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An exploration into perceived stigma, discrimination, and psychological wellbeing among people living with HIV in Bhutan

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ABSTRACT

Introduction: HIV-related stigma and discrimination affect health and wellbeing and pose greater challenges to PLHIV. Stigma and discrimination remain as a major obstacle in curbing HIV epidemic, undermining HIV prevention efforts including uptake of voluntary testing, counseling, access to HIV treatment services and care. This study explored the experience of stigma and discrimination and its perceived influence on the psychological well-being of PLHIV in Bhutan. **Methods:** Explorative qualitative in-depth interviews were completed with 28 PLHIV in four geographical locations Thimphu, Phuntsholing, Gelephu, and Samdrupjongkhar, Bhutan. Participants were interviewed on the experience of stigma and discrimination and the perceived influence on their psychological wellbeing. **Results:** About 43% participants, slightly more among females, mentioned having experienced stigma and faced discrimination. Content analysis revealed individuals in the community, family members and relatives, workstations and healthcare providers as the potential sources of stigma and discrimination. Two-third of the participants appeared to have better psychological wellbeing. Nevertheless, about 36% admitted either feeling sad, worried, or lonely due to their HIV status. Introspection, support from family, relatives and friends, and meditation were perceived to help alleviate negative thoughts about HIV status and its influence. **Conclusions:** Despite vigorous advocacy and awareness campaign, HIV related stigma and discrimination is still prevalent in the Bhutanese society influencing psychological wellbeing among PLHIV. Findings provided important insights meriting the designing of effective interventions including the involvement of certified counselors to counter stigma and discrimination, promote wellbeing and positive living among PLHIV in Bhutan.

Keywords: Bhutan; Discrimination; PLHIV; Psychological wellbeing; Stigma.

INTRODUCTION

Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) is one of the most stigmatized medical conditions and a serious public health challenge[1,2]. HIV related stigma and discrimination poses greater challenges to people living with HIV (PLHIV) and remains as a major obstacle in curbing HIV epidemic worldwide[3,4]. Globally, 38 million people (68% and 53% of the adults and children, respectively) were estimated to be living with HIV towards the end of 2019 and receiving lifelong antiretroviral therapy (ART)[5]. Ever since the first cases of HIV infection detected in Bhutan in 1993, the total cumulative number of cases as of December 2022 stands at 874 (456 males and 428 females), mostly (93.8%) acquired HIV through heterosexual route[6]. Till date, there is a paucity of scientific evidence related to issues surrounding stigma and discrimination and its influence on psychological wellbeing among PLHIV in Bhutan.

Stigma and discrimination are also the major social determinants that influences HIV epidemic[7]. Studies suggest that HIV related stigma and discrimination remain widespread and is a barrier to adoption of HIV prevention behaviors, uptake of voluntary testing and counselling, access to HIV treatment services and care, ART adherence, disease progression, and mortality[3,4,8,9]. Social ostracism, depression, self-isolation, social exclusion, marriage and relationship problems, family conflict, lack of social and family support, economic hardships, loss of job and unemployment are found linked with HIV related stigma and discrimination[10,11]. Compared to the general population, the rates of mental health problems are higher among PLHIV, fueling the risk for HIV transmission and negative health outcomes in the HIV cascade of care[12]. HIV-related stigma and discrimination has a detrimental impact on a variety of health outcomes[13] inflicting

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hardship and suffering[14], impelling the feeling of helplessness, increase emotional and mental distress, heighten anxiety, and lower psychological wellbeing[3,13,15]. Psychological health condition among PLHIV is increasingly becoming a public health concern due to traumatic and stressful experiences associated with HIV infection[16].

Prevalent among the healthcare providers, stigmatizing attitude of the healthcare providers is an important barrier for PLHIV who undermine the uptake of HIV-related health treatment services[17,18]. In the Iranian study, stigmatizing attitude was most prevalent among paramedics, nurses' aides, and housekeeping staff. Authors argued that it could be due to lower levels of education and awareness about PLHIV in these groups[17]. Higher educational level was associated with lower judgmental beliefs [18]. In the Indian study, a disturbingly high rate of stigma attitudes and intent to discriminate was revealed among the doctors, nurses and ward staff. Authors attributed such intent to transmission-fear and misconceptions, lack of experience in handling HIV positive cases, negative attitudes towards PLHIV, or lack of confidence in the standard universal measures to prevent infection[14]. Women reported more experience of interpersonal discrimination as per cross-country study on the experience of interpersonal discrimination, internalized stigma, and discrimination at the health facilities in sub-Saharan Africa, with verbal abuse and made to feel badly by others found relatively common in all the four countries[19]. In the first comparative level and extent of AIDS-related discrimination study conducted in Asia, 2002, majority of the discrimination faced was in the health sector, where a considerable number of respondents refused treatment after being diagnosed with HIV, delaying treatment and health services[20].

Studies on HIV/AIDS are abundant in different countries with varying report on the effects of HIV infection on multiple dimensions of life[21]. Given the debilitating nature of HIV infection such as stigma and discrimination, its chronicity, as well as paucity in the scientific study about perceived stigma and discrimination and their influence on psychological wellbeing of PLHIV in Bhutan, undertaking this study is timely, to address these knowledge gaps. We believe that the findings from this research as discussed in this paper would generate scientific evidence, inform the programs and decision-makers, healthcare providers, counselors, family members, relatives, and public on the challenges and issues surrounding stigma and discrimination and its impacts on the wellbeing of PLHIV in Bhutan. We believe this piece of scientific research findings would assist in curbing HIV epidemic in Bhutan.

METHODS

Design and settings

This research employed exploratory qualitative design. Principal investigator (PI) collected data from PLHIV between November 2018 and January 2019 from four geographical locations of Thimphu, Phuntsholing, Gelephu, and Samdrupjongkhar, Bhutan. These locations are purposively chosen as study sites due to maximum number of PLHIV residing in it.

Sample and sampling procedures

There is no specific guideline to determine the sample size necessary for qualitative research. A common range lies between 8 and 26[22,23]. Qualitative researchers argue that the richness of the data collected is more important than the number of participants. The attainment of saturation is often the guiding principle to assess the adequacy of the size of a purposive sample as was applied in this study. Saturation refers to point in the data collection where additional participants don't provide additional insights[24]. We proposed 30 participants (Thimphu=10, Phuntsholing=8, Samdrupjongkhar=7, and Gelephu=5) to fulfil the objectives of this study. During the collection and simultaneous transcription of the data, it was apparent that from the 23rd participant, no additional insights were emerging. Anticipating that new information would be generated on the phenomenon under investigation, we interviewed five more participants within the availability of time and resource. Data collection stopped at the 28th participant.

Firstly, we approached Lhak-Sam, who shortlisted the number of PLHIV available in the four study sites. Lhak-Sam is a registered Civil Society Organization (CSO), the first network of HIV positive people in Bhutan. Lhak-Sam helped in listing of the potential participants from each study sites. PI approached the potential participants through the contact number shared by Lhak-Sam, sought their willingness and reconfirmed their participation in the study. Then, a suitable time and place, convenient to the participant was fixed for in-depth interview (IDI). A short description of the study was provided that included goal and the objectives, ethical considerations, right to non-participation and maintenance of confidentiality. The description also included participants' role in the study, risks and benefits of their involvement, and presented the main research topics: stigma, discrimination, and psychological wellbeing (which are topics of the current paper), so that the participants could make informed choice about their participation. Participants were also approached through the snowball technique also referred to as 'chain referral' or 'networking' sampling[22]. Those who agreed to take part in the study signed the consent form before the interview.

Data collection

A face-to-face IDI was conducted in a quiet place. For the purpose of this paper, four open-ended-questions were asked to the participants: "What are the kinds of discrimination and stigmatization you experienced after detecting as HIV positive? How did you feel most of the time in the past month? How do you spend your normal days and time? and, What you do to make you worry less?". Each participant also completed a short socio-demographic questionnaire. Each interview lasted 45 minutes to 120 minutes.

Bhutanese PLHIV (both male and female), 18 years and above, residing in Thimphu, Phuntsholing, Gelephu, and Samdrupjongkhar, Bhutan, able to speak any of the languages in English, Dzongkha, Tsanglakha, and Lhotsamkha were allowed to participate in the study. The PI is compatible with all the four dialects. There were no specific exclusion criteria in this study.

Data analysis

The recorded verbatim was transcribed into English and the PI read through them several times to familiarize the content. To organize, elicit meaning and draw conclusion from the data collected, a content analysis was conducted using NVivo version 12[25]. We used content analysis to categorize the problems into a meaningful unit based on the participant's point of view[26]. Analysis began with the drafting of broad codes, followed by creation of child-code and was based on the guidelines used for data collection. Some categories were further divided into multiple sub-categories to assist in uncovering the meaning of the phenomenon under exploration. Qualitative data analysis requires an iterative process and to ensure analytical rigor, the transcripts were revisited several times with discussions among the research team. Therefore, several times of decoding and recoding of the code and categorization constantly happened throughout the analysis phase until the consensus was drawn among the researchers. Throughout the process of data collection and analysis, researchers were self-aware not to impose their opinion, but reflect and abide by the expression of the participant.

Ethical consideration

The Research Ethics Board of Health, Ministry of Health, Bhutan, granted the clearance to conduct this study (Ref. No. REBH/Approval/2018/043).

RESULTS

Twenty-eight PLHIV participated in this study. We briefly summarize the socio-demographic characteristics and discuss issues surrounding discrimination and stigmatization and their perceived influence on psychological wellbeing in this paper.

Participants

More than half (57.1%) of the participants were male and attended high school level education. The average age of the participants was 40.1 years (SD=7.8) with nearly two-thirds (67.9%) aged 36 years and over. 71.4% have some form of job to earn and half (50%) of them admitted earning a monthly income less than or equal to ten thousand Ngultrum. 75% were married. Except for a single unmarried participant, 96.4% participants had at least one or more children. 78.6% admitted living with their spouse and about 64.3% have family members living with HIV. 93% live within an hour of walk from the nearest health centers. Three-quarters (75%) of the participants reported having detected with HIV 2010 and before. Likewise, more than half (53.6%) reported being on antiretroviral therapy 2010 and before.

Table 1. Socio-demographic information of the study participants living in Thimphu, Phuntsholing, Gelephu, and Samdrupjongkhar, 2018-2019 (*n*=28)

Socio-demographic information	*n*(%)
Age (Mean±SD: 40.14±7.84)	
≤ 35 years	9(32.1)
36-44 years	11(39.3)
≥ 45 years	8(28.6)
Gender	
Male	16(57.1)
Female	12(42.9)
Level of education	
No education	5(17.9)
Primary (pre-primary to grade 6)	6(21.4)
High school (grade 7-12)	16(57.1)
Diploma/Certificate	1(3.6)
Marital status	
Never married	1(3.6)
Married	21(75.0)
Separated / Divorced	6(21.4)
Your household monthly income (*in Ngultrum*)	
≤10,000	14(50.0)
10,001-15,000	10(35.7)
>15,000	4(14.3)
Have children	
Yes	27(96.4)
No	1(3.6)
Number of children	Mean±SD:3.07±1.78
No children	1(3.6)
1-2 children	10(35.7)
3 children	8(28.6)
> 3 children	9(32.1)
Number of children	
Male	
0-1	14(50.0)
≥2	14(50.0)
Female	
0-1	15(53.6)
≥2	13(46.4)
You are currently living with	
Spouse	22(78.6)
Children	1(3.6)

Cont...

Cont...

Others	5(17.9)
Anyone of your family members living with HIV/AIDS?	
Yes	18(64.3)
No	10(35.7)
Current employment	
Yes	20(71.4)
No	8(28.6)
Walking distance from the health centers	
1 hour	26(92.9)
2 hours	0(0.0)
3 hours	2(7.1)
When detected with HIV	
2010 and before	21(75.0)
After 2010	7(25.0)
When started on anti-retroviral therapy	
2010 or before	15(53.6)
After 2010	13(46.4)

Stigma and discrimination

All the participants discussed issues surrounding stigma and discrimination. About 43% of the participants (12/28) mentioned facing discrimination with the prevalence slightly more among the females (7/12). The potential sources of stigma and discrimination include community (8/12), followed by family members and relatives (5/12), healthcare providers (3/12), and people at the workstation (2/12).

Discrimination

From people in the community

Eight participants (male=4, female=4) mentioned about the experience of discrimination from people in the community. Two (male=1 and female=1) and six participants mentioned having experienced discrimination from rural and urban dwellers, respectively. A male participant (Pt.1, 42 years), farmer, mentioned about discriminatory remarks he received from people in his village. He said *"As a farmer, I need to go out for fieldwork. [….] go to their (neighbors) place, eat and drink, and at times, they need to come to my house too. […] However, there are people in the villages who make mockery about my HIV positive status. I have been insulted in the public with comments such as 'this person has HIV and he will spread it'. […] Under the influence of alcohol, I had few arguments with them after hearing such comments".*

Likewise, a female participant (Pt.5, 30 years) shared how the people in her village warned her parents about her disease status. She said: *"In my village, my parents were told that I was HIV positive and I must have acquired it from engaging in unfaithful sexual activities. They told my parents not to visit my place […] even talking to HIV positive person would infect them with HIV. […] They were told to be careful if their daughter wants to visit home, she should not be allowed".*

Participants who live in an urban center shared similar experiences of discrimination from their neighbors and friends. A female participant (Pt.14, 29 years) who prefers to be alone than to socialize and face discriminatory remarks from friends, mentioned, *"When I am with my friends, some of them tell me they hesitate to share things with me – especially the edible things. […] Suppose, I share betel quid, they tell me that they don't want to take it, as they are scared they might contract HIV from me. People also tell me that they would not take if I have handled things".*

From family members, relatives and friends

Five of the participants (females=3 and males=2) expressed the experience of discrimination from their immediate family members, relative and friends. A young female participant (Pt.14, 29 years) who experienced discrimination from her immediate family members said: *"I was discriminated by my late father. My late father scolded my husband and me and he even flogged me. […] My late father treated us badly for being HIV positive. […] Maybe my late father was so upset because he loved me the most being the youngest child. He flogged me when we went home for vacation. I was 8 months pregnant then. […] I don't think and regret that I was flogged by my own father. After all, he must have loved me a lot that he couldn't take the fact that his daughter was HIV positive".*

A male participant (Pt.4, 44 years) described how his close friend discriminated him. He said *"I once went to the hospital and saw my old high school friend […] I smiled at him but he pretended he didn't see me and slowly he hid behind the tourist bus. […] If we meet them in a private place, they would ask us how we have been doing. They show double face. […] They fear their close friends might pass comments to them about having HIV positive friends. […] They change their face when they meet us".*

From the workplace

Two female participants mentioned how they faced discrimination from their workstation and were obliged to leave their job.

"Once, all the office staff were preparing to go to our boss's place for a baby shower. […] The boss told me that I could stay back if I cannot go. Boss was indirectly indicating me not to join others for the visit [...] I was more hurt because the boss took all the other staff except me.[…] I am no more working there". (Female, Pt. 20, 39 years)

Another female participant (Pt.5, 30 years) who was asked to leave the workstation because of the disclosure of her HIV status said *"I was in one of the weaving centers since I had the interest to learn to weave […] I disclosed my [HIV] status to them and asked them if that would be a problem for them. After about a week at the weaving centre, I was asked to leave".*

From the healthcare providers

Similar to the discrimination faced from the workplaces above, female participants (*n*=3/12) also mentioned about the discrimination faced from the healthcare providers. Discrimination faced were at the operation theatre during child delivery, eye check-up clinic and in the in-patient department. A female participant (Pt.22, 33 years) who experienced discrimination from the healthcare providers while delivering her baby said, *"In the operation theatre […] as a positive (HIV) mother, I was kept as the last case for operation in the operation list. I was feeling discriminated as they were discussing (among staff) that this case is B20 and must be extra careful. […] I was anaesthetized locally and I could hear him (Dr) warning all the staff in the operation theatre to be extra careful and be on full protection. […] I felt bad! When the operation was completed, I overheard him telling his staff that he conducted the delivery feeling worried and scared throughout the procedure. This was embarrassing for me".*

Stigmatization

While female participants expressed more about discrimination, it was interesting to note six participants (all males) talked on the experience of self (*n*=3) and social stigmatization (*n*=3). *"Since most of my dealing would be with the healthcare providers, family members, and people at the workstation, there may have been instances in the hospital where I felt discriminated. That is my self-stigmatization only. I do feel sometimes that the healthcare providers (sisters) discriminate me […] This happens especially when I go for my CD4 count check-up".* (Male, Pt.21, 49 years)

Another male participant (Pt.9, 43 years) added: *"Collecting medicine from a new person makes me feel uncomfortable. It takes time to build rapport with a new person. […] I will not be able to go and collect my medicine if the familiar person is not there in the pharmacy counter. I feel hesitated due to the issue of stigma and discrimination".*

Psychological wellbeing

About 36% (*n*=10/28) with no gender difference (*n*=5 each) admitted either feeling sad, worried, or lonely as a result of their HIV status. In other words, approximately two-thirds of the participants are managing their psychological wellbeing well. A male participant, who strives to be a role model for a healthier living for PLHIV, mentioned, *"I don't feel sad, worry, anxious, or feel lonely. This is because I live differently. I simply do not care what others say. […] The only thing that bothers me is to strive for maintaining my (health) status to be a role model for PLHIV. That is all!".*

Content analysis revealed three key themes that help participants cope with the negative influence of being HIV positive and promote their psychological wellbeing and positive living.

Introspection and coping mechanism for the emotional burden

Eleven participants, predominantly males (*n*=7), talked about introspection to cope with burden related to HIV infection and is perceived beneficial in increasing self-awareness and self-regulation. A female participant (Pt.2, 38 years) who often goes through sadness and frustrations admitted that being herself gives her adequate time to think more and manage better. She said, *"When I go through emotional breakdown, it's better that other person don't tell me anything, […] or else I land up getting more frustrations and headache. I often feel like living alone in a retreat to find inner peace. […]But, being a mother, I have to think about my children. I can stay alone, but my children cannot without me".*

"I do feel sad and lonely being HIV positive. […] I often think, how my life would be, if I have not contracted HIV. That is all I feel after all there is no cure to it. There are stories about HIV positive people giving up their life. Some have even committed suicide. […] I cannot think of giving up my life. […]Although it is depressing at times, I often have to console myself thinking that there are people who support me and I have the treatment that helps me lead a normal life". (Male, Pt. 7, 38 years)

Support from family, relative, and friends

Seventeen participants (females=9, males=8) discussed the perceived benefit of support from family, relatives and friends to counter negative thoughts about HIV status and enhance their psychological wellbeing. Male participants (n=5) find support from friends as a source of motivation for enhancing their wellbeing.

"I hardly get time to think I am HIV positive when I am with my little children. […] I engage in thinking about the welfare of my children. […] Keeping myself engaged all the time (especially mentally) is very important for me. […] I also weave cloths at home". (Female, Pt. 12, 32 years)

"Being in the company of friends and children makes me think less about my HIV status. However, if I am alone, I do think about my HIV status that makes me worry more". (Male, Pt. 21, 49 years)

"As wife and a mother, there are whole lots of work to do […] If time permits, I do gardening. I spend my time meaningfully and I don't get much time to think about my disease condition. That helps keep sadness and depression away from me. I also have friends with whom I do spend my time chit-chatting". (Female, Pt. 27, 52 years)

Nevertheless, two female participants perceived that keeping minimal interactions with friends and neighbors reduces stigma, discrimination, and promote their psychological wellbeing. One of them (Pt. 14, 29 years) said, *"Personally, I feel that being alone is better. I stay at home most of the time. At least I need not have to face ill remarks from friends. […] To avoid embarrassment and unnecessary tensions, the best option is to be yourself".*

Meditation and being mindful
Five participants (males=3) mentioned about the benefits of meditation. Meditation is perceived to help self-discover about the nature of how things are. One of the participants said *"There were instances I felt sad and lonely without any reason. When I contemplate on the emotions that come to my mind, there is no big reason for it. […] Anxiety and depression are evident in our day-to-day life and knowing you are going through such emotions, concentrating immediately on breathing exercise for 5-10 minutes makes me feel better. You can sense your spirit uplifted and feel rejuvenated. […] I am focusing more on meditation these days".* (Male, Pt. 25, 35 years)

Meaningful spending of time
Participants' response to meaningful time spending was based on their occupational background. The nature of work appears to play a significant role in preventing PLHIV from thinking more about their HIV status. Sixteen participants (male=11, female=5) mentioned spending most of their time working at their designated workstation. Six are housewives who spend most of their time with their children and weaving clothes. Two were farmers who spend most of their time working in the field. Two were driver. Having a job and meaningful engagement help divert thinking about their HIV status, and experience better wellbeing.

"Most of the time, I am in the detoxification centre, giving talk about rehabilitation, help find solutions for drug addicts and rebuilt life altogether. Sometimes, I follow up with my old clients to see how they are doing. […]My clients include drugs addicts, PLHIV, men having sex with men (MSM), and the LGBT communities. […] I am in constant touch with all of them. Looking at the nature of my work, you can say I am kind of stress-free because there is no time for me to sit, think and bog down with stress. My mind is busy all the time engaging in meaningful activities". (Female, Pt. 20, 39 years)

"As a farmer, I contribute my labor to my neighbors and in return they help me work in my field. That is how I spend my daily life. My daily work includes going out to the filed to plough. […] I remain active and will continue to remain active with my daily work". (Male, Pt. 1, 42 years)

Another female participant (Pt. 23, 25 years) who works at the health service centre, said *"During my working days, I am here in the centre. However, my main interest is in singing, which grew more after I became HIV positive. I sing at the Karaoke, record song and that is how I spend my free time. […] I also compose my own songs".*

All the six female participants who identified themselves as housewives mentioned spending most of their time with children and attending to their needs. A mother of two children, Pt. 14, 29 years, said *"As a mother, I spend most of the time with my two children. However, when they are out to school, I spent my leisure time watching television, movies and listening to music on the laptop".*

Driver by profession, a male participate (Pt. 7, 38 years) said *"I am driver and I have to go to work even during weekends. I drive water tanker to reach water to all those places in demand including the hotels. I have no holidays unless I ask for leave. […]I have no problem".*

DISCUSSION

This qualitative study was conducted to explore perceived stigma and the experience of discrimination by PLHIV in Bhutan and the state of their psychological wellbeing.

The stigmatizing attitude and discriminatory behavior from the community and immediate family members towards PLHIV corroborates the finding from study in Indonesia[4] and Hong Kong[1]. Dejman, Ardakani[10] believe that when family and community accepts PLHIV, treat without stigma and discrimination, susceptible individuals are more likely be motivated to seek for more diagnosis and treatment services and better in controlling the disease. Since the feelings of being rejected and emotionally distant from family members play a significant role in depression and suicidal ideation among PLHIV[9], there is a need to strengthen dissemination of HIV-related information to improve knowledge and attitude about HIV and AIDS among the families and communities. Perceived social support significantly better mental health outcomes[27]. In fact, some of the participants in this study stressed being in the company of friends and children makes them think less about their HIV status. Social support and connection are modifiable factors and merit investment to promote positive healthier living and wellbeing among PLHIV.

Consistent with the findings from the previous studies elsewhere[17-19], few participants (mostly females) in this study expressed the experience of stigma and discrimination from healthcare providers. Ekstrand, Ramakrishna[14] believe that HIV transmission-fear and misconception, lack of confidence in the application of standard universal measure to prevent cross-infection or lack of experience in working with the positive cases may be attributable towards difference in PLHIV treatment by the healthcare providers. This could be true as one of the female participants talked about the difference in treatment she received while delivering her baby from a well and non-experienced healthcare providers. Whether the higher experience of discrimination among the female participants could be attributed to an enhanced emotional response, more expression of thoughts, or hormonal changes[28,29] is worth exploring in the future. As healthcare professionals are generally looked up to as the role model for healthier living coupled with PLHIV needing to constantly remain in touch with their healthcare providers, the prevalence of stigma and discrimination among healthcare providers indicates the need for rigorous training to address HIV-related stigma and discrimination.

Some participants in this study expressed the perceived benefits of meditation through self-discovery in countering the negative effects of their HIV status. A study on the effect of meditation among multiple sclerotic patients showed decreased level of anxiety and depression due to increased mindfulness, conscientiousness, and increased intra and interpersonal characteristic traits such as self-directedness and cooperativeness which are necessary for self-evaluation[30]. Since a high level of mental illnesses is prevalent among PLHIV[31], mindfulness practice is potentially an important factor to strengthen psychological wellbeing, reduce fatigue, anxiety and depression[32] among PLHIV in Bhutan. Bhutan is a spiritual country and any strategies to boost maturity, trustworthiness, purposefulness, and enhance psychological wellbeing among PLHIV is worthwhile.

As suggested by Nyblade, Jain[33], increased awareness about stigmatizing attitude towards PLHIV, fear mitigation, and provision of non-stigmatizing care to patients could reduce stigma. It is desirable for all healthcare providers to have a universal understanding of care for PLHIV and facilitate more tolerant environment[18]. Social interventions are believed to offer an opportunity to share experiences among PLHIV and help reduce loneliness, negative feelings and stress and improve their wellbeing[34]. Amiya, Poudel[9] believe that emotional support and nurturing elements of feeling loved and cared would buffer negative psychological states of PLHIV and better psychological wellbeing[35]. Support and respect gained from family and friends are critical as necessary information sharing between improves their psychological wellbeing[36]. Although the perceived social support and interactions are consistently found to be the positive correlates of wellbeing[35] findings are not always universal as social undermining, which is an expression of negative emotions directed towards PLHIV strongly predicts poor quality of life and wellbeing[37]. Two female participants perceived that keeping minimal interactions with friends and neighbors reduces the experience of stigma and discrimination, and better their psychological wellbeing. Social undermining through stigma and discrimination is a less studied area among PLHIV and deserves further exploration. Understanding the forms of stigma and discrimination, where they occur, would be the first step to identifying effective ways of promoting compassionate, non-discriminatory treatment towards PLHIV.

Hope and resilience are crucial in coping with adversity[38]. An individual with high hope and resilience is believed to handle well the uncertainty, failure, and conflict[39]. Resilient individuals are capable to adjust with major life upheavals, become stronger, influential, and wiser[40]. In the current study, nearly three-quarters of the participants did not mention of feeling sad, worried, lonely, or depressed despite their HIV positive status. The non-expression of these negative emotions could be attributed to their increased resilience, hope, improved coping skills, and the benefits of social support received from their family, friends, and relatives. However, this qualitative study did not evaluate hope and resilience. Therefore, in the future study, it is imperative to assess hope and resilience and their influence on the health and wellbeing of PLHIV in Bhutan.

Implication and future directions

Stigma and discrimination against PLHIV still prevalent in Bhutanese society clearly indicate inadequacy in reaching HIV and AIDS-related information to the communities. This demands rigorous advocacy and activities on HIV to counter stigma and discrimination. The current practice of advocacy through traditional methods such as display of posters and stickers is not enough to discourse on critical topics like stigma and discrimination. Strategies to improve the level of understanding and strengthening the platform to talk more about stigma and discrimination could mitigate its negative impacts. At the policy level, the ministry of health could convene consultations involving relevant stakeholders to frame workplace policy and lobby for anti-discriminatory legislation to protect PLHIV from stigma and discrimination. Besides, a quantitative study could be designed in future to assess the prevalence of stigma and discrimination and their potential impact on wellbeing among PLHIV in Bhutan.

Since participants mentioned about the perceived benefits of meditation, programs and related agencies could take advantage of Bhutan's spiritual richness and the understanding of 'cause-condition-effect' and impermanence. Furthermore, training and workshops targeting society for better attitudinal change and the acceptance of reality by PLHIV could promote psychological wellbeing among PLHIV in Bhutan.

Limitation of the study

As is the case with most qualitative studies, the findings from this study cannot be generalized to the entire PLHIV population in Bhutan. In addition, there may have been bias reporting by participants, which may have influenced the study findings. Normalizing interaction and rapport building between the interviewer and the participants could mitigate bias reporting. Although HIV positive cases are prevalent across different occupational backgrounds, we could reach out to participants from a civil-society organization, civil servant, housewives, and farmers. Participants from arm forces, monks, commercial sex workers, and children may have had a different experience of stigma and discrimination and the perception of their wellbeing.

CONCLUSIONS

Stigma and discrimination are still prevalent in Bhutanese society despite rigorous advocacy. Community, family members and relatives, healthcare providers and the workplace are the primary sources of stigma and discrimination in this study. One-third of the participants also expressed feeling of sadness, worrisome, depressed related to their HIV status. Strengthening the existing multi-sectoral task force interventions including the involvement of certified counselors in service delivery is critical to combat HIV-related stigma and discrimination, thereby, achieving the target to end AIDS by 2030[41]. Furthermore, the integration of spirituality and mindfulness practices in the existing interventions could reduce the impact of stigma and discrimination and bolster positive living among PLHIV in Bhutan. Since this study was the first of its kind in Bhutan involving information directly from a conveniently sampled PLHIV in Bhutan, undertaking comprehensive quantitative research to assess the extent of stigma and discrimination, hope and resilience and its influence on wellbeing is worthwhile.

Suggestion and recommendations

The integration of normalizing mental health screening and care in all HIV testing and treatment settings would promote psychological wellbeing, mental health literacy, reduce stigma and discrimination, and strengthen HIV prevention and care outcomes[12]. Programs that deal directly with HIV control in Bhutan could focus on improving HIV-related knowledge not only for the general population but also for healthcare providers. The government could also encourage campaign on HIV/AIDS at workplaces such as government, corporate and private sectors.

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AUTHORS CONTRIBUTION

Following authors have made substantial contributions to the manuscript as under:

ND: Concept, design, data collection and analysis, manuscript writing and review

PC: Design, data analysis, manuscript editing and review

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TW: Design, manuscript editing and review

WW: Concept, design, data collection and analysis, manuscript writing and review

Author agree to be accountable for all respects of the work in ensuring that questions related to the accuracy and integrity of any part of the work are appropriately investigated and resolved.

CONFLICT OF INTEREST

None

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