capital city with the highest incidence of HIV provides testing only during 4 hours in two days in a week, results are available in a week after testing. Some of the institutions even inform about the results via phone, which might be for the recipient in case of positive result very dangerous and damaging information since he/she does not receive the immediate psychical support of the doctor.

### 3.2 Perception of HIV and People Living with HIV by Slovakians

The HIV-related stigma, its extent and impact on lives of PLWHIV highly, if not completely depends on the perception of HIV by the individuals constituting the society. Therefore, it is highly dependent on several sub-factors influencing the thinking and behavior of the individual - prejudices, myths, taboo and stereotypes based on cultural background, religious, philosophical, moral or political doctrines, education, environment and many more are more or less influencing one's ability to make stigmatizing judgements about certain group.

This case study is focused on the environment of Slovak society, in which HIV and HIV-related stigma are not a very discussed issue, and the general discussion about these issues gets outside the professional background only about the date of World AIDS Day on December 1.

The only known survey which included the issue of HIV-related stigma in Slovakia conducted in 2008 by the Institute of Public Affairs was measuring social distance towards certain social groups. The only question including HIV/AIDS related issues was asking about which group of people would them mind as neighbors the most with a result of 41% of respondents choosing an individual living with AIDS (Institute for Public Affairs, 2008). The higher social distance was demonstrated mainly by retirees - 53% (in contrast to students and creative workers - 22%), people with lower education - 44%, people with weaker contact with the western world and people with leftist political orientation - 48%.

For the purpose of this case study has been also conducted a smaller, non-representative, but for our needs necessary and beneficial survey/probe of opinions and attitudes towards HIV and PLWHIV in Slovakia. This survey has been conducted online via the internet and social media with voluntary respondents from all social groups with access to internet connection. The survey covered 500 respondents from the Slovak Republic.

According to gender identity, 42,6% of respondents identify themselves as men, 56,4% identify themselves as women and 1% identifies as “other” (this category includes transgender people, agender people, etc…).

Shortcoming of the survey might be found in uneven percentage composition of age of respondents, residence according to 8 regions of Slovakia (most of the respondent were from Bratislava region - 22,6% in contrast to Nitra region), social status dominated by students (56,2%) in contrast to pensioners (1,2%) and value orientation dominated dominated by liberal value orientation (48%) in contrast to conservative (12,4%) and pro-national (7,6%).

### 3.2.1 Basic education about HIV/AIDS

Vast majority of respondents claimed they have heard about HIV/AIDS (99,6%), a little lower group of them was able to identify HIV as a virus (92,6%) and AIDS as an immune system disease (90%), but only 46% of respondents have ever absolved some kind of education about HIV/AIDS. According to secondary analysis, only 50,3% of students and 42,3% of employed people absolved HIV/AIDS education. Primarily students are the most endangered group by HIV and other STI’s, however, only a half of them claimed they have absolved some training on the issue about problematics of HIV/AIDS what might be a possible threat since awareness (necessarily interconnected with proper education and information) of young people should be probably the highest since this is often also the most sexually active group.

The number right answers about the way of HIV transmission were quite high and satisfactory, only 0,8% of 100% respondents did not mark transmission through unprotected sex, only 93,2% marked transmission through blood and 79,8% transmission from mother to child, which shows us a deficit of 20%. But, 31% thought that HIV can be transmitted by saliva and only about 13% of respondents thought HIV can be transmitted through kiss or insect bites. other wrong answer had a low percentage of answers.

Same good results were shown in question about risky behavior, where the percentages of right answers reached statistically high proportions - unprotected vaginal intercourse (96,4%); unprotected anal intercourse (88,4%), needles sharing (95,2%); and all activities in which are people in contact with blood (86,4%).

13,6% of respondents marked sharing of the same toilets with PLWHIV, other wrong answers were statistically very low in values about 1%.

This part also contained two open voluntary questions asking respondents to describe HIV/AIDS by their own words, and to answer how can one himself/herself of HIV/AIDS.

Since these open question were voluntary, less respondents answered. To the first question answered by 231 respondents, more than a half of answers describing HIV as a virus and AIDS as immune system disease were right, and 15,6 % of them made connection between HIV/AIDS and death.

The second question was answered by 222 respondents - 68% reported as a way of protection condom, 15,8% faithfulness and non-promiscuous behavior. only 2,7% of people reporter HIV testing as a method of preventive protection showing us that the awareness about benefits of testing may be very low.

### 3.2.2 HIV awareness and opinions on living conditions of PLWHIV

This part of the survey for this case study was focused on the opinions of respondents about the riskiest social groups, their opinion about conditions for treatment of HIV and discrimination with one additional question to discrimination. This part also included two personal questions about HIV testing and HIV status.

According to the data obtained from the survey, most of the 500 respondents thinks that HIV concerns all people regardless of their behavior or social group (75,6%), however, more than a half of respondents still points out on the stereotyped groups of homosexually oriented people (55,6%) and drug users (64%) which suggests, that these inaccurate stereotypes creating false impression that e.g. heterosexual people are not at such risk of infection still present and will most likely preserve for the future. Paradoxically, the smallest (but not insignificant) number of respondents chose the answer of all people with risky behavior (51,2).

On the question “Have you ever absolved HIV testing?” most people answered “no, and I do not even think about it” (57%), only 14,4% thinks about it, 2,6% are already decided to get tested and 26% of all respondents has already absolved HIV testing. According to secondary analysis by cross tabulation analysis, from the percentages of individual answers, 59,2% of men got tested, and only 40,8% women. Vice versa, people who do not even think about testing are more women (65,3%) than men (34%). According to these results, women get tested less and refuse testing more, also in the group which is already decided to get tested are more men (53,8%) than women (46,2%). These results can suggest us that women might be in the future a more risk group than men and therefore prevention efforts focused on testing should in future focus more on women since they get tested less and cannot know their HIV status.
Secondary cross tabulation analysis according to sexual orientation shows that 50,8% of tested people are heterosexual, 35,4% are homosexual and 13,8% are bisexual. However, from the whole number of heterosexual people this makes only 18,2% while in the case of homosexual people, it makes 53,5% people, what clearly proves that more homosexual than heterosexual people actually gets tested on HIV. Therefore, this may suggest that they care about their sexual health more and possible increase of HIV transmission can be reduced by higher efficiency of HIV testing in this community. This can also oppose the myth that is still mainly a gay issue because more than 60% of HIV-positive people are gay people. This only means that probability of detection of HIV is higher due to the higher number of tested people from this community in contrast to heterosexual people. On the other side, from the whole number of heterosexuals, 65, 8% of heterosexuals within the variable of sexuality does not even think about testing which is in contrast to 26,7% from homosexual community nearly three times more. Therefore, much more dangerous is

due to unknown HIV status according to these statistics unprotected heterosexual sexual intercourse than homosexual.

Next question “Do you know your HIV status?”, which was linked to previous about testing, was asking if respondents know their HIV status. 55,6% of respondents claim that they know their HIV status and it is negative, only 0,8% are HIV positive, 33,4% do not know their HIV status and 10,2 are not sure about it. A basic comparison with answers on the previous question show us inconsistencies in a number of people claiming that they are HIV negative and people who actually got tested. The difference between them is 29,6% of people who claim HIV negative status without being tested. Paradoxically, more women than men claim despite that they are HIV negative - women (58,6%) than men (40,6%).

This 29,6% difference may include pensioners, people who were at the time of answer virgin and were not involved in any risky behavior, however, it also includes people who only think that their status is HIV negative and do not really know their health condition. As we already stated above, about a half of all PLWHIV in the world do not know their status. Jaro was during the interview with him also mentioning his experience during work on HIV prevention:

> *“One shocking thing was, that during a one project we provided testing on HIV and were simultaneously doing a survey for research with 380 valid questionnaires. From those 380 people, 18 people were HIV positive and a half of those 18 thought that there is no reason to be afraid that they can be HIV positive.”* (Jaro)

According to next question “Do you think that PLWHIV have in Slovakia good conditions for treatment?” predominant answer on a scale from 1 (certainly yes) to 5 (certainly no), the most common answer was according to the scale no. 3 (41,8%) representing that respondents do not have enough information to decide, however, the second most common answer was no. 4 - probably not (24,8%) and the third most common was certainly no (15,2%). These results may express distrust in Slovak healthcare system and its ability to treat patients with HIV and provide them proper conditions since most of the respondents chose rather neutral or negative answer.

This question is related to next one “Do you think that PLWHIV in Slovakia have problems with providing of healthcare? Most of the respondents chose the undecided option (31,8%), certainly yes answered 25,4% of respondents and probably yes answered 28,2% indicating that respondents may be aware of the stigma and discrimination of PLWHIV in refusing healthcare, or, at least, they presuppose that stigma of their medical condition is causing them problems even in the environment which should represent the most professional in the area of helping people regardless of any kind of disability or other aspects.

Question “Do you think that PLWHIV are in Slovakia discriminated?” is much more clear, nearly half of the respondents thinks that PLWHIV certainly are discriminated (47,6%) and the second most common answer states that they probably are discriminated (28,4%) what might suggest that people even if they do not have enough information, they assume that people with such identity are in Slovak social environment discriminated. Such reaction may be mainly a sign of anticipated stigma which can be present even in lives of HIV negative individuals since they are similarly able to presuppose that PLWHIV will be socially stigmatized.

This question was supplemented by additional voluntary open question answered by 210 respondents in which they were asked to define the signs of discrimination of PLWHIV. From the 210 answers, 77% were related to assumptions that PLWHIV face prejudices, social rejection, and social distance. 15,2% of people thought the PLWHIV are discriminated by doctors and healthcare workers - this number may be influenced by the fact that cases of discrimination of PLWHIV in healthcare are not officially known, nor publicized. 9,5% of respondents fevers to discrimination in work

Question “Do you think that PLWHIV in Slovakia have problems in work?” has respondents answered in a mostly confirmatory way as well as the previous question, 28,4% remained undecided and only a small percentage of respondents answered that they do not think that PLWHIV awe problems in work. However, this attitudes might by also interconnected mainly with anticipated stigma, since very few if any case is publicly known, these attitudes can be without reported and confirmed cases built only on presuppositions of HIV-related stigma and discrimination.

The same happens in the last question of section “Do you think that PLWHIV in Slovakia can be due to HIV excluded from their environment?” where was the most common answer probably yes (39,6%), 18,6% of people did not decide and 32% thinks that certainly yes, PLWHIV can be due to HIV socially excluded. In this case, the undecided group decreased, probably because of the anticipated stigma, where people already predict that PLWHIV will face social exclusion.

The percentages of these answers about respondents opinions provide us with an insight into the social perception of PLWHIV in Slovakia as they think it might be and affect PLWHIV, since there are only very few cases of discrimination due to HIV related stigma publicized and therefore, people can decide mainly on the basis of anticipated stigma perceived on the basis of internalization of social processes and structures determining these attitudes.

Also, each question demonstrated that many people remain undecided (at least about 30% except the last question), probably many because of lack of information about this issues in the public sphere. However, Answers on these question also provide us with an insight on how ordinary people perceive Slovak society - their answers express relatively strong assumptions that PLWHIV experience stigma, exclusion, bad services and discrimination.

### 3.2.3 Questions of personal attitudes in interaction with PLWHIV

The last part of the survey about the awareness and attitudes about HIV and PLWHIV was a part in which had the participants express their agreement or disagreement with a statement on a scale from 1 (I fully agree) to 5 (completely disagree). This set of questions is aspiring on highly subjective perceptions and attitudes based on value orientations combined with applied awareness about primary facts about HIV.

Because of the nature of these questions and the uneven balance of value orientations in demographics with a proportionate predominance of liberal value orientation (48%) to values of social democracy (32%), conservatism (12,4%) and pro-national value orientation (7,6%).

Further possible weaknesses of the data obtained in this section are standard deviation occurring during quantitative research as e.g. that people (respondents) have a psychological tendency to think about themselves in positive meaning. People position themselves into a negative position, but naturally do the opposite and express themselves in a positive light. Therefore, they also do not have to answer the questions according to their ow opinions and attitudes but are trying to adapt to what they presuppose the researcher expects, to make a positive impression and prevent potential shame for their responses. Basically, they think about what the researcher will think about their answers, what might be also an expression of conformity. In the third place, some of the questions have very personal, maybe even intimate character in context with HIV and PLWHIV and mutual confrontation, what inevitably aspires on rather emotional than rational reactions. However, during filling out the questionnaire, they were not confronted with any emotional impacts and had a chance to answer the questions on the basis of their rational part, but during a direct confrontation in life, it is very possible that the answering part will be emotional. Rational and emotional reactions can be considerably different, so the way they have answered the question in the survey does not have to coincide with their possible reaction in real life. (Denzin, & Lincoln, 2011; Patton, 2001; Creswell, 2013)

Also, according to a personal discussion with people who happened to fill in the survey, they independently pointed out that they are not sure if they would really react in a confrontation with PLWHIV as they have answered in the survey.

The first statement was “Even with HIV one can live a fulfilling life.” where results did not show us anything abnormal, most of the people at least partially agreed (32,8%, the undecided formed 20%, negative answers did not reach statistically important values, Only 16,2% rather disagreed adorn only 5% strongly disagreed.

This shows us that people are to some level aware of the fact that HIV does not constitute a major barrier to life anymore.

Second statement was focused on perception of PLWHIV visiting public health providers in a statement “PLWHIV can/have the right to visit the same doctors (e.g. dentist) as me.” where majority of respondents did fully (47,2%) or at least partially (21,8%) agreed, 15% left undecided and disagreeing groups did not reach even 10%.

“I would not have a problem to work with PLWHIV.” was a statement that gained a simple majority (51,4%) of positive answers of the agreement, and disagreement have compared to the previous question lowered to a value slightly over 5%.

Similar statement “I would not have a problem to have a friend who is living with HIV” gained the full agreement of 58,2% of people and partial agreement of 21,2%, undecided remained 12% of people and negative answers decreased to a value about 4%.

Statement opposing the previous one, that “I would find HIV positive status during a contact with HIV-positive individual as an obstacle” has been as least partially refused by 28,6% and 26,8% strongly disagreed, while fully agreeing were 8,6% of people and partially agreeing were 17,4% of people. 18,6% remained undecided.

With the statement “PLWHIV are a danger to the society.” fully disagreed 36,6% of respondents and 31,6% disagreed partially. 22,6% remained undecided while only 3,4% fully agreed and 3,8% partially.

“It is natural that PLWHIV rightly experience in the society mainly negative reactions.” was refused by 26,6% of respondents, , 18,8% of people rather disagree, 24,4% remain undecided, 16,2% rather agree and 14% strongly agree that the stigma and discrimination are natural, they should expect it and simply deal with it. to this statement is bounded another one claiming that “PLWHIV are solely responsible for their infection”  where only 2,6% strongly agrees and the predominant group 33,2% remains undecided and 28% of people rather disagree. this may indicate that people do not want to judge and would rather stay neutral or strand on the more positive side as an expression of empathy or simply do not want to harm their own identity by making moral judgments about other people.

“I can imagine having safe sexual intercourse with a person living with HIV.” was in this part probably the most controversial question which has shown significant differences between individual answers. 52,9% of respondents completely disagrees with such idea even despite the fact that it is safe sex. Only 19,1% would rather disagree and 17,1% remained undecided, only about 10% of asked would agree. The attitude of respondents is in this statement is a purely personal thing, but it needs to be mentioned that PLWHIV often speak about lack of partners willing to start a relationship with them from what are rising feelings of solitude and also sexual frustration, however, with proper treatment and condom use, they can have sexual life as anyone else, but they often have to look for someone with the same diagnosis.

> *“As everyone, I also do not want to stay alone until the end of my life. Friends are great, but having a partner is for life also very important, but to find someone for life is more difficult than without this illness”* (John)

> *“I know that many people know that I’m HIV positive and they talk about it, even in other towns. It simply gets there. That information circulates and relatively many people know it no matter if I told them. So I know that when I’m trying to date someone, maybe they would give me a chance, but they already work with the information and suddenly they stop.”* (Roman)

The last statement was meant to find out, how people would react to PLWHIV as employers: “If I would be an employer, after finding out about employee's HIV positive status, I would….” - respondents are supposed to choose one of four options. 32% would not do anything and treat him like before, 49,6% would try to find out how to help him/her, 3% would think about dismissing him/her, only 0,6 would immediately dismiss him/her and 14,8% would inform about it all people in contact with him/her, what is a gross violation of right to privacy, similar situation as happened to John, but in the area of healthcare:

> *"The general doctor called my sister that she should get tested if she is not infected too. She told her without my consent"* (John)

In this part of the survey analysis, respondents of the survey express their attitudes towards statements related to PLWHIV and their position in the society. As we have already stated in the beginning of this part, we have to consider individual psychology in relation to their behavior in cases as this, during monitoring of attitudes according to their value orientation when they are not directly confronted with reality, but answer questions based on certain statements in an artificially created situation. We certainly have to consider some distortion in comparison with real life situation. While in real life, mainly during a confrontation with issues and dilemmas of interpersonal interactions, people tend to react on the the background of emotional responses, simulations like this part of the survey are by the respondent evaluated on a the basis of rational thinking. Basically, this means that the answers of our respondents in this part can be taken as an indicator, even the best reactions can be during a confrontation in real life completely different due to a different center of evaluation of situation (emotionality instead of rationality).

Emotions are in human life a tremendous influence on behavior and e.g. fear of HIV transmission in interaction with PLWHIV can completely change the perception of the situation by the respondent and make him behave irrationally. Emotions are an essential part of interpersonal relationships and certain combinations of emotions in the context of the relation between people, environment and situation can lead to different variations of behavior, therefore, rational answers in simulations do not have to necessarily match our real behavior, therefore we should take such decisions as relative, not ultimate. They reflect only rational attitudes, but behavior in real confrontation may be different

# 4. Conclusion

During this case study, many more or less complicated aspects of social stigma related to HIV/AIDS has been examined from sociological as well as socio-psychological point of view and found several different points of view and approach, from which can be the issue of social stigma and social exclusion of PLWHIV conceptualized to specific policies from which we could be able to come up with a specific solution how to reduce its negative impact on PLWHIV as well as preventive efforts in Slovakia, what should be in the interest of the whole society and public health, as well as in interest of liberal democracy with the principles of zero discrimination and social exclusion.

HIV/AIDS is not anymore the scary and deadly disease to which we above referred as to the disease “worse than cancer”. However, medicine develops but society sometimes stagnates. HIV/AIDS became more a chronic illness than an infectious mass killer, but our society and its internal processes somehow forgot to unstick this label from this infection, and that is what is most probably holding us back in successful suppression of this virus.

Built on the basis of sociological theory of health and stigma , still study analyzed the illegitimate sick role of individual in society through the scope of Goffman’s theory of social stigma along with later conceptualization of this concept, applied in the cases of PLWHIV, their experience and perception of reality and the environment in which they live their lives with HIV and face the consequences of this socially constructed phenomena, which happened to became something as an essential symptom of HIV itself, since there is no individual living with HIV that does not face certain kind and range of stigma. In the purpose of better understanding of this concept, we provided a brief analysis of stigma, its variations, sources, social and psychological impacts and further implication on the well-being of PLWHIV as well as the social structures and attitudes towards prevention of STI’s and HIV in particular.

The concept of illegitimate sick role is inevitably bounded to the social stigma of the certain illness categorized into this sick role, where it splits its influence into socio-psychological, sociological and psychological influences differentiating stigma into enacted, internalized and anticipated stigma. All of these are in case of HIV-related stigma in Slovakia present, and are according to specific ratios, which are influenced by various combinations of specific influencing factors (social support, experience, environment, etc…) in each individual's life specifically (from what we cannot make generalizations without further research), shaping the lives of PLWHIV as well as the awareness and certain trends in the society.

The theoretical frame of HIV-related stigma combined with data obtained from the qualitative and quantitative field research have shown, that despite the fact that all three kinds of stigma (enacted, anticipated, internalized) are in certain aspect very strong, the one that may be crucial for lives of PLWHIV as well as preventive efforts of HIV testing and open troubleshooting in the society might be the anticipated stigma - the one, which is basically based on premature judgements about life with HIV in Slovak society. this stigma is considerably present in lives of PLWHIV as well as social attitudes towards HIV what has been proved also through the interviews and survey about attitudes of HIV-negative individuals. Each interviewed individual showed some extent of anticipated stigma influencing his way of life and decisions made within it, what which further causes that PLWHIV are hiding and concealing their status, what is lowering the social visibility of their problems and causes lack of social contact, what results in decreasing of HIV awareness and understanding of what does it mean to live with HIV. Due to this, social support which is needed to face and probably also overcome the stigma cannot arise in context broader than the one which is limited by only personal impact of PLWHIV who reveal their status only to their closest environment, due to anticipated stigma combined with experience with enacted stigma mainly from the field of healthcare provision, specific negative experiences and rejection in terms of closer relationships or multiple stigmas. This creates a vicious circle of PLWHIV being afraid of being stigmatized, and society which needs to increase its awareness, which needs to get in contact with this issue and to face and deconstruct its own prejudices, stereotypes or myths using the stigma based also on the lack of social contact. As Roman said, they are not radioactive.

However, not only social relations but also the state and its policies play an important role in suppression of HIV-related stigma and increasing of HIV awareness as well as inclusion. Slovak republic probably already has the theoretical basis of rights, laws, policies and strategies which could be used as tools in active solving of this problems, but it lacks their implementation and e.g. despite all the laws and policies protecting the human rights and rights of patients, PLWHIV still face serious problems with healthcare provision and lack the support to be able to solve it. There are no doubts that refusals of healthcare which they face are a direct discrimination and violation of patients and human rights and they (PLWHIV) would probably succeed if the would start to address it to competent authorities, however, since the lack of social support, they are reluctant to address it, since it inevitably leads to public disclosure of their stigma. And our vicious circle is back. However, state should probably show more interest and invest into the issue of HIV-related stigma and prevention since it would be still less difficult than to face further consequences of already increasing numbers of HIV diagnoses, what might be closely interconnected with the lack of prevention and awareness together with the denial that this is issue of all of us. As we have seen in the results of the survey, 65,8% of all heterosexual people involved in the survey does not even consider HIV testing and only 18,2% got tested. Women think about testing less and get tested less. HIV is not only an issue of homosexual people, nor men, it is an issue of all regardless of gender identity or sexual orientation. These issues certainly deserve a further research that could provide us representative data for further actions. Interpretation of national data that 62,8% are MSM is not enough since also this number of the ostensibly higher prevalence of HIV in MSM can be as we have already proved, only a result of much worse outreach on heterosexual people.

As we have already mentioned before, also the issue of criminalization of PLWHIV is something that can be improved only by the state. PLWHIV already face the consequences of social stigma that can affect their mental health, making them look like criminals, what they certainly are not, does not prove any signs of prevention or other positive impact and states should, according to the policy of UNAIDS, abolish these laws, since they can more harm than benefits. Harm reduction policies can be in a long term very efficient approach to solutions of social problems.

According to the results of our survey, many people show quite stable basic knowledge about HIV/AIDS and kind of uncertainty or indecision in the case of questions directed at attitudes about HIV and perception of PLWHIV. If they are uncertain, it is an ideal ground to provide them with information leading them to knowledge and awareness, but if we let it be, uncertainty may lead to rather negative phenomena, since the positive ones lack in the society. Sex education is in Slovak educational system missing and every interviewed individual living with HIV reported that one of the problems of HIV-related stigma is a lack of information about HIV, except the basic one. and lack of awareness and self-awareness in the case of STI's and HIV. however, during the realization of the field research of this case study, many people expressed interest in the issues addressed in this study. This could be potentially a good breeding ground for the cultivation of the issue of HIV-related stigma and its broader consequences on individuals living with HIV and in society.

HIV-related stigma and its broader consequences are in Slovakia still partially unexplored and require further research that could provide us with valuable data that could be later used as a solid basis for preventive efforts and social support of PLWHIV living in anticipated stigma with feelings of social rejection. HIV is not anymore an issue leading to the inevitable death of AIDS and as a health condition can be  the virus controlled on a very high standard - as a dog on a leash, you just have to take care of yourself. However, this does not decrease the importance of controlling the spreading in the society, however, if it is spreading and increasing as a result of stigma, low awareness, and denial of preventive methods, we increase our attention. Slovakia might be right that case.

## 4.1. Recommendations for further research

The theoretical analysis and research of social stigma in terms of the sociology of health and illness brought a wide range of issues related to in HIV-related stigma. Not all of them got enough of space to be issued in this case study, and some of them require further research.

From the issues already mentioned above, several of them deserve further attention and research in the area. For all of the issues addressed in this case study, further and more detailed research should be dedicated to attitudes towards HIV testing and awareness about its benefits. Attention should be also dedicated to the relation of HIV stigma with multiple stigmas, and influence of multiple stigmas on the perception of PLWHIV and with insight on tendencies of stereotyping.

For the preventive efforts, more detailed research should be done in the area of education about HIV and awareness of risky behavior together with research about risky sexual behavior in society

Last, but not least should be also more deeply and in detail issued the issue of violation of human rights of PLWHIV, mainly in focus on the provision of healthcare and the position of the state in this issue in the meaning of stigma reduction initiatives organized or supported by the state and their results.

## 4.2 Personal note

Work on a thesis like this was a tremendous academic experience which I would like to strongly recommend to anyone who might be at least a bit interested. The joys and despair of academic research in social sciences hide many interesting nooks and crannies for personal challenges, the discovery of education and knowledge hidden from the eyes of public that should be brought to the light of the world in the form of knowledge and awareness increasing programs, from people to people. Work on this research provided me a better understanding of social relations in terms of stigma and social rejection that can be applied not only in cases of PLWHIV but also other marginalized groups. However, one of the most valuable experiences was the field research that provided me an insight on the sources and relations of HIV-related stigma in society and social behavior of the HIV-negative majority. Qualitative research gave me a detailed insight into lives, attitudes and feelings of people living with HIV, and although I could not use all the data that they gave me, they were a significant component of the orientation of my case study. This specific experience also provided me another important aspect of life - several new friendships and more confidence and honesty in those that I already had.

# Resumé

Táto prípadová štúdia zameraná na výskum sociálnej stigmy a sociálnej inklúzie ľudí žijúcich s HIV na Slovensku sa v základnom, no dostatočne širokom zábere snaží zhrnúť všetky dôležité aspekty sociálnej stigmy a jej sociálnych i psychologických dôsledkov, bez ktorých sa samotnou teóriu stigmy a jej aplikáciou na marginalizované skupiny nemožno zaobísť. Štúdia vychádza z teoretických základov konštruktivistckej a humanistickej paradigmy sociológie so špecializovaným zameraním na sociológiu zdravia a choroby.

Teoretický základ prípadovej štúdie stavia na sociologickej teórii existencie spoločenskej roly chorej osoby tzv. “sick role”, na základe ktorých sa jednotlivec v rámci interakcie so spoločnosťou identifikuje s určitou rolou a na základe toho získava isté, zväčša dočasné výhody pre zaistenie jeho zdravotného stavu a ochrany jeho okolia (napr. tzv. PN v práci, úľavy od povinností, etc.). Infekcia HIV je na základe svojej povahy a jej vnímania verejnosťou kategorizovaná ako nelegitímna spoločenská rola chorej osoby (illegitimate sick role), považuje sa za niečo, za čo je priamo zodpovedná chorá osoba sama a zväčša sa na ňu neviažú žiadne spoločenské benefity, ale naopak, sociálna stigma, na ktorú sa môže viazať sociálna exklúzia.

Na základe teórie nelegitímnej spoločenskej roly chorej osoby buduje táto prípadová štúdia koncept sociálnej stigmy podľa Goffmana, ktorá rozvíja zdroje a vplyvy sociálnej stigmy na jednotlivca v kontexte ochorenia/infekcie HIV, spolu so sekundárnou literatúrou rozvíjajúcou jednotlivé sub-koncepty sociálnej stigmy a odvíjajúcou širšie spoločenské následky sociálnej stigmy viazanej na HIV a ľudí žijúcich s HIV, a negatívnymi vplyvmi na preventívne zámery v oblasti ochrany a potlačovania čírenia vírusu HIV v spoločnosti.

Základ teórie sociálnej stigmy ako silne diskreditujúceho atribútu zvyšujúceho sociálny dištanc “normálnych” ľudí od stigmatizovaných podľa Goffmana rozvíjajú ďalší sociálni vedci ako Earnshaw a Chaudoir o sub-koncepty prijatej stigmy,

predpokladanej stigmy a internatlizovanej stigmy ktoré aplikujú na HIV stigmu, ktorú táto prípadová štúdia dopĺňa o aplikáciiu týchto sub-konceptov na kvalitatívne rozhovory s ľuďmi žijúcimi s HIV na Slovensku a analyzuje je vplyvy.

Jeden z priamych dôsledkov sociálnej stigmy HIV sú negatívne vplyvy na mentálne zdravie jednotlivca, kde môže spôsobovať stavy úzkosti a strachu, depresie, pocit sociálneho vylúčenia, atď. Ďalším zo závažných dôsledkov HIV stigmy v spoločnosti je jej negatívny vplyv na spoločenskú percepciu ľudí s HIV a problematiky HIV kde môže aj v dôsledku generalizácie viacnásobnej stigmy s HIV u homosexuálne orientovaných ľudí, drogovo závislých ľudí či pracovníkov v sex-biznise, ktorí patria k už stigmatizovaným skupinám z dôvodu iných atribútov, vznikať dojem že sa táto problematika HIV-negatívnej majority netýka a znižovať vnímanie dôležitosti používania preventívnych metód ochrany pred prednosom HIV, testovania a zodpovedneého sexuálneho správania u tejto skupiny. Démonizácia HIV a ľudí žijúcich s HIV môže u HIV-negatívnych jednotlivcov z akejkoľvek sociálnej skupiny spôsobovať negatívne pocity strachu a úzkosti z predstavy že môže byť HIV pozitívny, čo pôsobí odrádzajúco od absolvovania HIV testovania a uvedomelosti o problematike HIV, a môže vyvolávať reakcie odmietania a potláčania pocitov že by mohli byť ohrození vírusom HIV a mali by absolvovať testovanie.

Štúdia je doplnená o kvalitatívne a kvantitatívne dáta z výskumu realizovaného v rámci práce na štúdii. Kvalitatívne dáta boli získané z anonymných osobných a písomých rozhovorov s ľuďmi žijúcimi s HIV na Slovensku a kvantitatívne dáta boli získané z analýzy prieskumu/sondy spoločenského povedomia o HIV/AIDS a postojov k ľuďom žijúcim s HIV na Slovensku na vzorke 500 dobrovoľných respondentov žijúcich na území Slovenskej republiky. Tie boli implementované v rámci teoretickej analýzy aspektov sociálnej stigmy a jej dôsledkov.

V rámci sumarizácie podmienok v oblasti HIV a prevencie na Slovensku štúdia sumarizuje legislatívne prepojenie na tematiku HIV/AIDS z oblasti ľudských práv, práva SR, medicínskeho práva, nariadení a vyhlášok MZ SR. S touto oblasťou úzko súvisí problematika kriminalizácie ľudí žíjúcich s HIV v prípade prenosu vírusu HIV na druhú osobu, v dôsledku ktorej dochádza k posilňovaniu démonizujúcich postojov k ľuďom žijúcicm s HIV. Medzinárodné stratégie prevencie HIV a eliminácie HIV stigmy ako prekážky úspešnosti preventívnych zámerov zastaviť šírenie HIV takýmto priamo na HIV viazaným legislatívam terstného práva oponujú a považujú ich za viac škodlivé ako prínosné či preventívne, nakoľko preventívne výsledky kriminalizácie prenosu HIV neboli nikdy priamo dokázané. preto sa odporúča upustiť od právnych úprav, ktoré sú špecificky viazané na prenos vírusu HIV za účelom trestnoprávneho stíhania, a obmedziť tieto procesy iba na zámerné šírenie vírusu.

Významnou časťou dôsledkov HIV stigmy na životy ľudí žijúcich s HIV je omdietanie spokytovania zdravotnej starostlivosti zo strany lekárov, najčastejšie, podľa výpovedí samotných ľudí žijúcich s HIV, sa takéto správanie a odmietanie ošetrenia vyskytuje v oblasti zubného lekárstva kde lekári, v dôsledku čoho majp ľudia s HIV problémy s nájdením lekára ktorý ich bude dlhodobo prijímať a ošetrovať, čo podľa niektoých výpovedí môže trvať aj roky. Nakoľko pre všetkých ľudí bez ohľadu na HIV status platia rovnaké práva, odmietanie podania zdravotnej starostlivosti z dôvodu HIV infekcie pacienta je porušovaním práv pacienta a ľudských práv, lekári as tak dopúšťajú  priamej diskriminácie

Z osobných rozhovorov s ľuďmi žijúcimi s HIV na Slovensku zisťujeme, že problémy s poskytovaním zdravotnej starostlivosti sú ich najvážnejším problémom v dôsledku HIV stigmy, prejavy stigmy v rodine či medzi priateľmi nie sú, napriek výskytu u niektorých jednotlivcov, veľmi výrazné a ich najbližšie sociálne prostredie je skôr podporujúceho charakteru. Spoločenská podpora je v otázkach sociálnej stigmy jednou z najvýznamnejších faktorov aby mohli úspešne čeliť stigme a vyrovnávať sa s ňou. Zároveň je dôležitá aj pre zmenu spoločenskej atmosféry, na ktorú má HIV stigma negatívny vplyv a tak znižuje efektivitu preventívnych programov.

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