

Social Factors Contributing To The Spread Of HIV Infection

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Abstract: The article presents a sociological analysis of HIV prevention in the context of social inequality. It examines how poverty, gender disparity, low education levels, migration, stigma, and limited access to healthcare affect preventive efforts. Based on international experiences and local sociological observations, the research emphasizes the importance of equitable access to information, awareness, and health services for effective HIV prevention in Uzbekistan.

Keywords: HIV prevention, social inequality, gender, poverty, stigma, migration, Uzbekistan.

Introduction: HIV (Human Immunodeficiency Virus) remains a critical public health concern not only as a medical condition but also as a social issue. While global infection rates have shown decline, prevention remains a challenge in many developing countries, including those in Central Asia. In Uzbekistan, HIV prevention is a priority area of state policy. This study focuses on the sociological determinants that shape HIV prevention efforts, particularly the barriers caused by poverty, gender inequality, and stigma. The research highlights that the success of prevention strategies depends not only on medical measures but also on addressing broader social inequalities that restrict awareness, access, and participation in health programs.

LITERATURE REVIEW

Many scholars and organizations have explored HIV prevention through a sociological lens. Michel Foucault (1994) discussed health as a social mechanism tied to power relations, while Émile Durkheim (1893) linked social order and solidarity to public health outcomes. Talcott Parsons (1951) examined society's attitudes toward illness through his concept of the "sick role." According to WHO (2023) and UNAIDS (2022), social inequality — expressed through poverty, education gaps, gender discrimination, and stigma — remains one of the major barriers to effective HIV prevention. Uzbek researchers such as Murod Bekmurodov (2015) and Malika Nurmatova (2022) have shown that

marginalized populations with limited access to information and healthcare are at higher risk. British scholars Parker and Aggleton (2003) developed a conceptual model emphasizing that stigma and discrimination hinder preventive behaviors. The reviewed literature collectively underlines that prevention cannot succeed without reducing social inequality.

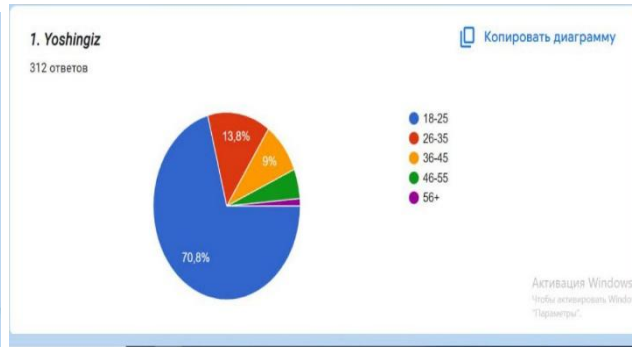
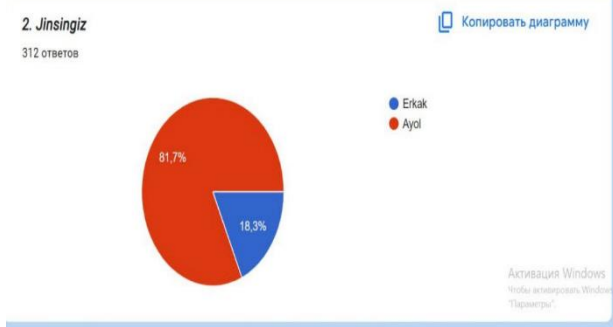
METHODOLOGY

The study is based on sociological observations and surveys conducted in the Jizzakh and Syrdarya regions of Uzbekistan during 2024–2025. Its aim is to assess public awareness of HIV prevention, analyze attitudes toward preventive behavior, and identify social barriers. Respondents represent various age, gender, and socio-economic groups. The main methods include sociological surveys, interviews, and document analysis. The data were processed using descriptive statistics to determine relationships between social status, gender, and awareness levels.

MAIN PART

The sociological analysis of HIV prevention in Uzbekistan confirms that social inequality plays a decisive role in shaping awareness, behavior, and access to healthcare services. The empirical findings from a sociological survey of 312 respondents conducted in 2024–2025 in Syrdarya and Jizzakh regions demonstrate that poverty, gender disparities, limited education, and stigma are critical obstacles to

achieving sustainable prevention outcomes [1][2][3].



According to survey data, 81.7% of participants were women, and 54.8% were aged 18–25. This indicates that youth and women form the majority of socially active groups in HIV prevention efforts. However, the

awareness level remains inadequate: only 45.2% of respondents reported sufficient knowledge, while 45.2% stated they only partially understood HIV transmission mechanisms

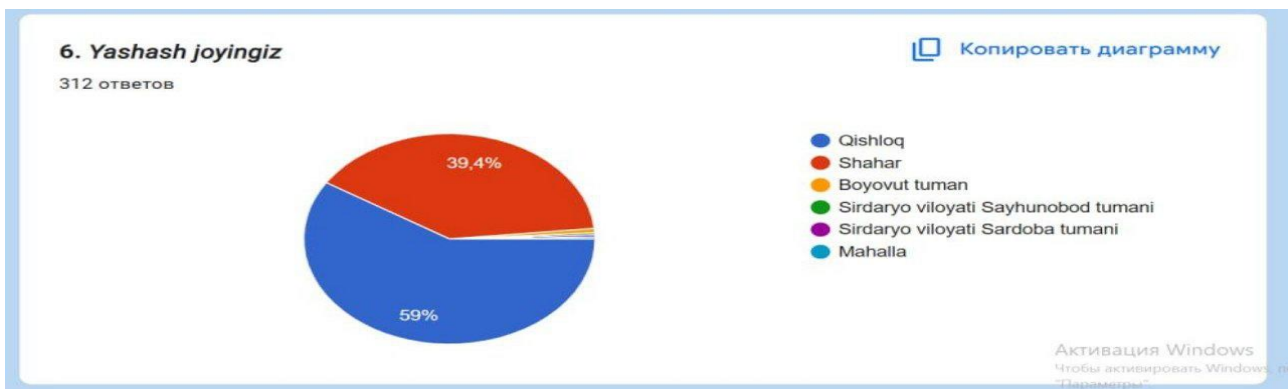


These results correspond with Shukurova's (2024) findings that health literacy among Uzbek youth, especially in rural areas, remains insufficient [1][3].

prevention programs. Participants from rural areas (39.4%) demonstrated lower engagement in testing and awareness activities compared to urban respondents (59%)

Socio-economic and gender inequality

Socio-economic vulnerability directly limits access to



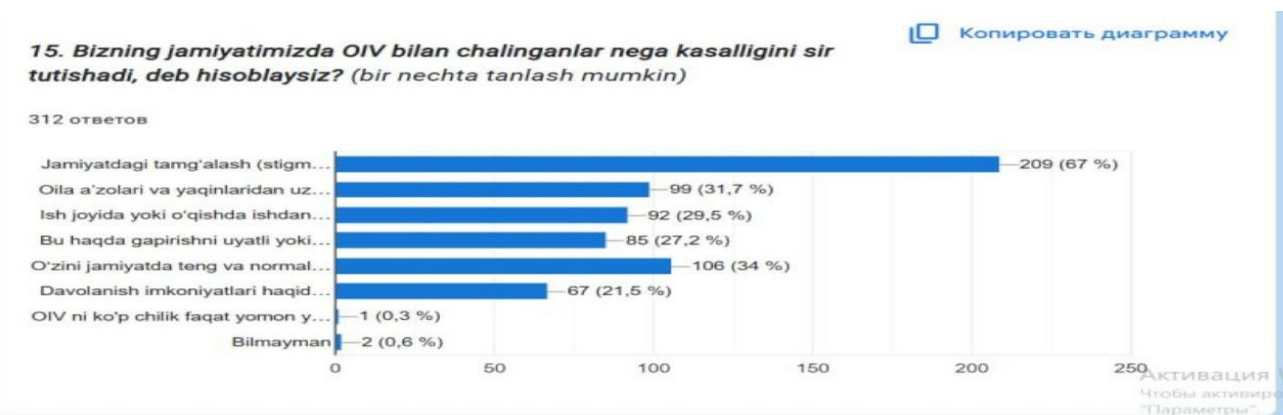
This outcome is consistent with Bekmurodov's (2015) argument that low-income and unemployed citizens face structural barriers to healthcare [6]. Moreover,

only 16.3% of respondents had ever participated in prevention training, while 31.7% expressed interest in joining such activities in the future



This suggests an uneven distribution of preventive education across regions [9].

Gender inequality remains a serious concern. The survey



showed that 67% of respondents believe people hide their HIV status due to stigma, and 31.7% fear discrimination or job loss. Such data align with the conceptual framework developed by Parker and Aggleton (2003), which views stigma as a systemic barrier to prevention [10]. Shukurova (2024) also highlights that unequal access to reproductive health information deepens vulnerability among women in Uzbekistan [1][2][7].

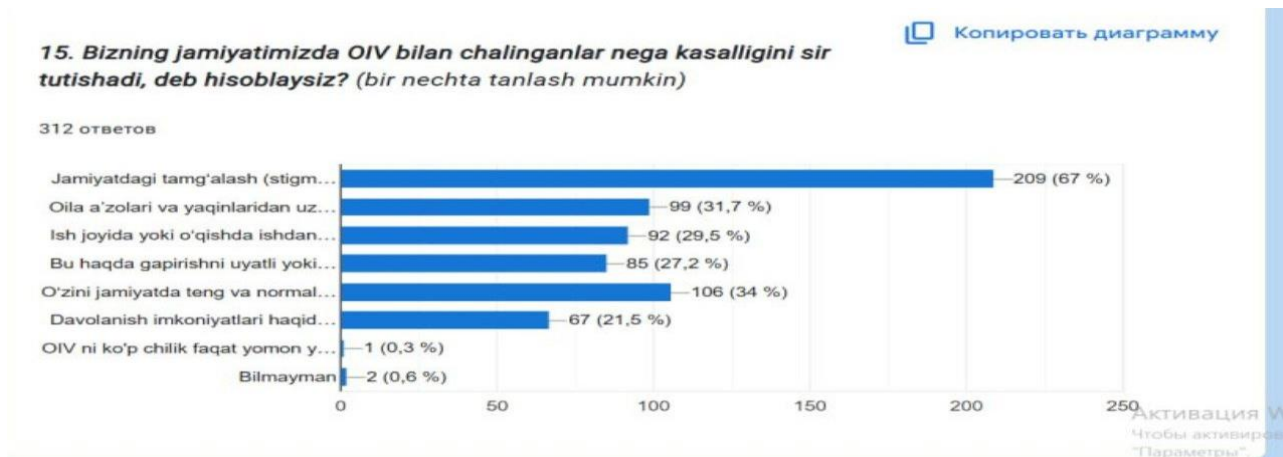
Stereotypes and awareness barriers

The results reveal that 48.4% of respondents consider HIV a “taboo topic” (12-savol), which hinders open

discussion and timely medical support. Only 9.9% recognize HIV as a global public health issue requiring open dialogue. This reflects cultural silence described in Shukurova’s (2023) research on youth psychology, where stigma and social judgment weaken awareness and self-expression [4]. According to UNAIDS (2022), these moral and cultural taboos directly delay testing and treatment [5].

Institutional responsibility and prevention actors

Respondents identified medical institutions (85.3%) as the main actors in prevention, followed by educational institutions (37.5%) and mass media (30.4%)



However, 53.2% of respondents considered governmental efforts “partially sufficient”,



indicating weak coordination between the state, healthcare, and education systems. Durkheim's (1893) theory of social solidarity supports this conclusion, emphasizing that successful health policies depend on collective institutional responsibility [2].

Shukurova (2024) stresses that effective HIV prevention in Uzbekistan should integrate medical, educational, and social work institutions, focusing on community empowerment and gender equality [1][3][8].

Social awareness and behavioral factors

Knowledge of transmission methods remains uneven. 89.1% of respondents correctly identified blood transmission, but only 26.6% mentioned mother-to-child transmission, and 14.4% mistakenly believed it spreads through casual contact. This demonstrates the persistence of misinformation, confirming Foucault's (1994) notion that knowledge and power relations determine access to truth in health contexts [1]. In addition, 74.7% of respondents supported free treatment, and 63.1% emphasized psychological assistance for HIV patients, confirming the growing demand for human-centered, inclusive policies [2][3].

Summary

The results clearly indicate that HIV prevention in Uzbekistan is constrained by multiple dimensions of social inequality — economic, gender, cultural, and institutional. This research, supported by Shukurova's 2024 and 2023 studies, as well as international frameworks by WHO (2023) and UNAIDS (2022), underscores that eliminating inequality is a prerequisite for achieving the UN Sustainable Development Goals by 2030 [2][3][5].

CONCLUSION

The study confirms that social inequality — encompassing poverty, gender disparity, and stigma — critically affects HIV prevention in Uzbekistan. The sociological perspective highlights that prevention cannot rely solely on medical interventions; it requires

comprehensive social action. The following recommendations arise from the research:

1. Expand preventive education programs, particularly among youth and women.
2. Strengthen gender equality and economic empowerment initiatives.
3. Integrate anti-stigma campaigns in collaboration with religious and community leaders.
4. Enhance cooperation between healthcare, education, and civil society sectors.
5. Promote equitable access to information and services across all social groups.

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