



HIV/AIDS Related Stigmatization and Discrimination

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ABSTRACT

HIV Stigmatization and discrimination have been found to cut across countries of the globe without exception. The consequences of stigma are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and educational settings, psychological damage and a negative effect on the success of HIV testing and treatment. The objective of this present study was to assess the level of HIV/AIDS associated stigmatization in a Federal Medical Centre. The study was done through the administration of pretested self-administered questionnaire comprising two sections to 200 HIV/AIDS patients during clinic sessions. Majority of the respondents (71%) were females. The highest age group was within the range 36-45years (37%). A remarkable number (68.8%) of the respondents were married, 45.9% completed secondary school level while 50% were self-employed. Majority (30.0%) of the respondents knew their status through testing, 74.7% felt depressed on knowing their status, 80.0% disclosed their status to their family members, 81.0% felt uncomfortable attending clinic for treatment while 70.65% preferred attending a clinic far away from their homes. The impact of stigma and discrimination can be said to very high among these HIV/AIDS patients as reasons given for not wanting to be seen in social gatherings, wanting to go far away from home to obtain treatment and some other reasons are all stigma and discrimination related.

KEY WORDS: HIV/AIDS, Stigma, discrimination, FMC,

INTRODUCTION

The HIV/AIDS pandemic has not only been the worst tragedy in contemporary history, but has also posed serious demographic, humanitarian, economic and developmental crisis [1]. While cases have been reported in all regions of the world, almost all those living with HIV (97%) reside in low and middle-income countries, particularly in sub-Saharan Africa [2]. Nigeria currently has one of the highest HIV burden worldwide, with 3.1 million PLHIV and about 215, 000 annual AIDS deaths [3-4].

HIV Stigmatization and discrimination have been found to cut across countries of the globe without exception. Numerous household surveys and other probability-sampled surveys reported extensive stigmatizing attitudes among the general population across all samples studied in settings as diverse as China, US, Hong Kong, South Africa, Jamaica, Brazil, Nigeria, Thailand, Tanzania, Zimbabwe,

Burkina Faso, Zambia, and Ghana [5-6]. Joint United Nations Programme on AIDS (UNAIDS) defines HIV-related stigma and discrimination as: "...a 'process of devaluation' of people either living with or associated with HIV and AIDS...Discrimination follows stigma and is the unfair and unjust treatment of an individual based on his or her real or perceived HIV status." [7].

Ban Ki-moon in 2008 opined that stigma is a chief reason the AIDS epidemic continues to devastate societies around the world [8]. The consequences of stigma are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage and a negative effect on the success of HIV testing and treatment [9]. In a survey of more than 1,000 healthcare professionals working directly with HIV patients in four Nigerian states, 43 per cent



observed others refusing a patient with HIV hospital admission [10]. In the Dominican Republic, a study highlighted the importance of "verbal stigma", with more than 60% reporting being gossiped about and between 25-30% reporting verbal abuse [11]. Studies among employers in both China and Nigeria found strong reluctance to hire or retain employees with HIV [12-13] suggesting that the workplace is a setting for potential discrimination regardless of region. HIV itself comes with a lot of challenges and when coupled with stigma becomes devastating. Globally, stigma and discrimination are associated with lower uptake of HIV preventive services, including under- or non-participation in HIV information meetings and counselling [14] and reduced participation in programmes to prevent mother-to-child transmission [15-16]. Stigma and discrimination can lead to delay in presentation to the health services, prolonged risk of transmission, poor treatment adherence and increased risk of disability and drug resistance. A study [17] found 89% of antenatal clients in Nigeria were willing to test for HIV while those who were unwilling to be tested cited strong fears of stigma. "Perceived stigma" was a predictor for declining to test for HIV among both men and women in a study of Nigerian youth and adults in South Africa [18-19].

The objective of this present study is to assess the level of HIV/AIDS associated stigmatization in a Federal Medical Centre.

METHODS

Study location

This prospective study was carried out at the Virology Department, Federal Medical Centre (FMC) Abeokuta, Ogun State Nigeria.

Study population

This comprised HIV patients who accessed health at the Virology Department, Federal Medical Centre (FMC) Abeokuta, Ogun State Nigeria from 1st September to 30th November, 2012.

Study design

The instrument used to collect relevant data was the questionnaire which was designed to be self-administered. The questionnaire contained two sections namely socio-demographic characteristics and stigma-related information. Two hundred copies were administered during clinic sessions to the patients who were willing to participate and the same retrieved immediately after being successfully filled on each session. Consent to participate was obtained from the patients before the administration of the questionnaire.

Ethical consideration

All procedures in this research were carried out according to the research protocol approved by the Local Ethical Committee of Federal Medical Centre Abeokuta, Ogun State, Nigeria (HREC/07/13/2012).

Inclusion criteria

HIV positive patients who accessed treatment at FMC Abeokuta within the study period, 18 years and above and willing to participate.

Exclusion criteria

Non-HIV individuals and HIV positive individuals who were not willing to participate nor accessed treatment in this location were excluded in this study.

Data analyses and presentation

Statistical analysis was carried out using SPSS version 10 (Statistical Package for Social Sciences Inc., USA) after the obtained data had been coded and entered into the computer. Data fed into the computer software were double-checked to ensure accuracy. Results were expressed as percentage with statistical significance set at P value ≤ 0.05 .

RESULTS

Social demographic characteristics of HIV/AIDS patients

Out of 200 copies of questionnaire administered to the HIV/AIDS patients, 170 were correctly filled and returned giving 85% retrieval.

Majority of the respondents (71%) were females while relatively few (29%) were males. The highest age group was within the range 36-45years (37%) while the least age group was that above 50years (3.5%). Higher numbers, (52.9%) of them were living within Abeokuta and its environs. A remarkable number (68.8%) of the respondents were married, 19.4% of them were single while 10.5% were either divorced/widowed/separated. On educational background, 45.9% completed secondary school level, 31.7% had none/primary school education while 20% had tertiary /and above education. About 50% of the respondents were self-employed, 28.8% were salary earners and 17.6% were unemployed. The average monthly income of the respondents revealed that 24.1% were receiving $> \#10000$, and 13.5% received between $\#4100 - \#7000$. P-values of 0.030, 0.000, 0.040, 0.000, 0.000, 0.008, and 0.000 indicated statistical significance for sex, marital status, tribe, location, employment, educational background and average monthly income in HIV/AIDS disease. (Table1).

Stigma- related information of HIV/AIDS patients

Majority (30.0%) of the respondents knew their status through testing, 20.0% when they became sick while 74.7% felt depressed on knowing their status, 15.3% felt ashamed. Those who disclosed their status to their family members were in the majority (80.0%), 54.7% felt comfortable doing so but 39.4% felt otherwise. Specifically, 74.1% disclosed their status to their husbands/wives, while 81.0% felt uncomfortable attending clinic for treatment, 32.9% felt comfortable displaying their medications but 65.9% felt not comfortable. The reason given was "Don't want people to know my status" (61.2%). Although 56.2% of the respondents were willing to attend social gatherings, 28.2% felt reluctant. The reason given for being reluctant included "may be seen by those who know me in the clinic (42.4%), those who know my status may tell others (31.2%), those who know my status may avoid me (23.5%), don't know (2.9%)". While 70.6% preferred attending a clinic far away from them, 25.9% preferred otherwise and 3.5% gave no respond. P-values of 0.000 indicated statistical significance for how and when the patient came to know his or her status, patient's feelings on knowing status, on if he or she had disclosed status to spouse, feelings about going on social gathering, on if the patient would prefer being referred to a clinic near his or her house or far away from the house (Table 2).

DISCUSSION

Respondents were majorly females within the age group 36-45 years. Majority attained secondary school education level and were mainly self-employed. The HIV epidemic has been found to disproportionately affects girls and women within the Sub- Sahara region, where women are 3.4 times more likely to be infected with HIV/AIDS than their male counterparts. [20]. In Nigeria, the HIV prevalence rate for women between the ages of 15-29 years was at 13.2% by 2005 [20]. The WHO estimates that youths ages 15 to 24 comprised 50% of all new HIV infections and consequently must be targeted for education in decreasing transmission and reducing the stigmatization of an HIV diagnosis [21]. This study indicated statistical significance of sex, marital status, tribe, location, employment, educational background and average monthly income in HIV/AIDS disease.

A researcher [22] found factors that constituted major hindrance to the acceptance of HIV/AIDS Voluntary Counselling and Testing (VCT) by the

youths in Kwara State to be ignorance, fear of being positive, cost of VCT, inadequate number of VCT centres and stigmatization. Disclosure of status to their family members and partners was found to be encouraging among the respondents but majority were not comfortable displaying their medications. Our findings contrasted previous studies that found stigma and discrimination to adversely affected disclosure to partners, health care providers and family members [23-24]. The main reason adduced for not wanting to display their medications was because they did not want people to know their status. Also many of the patients did not want to access treatment in clinics near their abode, a situation that could lead to both clinic and medication nonadherence.

Some other researchers have connected stigma and discrimination with postponing or rejecting care, travelling outside local communities for care because of fear of breaches of confidentiality, and nonadherence to medicines [25-26]. Stigma may also compel people to conceal medicines, which may result in inconsistent doses [26]. In Jamaica, researchers found that more than two-thirds of newly diagnosed AIDS cases in 2002 tested late in the progression of their illness, a phenomenon linked to stigma and homophobia. The remaining third were reported as deaths, indicating patients failed to seek care and support as their disease progressed [24]. [It is said that knowledge is power. Therefore](#) education should be the initial step in stigma reduction that could be combined with other strategies. Education brings increased knowledge about a specific illness and provides facts that counter false assumptions on which stigma is based. Brown and Raja, 2001 [27] in their review on stigma reduction strategies within HIV/AIDS found four studies in which educational approaches were used and these studies all had a positive effect in terms of increased tolerance of people living with HIV/AIDS. Participatory education which encourages people to reflect on their own attitudes and actions has been found to be especially effective for inspiring individual change around stigma and discrimination at any level, but in particular, at the community level [28-29].

Table 1: Socio-demographic characteristics of respondents

S/no	Parameter	Frequency	Percentage (%)	Chi square	P-value
1	Age				
	18-25	12	7.1		
	26-36	55	32.4		
	36-45	63	37.0	4.136	0.388
	46-55	34	20.0		
	Above 55	6	3.5		
	Total	170	100		
2	Sex	46			
	Male		28.2		
	Female	122	71.8	4.725	0.030
	Total	170	100		
3	Marital status	33			
	Single		19.4		
	Married	117	68.8	3.264	0.000
	Divorced/widowed/separated	18	10.6		
	No response	2	1.2		
	Total	170	100		
4	Religion	56	32.9		
	Muslim				
	Christian	110	64.7	12.768	0.278
	Traditional	4	2.4		
	Total	170	100		
5	Tribe	121	71.2		
	Yoruba				
	Igbo	18	10.6	2.543	0.040
	Hausa	19	11.2		
	Others	12	7.1		
	Total	170	100		
6	Location	90	52.9	6.895	0.000
	Within Abeokuta				
	Outside Abeokuta	74	43.5		
	No response	2	3.5		
	Total	170	100		
7	Employment status	49	28.8		
	Salaried				
	Self employed	85	50		
	Unemployed	30	17.6	5.231	0.000
	No response	6	3.5		
	Total	170	100		
8	Education background	54	31.8		
	None/primary				
	Secondary	78	45.9	9.657	0.008
	Tertiary& above	34	20		
	No response	4	2.4		
	Total	170	100		
	Total	170	100		
11	Average income monthly				
	500-2000	18	10.6		
	2100-4000	22	12.9		
	4100-7000	23	13.5		
	7100-10000	14	8.2		
	>10000	41	24.1	4.523	0.000
	No response	52	30.6		
	Total	170	100		

Table 2: Stigma-related information from respondents

S/no	Parameter	Frequency	Percentage (%)	Chi square	P- value
1	When/ how did you get to know your status				
	Coming for test	51	30.0	2.754	0.000
	During pregnancy/ delivery	23	13.5		
	When sick	34	20.0		
	Before marriage/ contact from husband	6	3.5		
	Through blood transfusion	6	3.5		
	No response	50	29.4		
	Total	170	100		
2	How did you feel when you knew your status?				
	Depressed	127	74.7	6.842	0.000
	Ashamed	12	7.1		
	Don't know	26	15.3		
	Other options	5	2.9		
	Total	170	100		
3	Who have you disclosed your status to?				
	Family members	136	80.0	16.854	0.060
	Friends	8	4.7		
	No response	26	15.3		
	Total	170	100		
4	Do you feel comfortable disclosing your status to your relatives?				
	Yes	93	54.7		
	No	67	39.4	7.685	0.309
	No response	10	5.9		
	Total	170	100		
5	Have you disclosed your status to your husband/wife?				
	Yes	126	74.1		
	No	40	23.5	1.694	0.000
	No response	4	2.4		
	Total	170	100		
6	Do you feel comfortable coming for clinic/ treatments?				
	Yes	30	17.6		
	No	138	81.2	0.001	0.005
	No response	2	1.2		
	Total	170	100		
7	Do you feel comfortable displaying your medications?				
	Yes	56	32.9		
	No	112	65.9	4.725	0.0030
	No response	2	1.2		
	Total	170	100		
	If no. Why?				
	Shame	31	18.2		
	Don't want people to know my status	104	61.2		
	No response	35	20.6		
	Total	170	100		
8	How do you feel about going to social gathering?				
	Willing	48	28.2		
	Reluctant	96	56.5		
	Don't know	14	8.2	0.018	0.000
	No response	12	7.1		
	Total	170	100		

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	If reluctant, Why?				
	May be seen by those who know me in the clinic	72	42.4		
	Those who know my status may tell others	53	31.2		
	Those who know my status may avoid me	40	23.5		
	Don't know	5	2.9		
	Total	170	100		
9	How do you feel going to school or work?				
	Happy	98	57.6		
	Sad	52	30.6	1.049	0.306
	Don't know	12	7.1		
	No response	8	4.7		
	Total	170	100		
10	Would you like to be referred to clinic near to your house?				
	Yes	42	24.7		
	No	118	69.4	0.852	0.000
	No response	10	5.9		
	Total	170	100		
11	Would you like to be referred to clinic far from your house?				
	Yes	120	70.6		
	No	44	25.9		
	No response	6	3.5	1.666	0.000

CONCLUSION

The impact of stigma and discrimination can be said to very high among HIV/AIDS patients in this center as reasons given for not wanting to be seen in social gatherings, wanting to go far away from home to obtain treatment and some other reasons are all stigma and discrimination related.

HIV/AIDS related stigma not only has negative impacts on the lives and health of individuals with HIV but also on families, communities and nations at large. [Stigma can contribute to HIV/AIDS incidence as those infected are likely to hide their status, thereby promoting risky life style. Educating the patients as well as the populace is advocated as a strategy for HIV/AIDS related stigma reduction.](#) Education may include interventions that aim at improving the knowledge of the general public and community groups about a specific illness and provides facts that counter false assumptions on which stigma is thought to be based.

CONFLICT OF INTEREST: The authors declare no potential conflict of interest.

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