

ORIGINAL RESEARCH ARTICLE

An Exploratory Study of Stigma and Discrimination among People Living with HIV/ AIDS in Abuja Municipal Area Council, Nigeria

DOI: 10.29063/ajrh2019/v23i1.9

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Abstract

This study examined the magnitude of HIV/AIDS stigma and discrimination among people living with HIV/AIDS (PLWHA) in Abuja Municipal Area Council (AMAC). A descriptive cross-sectional study was conducted using both qualitative and quantitative methods to survey 100 PLWHA resident in AMAC-FCT. Participants were selected through a combination of two-stage and systematic random sampling technique using a table of random numbers. A 40-item structured questionnaire adapted from the HIV Stigma Scale and a semi-structured focus group discussion (FGD) guide were used to collect data. Quantitative data were coded and entered SPSS statistical software. Frequency tables were generated, and data subjected to descriptive and inferential statistics. Cross tabulations examined pattern of associations between respondent's characteristics while qualitative findings utilized content analysis along five specific themes to demonstrate the way HIV/AIDS stigma manifested among respondents. Participation was 100% and HIV/AIDS stigma prevalence was high at 67%, with mean age 33.01years (SD±5.94years) for respondents. Findings confirmed rejection of PLWHA by sexual partners, family members and friends, dismissal from work, decrease in the quality of health care services and sometimes outright denial of services. A high correlation was found between the scales and subscales of the HIV Stigma Scale with all correlation values reaching statistical significance ($p = 0.01$). Regret for disclosure of status and ending social interaction by PLWHA was reported as consequences of disclosure and potential hindrance for disclosure which will encourage ongoing transmission of the virus. Our study provides evidence on stigma and discrimination of PLWHA in AMAC, FCT-Abuja in the face of limited evidence to drive HIV prevention interventions. Further studies should investigate other predictors and reasons for stigma and discrimination among this population. (*Afr J Reprod Health* 2019; 23[1]: 88-99).

Keywords: Stigma, Discrimination, PLWHA, HIV/AIDS, AMAC, Abuja-FCT

Résumé

Cette étude a examiné l'ampleur de la stigmatisation et de la discrimination liées au VIH /SIDA parmi les personnes vivant avec le VIH / SIDA (PVVS) au sein du conseil régional municipal d'Abuja (CRMA). Une étude transversale descriptive a été menée à l'aide des méthodes qualitatives et quantitatives pour interroger 100 PVVIH résidant dans le CRMA. Les participants ont été sélectionnés en combinant une technique d'échantillonnage aléatoire à deux degrés et systématique à l'aide d'un tableau de nombres aléatoires. Un questionnaire structuré de 40 questions, adapté de l'Echelle de stigmatisation du VIH, et un guide de discussion à groupe cible semi-structuré (DGC) ont été utilisés pour collecter des données. Les données quantitatives ont été codées et notées dans le logiciel statistique SPSS. Des tableaux de fréquence ont été générés et les données soumises à des statistiques descriptives et inférentielles. Les tableaux croisés ont examiné la structure des associations entre les caractéristiques des interviewés, tandis que les résultats qualitatifs se sont servis d'une analyse du contenu selon cinq thèmes spécifiques pour démontrer la façon dont la stigmatisation du VIH / SIDA se manifestait parmi les interviewés. La participation était de 100% et la prévalence de stigmatisation du VIH / SIDA était élevée à 67%, l'âge moyen étant de 33,01 ans (DS ± 5,94 ans) pour les interviewés. Les résultats ont confirmé le rejet des PVVS par les partenaires sexuels, les membres de la famille et les amis, le licenciement au travail, la diminution de la qualité des services de soins de santé et parfois le déni total des services. Une corrélation élevée a été remarquée entre les échelles et les sous-échelles de l'échelle de stigmatisation du VIH, toutes les valeurs de corrélation atteignant une signification statistique ($p = 0,01$). Les regrets concernant la divulgation du statut et la fin des interactions sociales des PVVS ont été signalés comme des conséquences de la divulgation et un obstacle potentiel à la

divulgate, ce qui encouragerait la transmission continue du virus VIH. Notre étude fournit des preuves sur la stigmatisation et la discrimination des PVVS dans le CRMA-Abuja, face au manque de preuves permettant de conduire des interventions de prévention du VIH. Des études complémentaires devraient examiner d'autres facteurs prédictifs et les raisons de la stigmatisation et de la discrimination au sein de cette population. (*Afr J Reprod Health* 2019; 23[1]: 88-99).

Mots-clés: Stigmatisation, discrimination, PVVSH, VIH / SIDA, CRMA-Abuja

Introduction

Nigeria is the most populous country in Africa with an estimated population of 160 million¹ and HIV/AIDS prevalence of 4.1 percent². HIV/AIDS prevalence is as high as 12.6% in certain regions and age group³. Poor progress in reducing HIV/AIDS prevalence has been attributed to lack of treatment and care by PLWHA but current thinking has found association between outcomes and HIV/AIDS stigmatization/discrimination⁴. Stigma is defined as an undesirable or discrediting attribute that an individual possesses, thus reducing that individual's status in the eyes of society⁵. Stigmatization can lead to prejudicial thoughts, behaviors, and actions on the part of governments, communities, employers, health care providers, coworkers, friends, and families⁶⁻⁸. This may include the experiencing of domination, oppression, the exercise of power or control, harassment, categorizing, accusation, punishment, blame, devaluing, prejudice, silence, denial, ignorance, and anger, a sense of inferiority, social inequality, exclusion, ridicule, resentment or confusion. It may sometimes lead to violence against PLWHA⁹.

Literatures on HIV/AIDS related stigma and discrimination is highly limited. Limited information on stigma and discrimination in Nigeria has been from anecdotal evidence provided by PLWHA and sensational newspaper reporting. This has led to widespread assumptions about its extent and distribution, the validity of which is difficult to establish. Existing studies on AIDS stigmatization have focused on negative attitudes of the people of Nigeria (perpetrators) towards PLWHA (targets), extremely few systematic studies have actually investigated the relationship between stigma and the stigmatized. This study therefore, examined the magnitude of HIV/AIDS Stigma and Discrimination amongst

People Living with HIV/AIDS (PLWHA) in Abuja Municipal Area Council (AMAC), Federal Capital Territory (FCT) –Nigeria and to provide recommendations for improvement.

Methods

Study design

The study was a descriptive cross-sectional urban survey using both qualitative and quantitative methods. For the quantitative method, personal interviews were conducted for 100 PLWHA while four focus group discussions (FGDs) were used to elicit responses for the qualitative survey. This was used to explain the perceptions, knowledge, attitudes, and pattern of HIV/AIDS related stigma and discrimination on PLWHA and to discover reasons for some of the results obtained from the quantitative study.

Study area

The research was carried out in the Abuja Municipal Area Council (AMAC) of the Federal Capital Territory (FCT) Abuja. AMAC is one of the six local councils that make up the FCT and the others are Abaji, Bwari, Gwagwalada, Kuje, and Kwali local councils. AMAC is the headquarters of the FCT and is mostly urban. AMAC is highly cosmopolitan and well planned, with relatively adequate social services and amenities, such as good network of roads, hospitals and schools with adequate representation of all ethnic and religious groups.

Sample size

The study sample size was calculated based on the 2003 Nigeria Demographic Health Survey (NDHS) which reported that 60.3% proportion of Nigerian people show discriminatory attitudes

towards people living with AIDS in Nigeria. The precision or relative error considered acceptable to fall within 10% of the true value (0.1) with the level of confidence (95%) desired, therefore minimum sample size calculation was based on the formula¹⁰.

$$n = \frac{Z_{\alpha}^2 * P(1-P)}{d^2}$$

Where: n = sample size; $Z_{\alpha} = 1.96$ for $\alpha = 0.05$; P = the estimated proportion of population with characteristics = 0.603; d = precision = 0.1

$$n = \frac{1.96^2 \times 0.603 \times 0.397}{(0.1)^2}$$

$$n = 91.96 \approx 92$$

The sample size was increased to 100 to address any possible attrition.

Sampling technique

A two-stage sampling technique was used to select the study sample. First, as at the time of study, June 2008 a list of all registered support groups in AMAC, FCT-Abuja with their detailed membership was obtained from (FCT chapter of – NEPWHAN) as the sampling frame. The study was restricted to registered members of the support groups. A random sample was used with a table of random numbers to select the participating support groups then a systematic random sampling technique was used to select each respondent into the study. For the FGDs, a purposive sampling technique was used to select eight (8) respondents for each of the four FGDs from all the support groups in AMAC with a representative sample of male and female irrespective of previous participation in the quantitative survey. A group between the size of four and eight is usually ideal¹¹.

Data collection methods

A 40-item structured questionnaire adapted from the HIV Stigma Scale by Berger, *et al*¹² was used for data collection due to its external validity. The instrument consists of 3 parts. Part 1 consists of a socio-demographic characteristic, Part 2 consists of questions for documenting perceived instances of stigmatization and discriminatory attitudes and Part 3 consists of questions for documenting

AIDS stigma and discrimination on respondents' daily lives and social relations.

Semi – structured FGD guide was used for the FGDs. These were pretested for clarity and content validity. Following nearness of residence, the 100 respondents chosen for the study were grouped into four different locations and each of these locations were facilitated by one supervisor and one research assistant. Each location had a total of 25 respondents irrespective of support group affiliations. The questionnaire was completed by respondents under the guidance of the supervisors and research assistants. At the end of the personal interviews with the 25 PLWHA, the 8 respondents chosen for the FGDs per location were organized for the focus group discussions. Four (4) semi-structured FGDs were conducted across the support groups in AMAC, one in each location. With the guidance of a semi-structured FGD guide, the moderator posed open ended questions to explore the views of PLWHA in AMAC regarding stigma and discrimination. Notes were taken, discussions tape recorded, and transcribed and final report generated using Microsoft word package.

Data management and analysis

Each answered questionnaire was coded and entered into a computer using the SPSS statistical software (SPSS Inc. Chicago, IL, USA). Scoring was based on the four subscales of the HIV stigma scale (personalized stigma, disclosure, negative self-image and public attitudes)¹³. Data analysis included the generation of frequency tables and an initial exploratory analysis. This was to ensure that categorical and numerical values fell within plausible and permissible limits. The output of the exploratory analysis determined the appropriate statistical methods, including multivariate techniques to apply for further analysis. The data collected was subjected to descriptive (i.e. mean) and inferential (i.e. t-test and ANOVA) statistics. Cross tabulations examined pattern of associations between respondents' characteristics using χ^2 ¹⁴. Data from the FGDs were organized thematically into five categories that demonstrated the way HIV/AIDS stigma manifested among respondents as shown in Table 1, then content analysis was applied. Direct quotes from respondents were used

Table 1: Description of content analysis categories from focus group discussion (FGDs)

Category	Description
General KAP (knowledge, attitude and practice) Information on HIV/AIDS	All verbalizations on KAP (Situation, policies and spread of HIV/AIDS)
Voluntary Counseling and Testing	All verbalizations of VCT (Views, effects and recommendation)
Disclosure of Sero-Status	All verbalizations of Disclosure of status (factors, effects and promotion)
Stigma and Social Interactions (Sexual Partners, Family Members, Friends/Colleagues/Co-workers, Health Care practitioners, Community Members)	All verbalizations of stigma experiences with Sexual Partners, Family Members, Friends/Colleagues/Co-workers, Health Care practitioners, Community Members
Conclusion and Recommendation	All verbalizations of care, treatment, support and measures taken with recommendations

to substantiate verbalizations on each category of the five themes.

Results

Table 2 shows the distribution of the socio demographic characteristics of the respondents. The mean age was 33.01years (SD=5.94) with males higher than females (36.8 vs 31.2) years. The difference in the mean ages between the males and females was statistically significant ($p=0.000$). There was a female preponderance of 69 (69%) compared to 31(31%) of males among the respondents. The differences in the gender distribution across the various age categories are highly statistically significant (χ^2 , $p=0.000$). The age distributions of HIV stigma scale and subscales are presented in Table 3. For the HIV stigma scale, the respondents in the age group 30-34 appeared to face more stigma and discrimination with the highest mean score 110.9 ± 16.3 compared to other age groups. The observed differences in the distribution across the various age groups were not statistically significant ($p=0.232$). Further analysis did not reveal any influence in the HIV stigma scale and subscales based on gender. Content analysis of the FGDs and direct quotes from respondents revealed difficulties and consequences imposed by HIV/AIDS stigma and discrimination on specific social relations with family members, friends, sexual partners, co-workers, and health professionals.

Table 4 shows females with a higher mean score of 107.0 ± 16 compared to the mean score of 105.42 ± 19.6 for the males, indicating that

more females PLWHA faced stigma and discrimination more than their male counterparts although the difference was not statistically significant ($p=0.671$).

Table 5 shows different magnitude and consequences of HIV/AIDS seropositive disclosure. In 77% of cases respondents stated that “people find flaws in one’s character following disclosure of one’s HIV positive status”. Also 71% reported that “people don’t want me around their children”. Various other levels of discriminations were also very common.

Table 6 shows a high correlation between the scales and subscales of the HIV stigma Scale used was observed with all correlation values reaching statistical significance ($p=0.01$).

Findings from Qualitative Studies

1. Knowledge, Attitude and Practices (KAP) of HIV/AIDS showed respondents having general knowledge of HIV/AIDS in AMAC as they described the scourge from several perspectives. They opined that HIV prevalence is highest in AMAC compared to other area councils in the FCT because of its urban nature. Furthermore, they complained that despite the high awareness of HIV/AIDS in AMAC, many people still have unprotected sex both young people and adults. They emphasized that the practice of support groups gives PLWHA support and relief. A female respondent said;

“In AMAC, a lot of people believe that if you are positive when you go to the support groups, you will see so many who

Table 2: Socio-demographic characteristics of people living with HIV/AIDS in AMAC FCT-Abuja, Nigeria

Variables	Frequency n (%)
Age group(years)	
20-24	6(6.0)
25-29	20(20.0)
30-34	33(33.0)
35-39	21(21.0)
40-44	14(14.0)
45+	2(2.0)
Not Indicated	4(4.0)
Total	100(100.0)
Gender	
Male	31(31.0)
Female	69(69.0)
Total	100(100.0)
Marital status	
Single	19(19.0)
Married	53(53.0)
Living together	6(6.0)
Separated/divorced	5(5.0)
Widowed	17(17.0)
Total	100(100.0)
Religion	
Christianity	96(96.0)
Islam	4(4.0)
Total	100(100.0)
Education	
No formal education	4(4.0)
Primary	20(20.0)
Secondary	44(44.0)
Diploma	21(21)
First degree	6(6.0)
Postgraduate	3(3.0)
No response	2(2.0)
Total	100(100.0)
Occupation	
Student	7(7.0)
Public servant	19(19.0)
Trader	17(17.0)
Private business	19(19.0)
Artisan	16(16.0)
Housewife	9(9.0)
Unemployed	13(13.0)
Total	100(100.0)
Ethnicity	
Yoruba	5(5.0)
Hausa	10(10.0)
Ibo	21(21.0)
Tiv	22(22.0)
Idoma	10(10.0)
Others	22(22.0)
No response	10(10.0)
Total	100(100.0)

are also HIV positive and that makes you happy. This drives away the fear that one will die of HIV/AIDS in fact the way we relate with one another in the support

group gives us so much happiness. We are not happy because we are infected, but we are happy when we see one another and share experiences of hope that life is still normal for us. Unlike in the villages where you lose all hope once you are tested positive. At the support groups, we get medical assistance, take advices and make friends”.

Another male respondent said;

“The support groups are very good, when I tested positive newly, anxiety wanted to kill me, my family rejected me and I didn’t know that there were support groups in Abuja but when I started going out at least I was relieved and now I can boldly say that I am better than when I was alone. In my village, once they hear that anyone is positive, that is the end for you so I will like to advise the government or anyone that cares to go to the villages and create awareness on HIV/AIDS so that the rejection will be reduced”.

a. Legislations/policies on HIV/AIDSs in the Nigeria

Respondents showed very little knowledge about existing policies on HIV/AIDS as they opined that these policies have not been widely disseminated and implemented. They complained about the non-implementation of the workplace policy to stop sero-positive persons from losing their jobs. A female respondent said;

“Most members of our support groups got thrown out from their workplace and nobody fights for them in this country. We have graduates who lost their jobs because they tested positive”.

b. Factors that promote the spread of HIV/AIDSs

In exploring these factors, respondents opined that;

1. Poverty: leads to patronage of commercial sex as a trade.
2. Stigma and discrimination lead to non-disclosure of HIV sero-status

Table 3: HIV Stigma scale and subscales by Age (years)

	Mean±SD	F-value	P-value
HIV stigma scale			
20-24	103.17±14.08		
25-29	103.25±18.05		
30-34	110.91±16.33	1.399	0.232
35-39	108.33±18.52		
40-44	99.86±16.96		
45+	91.50±9.19		
Personalized stigma subscale			
20-24	48.83±4.99		
25-29	45.35±9.98		
30-34	50.24±10.56	0.876	0.500
35-39	47.95±10.39		
40-44	45.21±10.42		
45+	44.00±2.83		
Disclosure subscale			
20-24	27.00±6.23		
25-29	28.60±5.62		
30-34	29.18±4.28	1.185	0.323
35-39	28.57±5.21		
40-44	26.50±3.95		
45+	23.00±2.83		
Negative self-image subscale			
20-24	29.33±4.50		
25-29	30.05±5.46		
30-34	32.39±6.46	1.058	0.389
35-39	32.47±6.66		
40-44	29.85±6.77		
45+	26.00±7.07		
Public attitude subscale			
20-24	53.67±10.76		
25-29	54.25±10.62		
30-34	57.64±9.42	1.425	0.223
35-39	57.10±8.64		
40-44	50.93±10.56		
45+	47.50±3.54		

Table 4: HIV Stigma scale and subscales by Gender

	Mean±SD	t-value	p-value
HIV stigma scale			
Male	105.42±19.59	-0.426	0.671
Female	107.00±15.95		
Personalized stigma subscale			
Male	47.39±10.58	-0.326	0.740
Female	48.10±9.65		
Disclosure subscale			
Male	28.10±4.91	-0.239	0.811
Female	28.35±4.83		
Negative self-image subscale			
Male	30.55±7.89	-0.941	0.349
Female	31.83±5.41		
Public attitude subscale			
Male	55.23±9.74	-0.182	0.859
Female	55.61±9.76		

- Unemployment leads to frustration: A female respondent said;

“There was this person, that was going to help me get a job and he insisted that I must have sex with him before he gives me the job, but I refused. Another opportunity came and the person insisted I have sex with him and if I did not control myself and if not for God, I will pass on the virus to the man after the second temptation and he will not know because I don’t look like I have HIV/AIDS”.
- Ignorance leads to denial about the reality of HIV/AIDS: A male respondent said.

“There is also this belief that baffled me as I was discussing about condoms with the person who told me that his father gave him a native medicine assuring him that whatsoever the sickness is, that he cannot contact it from another person and this is highest among the youths”.
- Polygamy leads to continuous and new transmissions
- Labour migrations/Travellers/Widow inheritance helps to spread HIV.

2. Voluntary Counseling and Testing (VCT)

Respondents opined that more women come for VCT than men while the less educated show up better than the elite though many people are still afraid to know their status. Most people who test positive to HIV need psychosocial support because some become suicidal and withdraw from people. However, respondents opined that the degree of negative reactions from positive sero-status has reduced compared to what it used to be in the past when people committed suicide at the news of their positive sero-status. With adequate counselling, people look for how to reduce the tension and rejection they feel inside by going to register with a support group where they will be free to join other positive people and not be discriminated against.

3. Disclosure of Sero-Status

Respondents opined that many people don’t like to disclose their status due to stigma and

Table 5: Magnitude of HIV/AIDS related stigma and discrimination

Serial	HIV/AIDS Related Stigma and Discrimination	n (%)
1	Hurt by people’s reaction following disclosure of my HIV positive status	67 (67)
2	People close to me stopped calling me	59 (59)
3	People expressed opinions that respondents deserved what they got because of their life styles	30(30)
4	People close to me avoid me because of fear of extended stigma and discrimination against them	65(65)
5	People don’t want me around their children	71(71)
6	People physically backed away from me	62(62)
7	People’s actions towards me portray my situation as if is my fault to be HIV positive	61(61)
8	Stopped socializing with some people because of their reactions to my HIV positive status	45(45)
9	Lost friends following the disclosure of my HIV positive Status	57(57)
10	My good points are often ignored because of my HIV positive status	58(58)
11	People seem to be afraid of me once they learn about my HIV positive status	69(69)
12	People find flaws in one’s character following disclosure of his/her HIV positive status.	77(77)

Table 6: Correlation of HIV related stigma scales and subscales

	HIV stigma scale	Personalized stigma subscale	Disclosure subscale	Negative self-image subscale	Public attitude subscale
HIV stigma scale	1				
Personalized stigma subscale	0.893*	1			
Disclosure subscale	0.819*	0.561*	1		
Negative self-image subscale	0.827*	0.664*	0.654*	1	
Public attitude subscale	0.929*	0.859*	0.726*	0.667*	1

*significant at 0.01

discrimination and this has contributed to on-going spread of HIV virus in AMAC, for instance, a female respondent said;

“When I knew my status, I was in the hospital so my younger and older brothers who were with me got to know. Before then I was living with my older brother so when I got back from the hospital my older brother’s wife became an obstacle and at a point, they asked me to leave their house”. (FR)

The FGD further revealed that most people disclose their status to access help, encourage others and save lives. Most respondents confirmed that they had only disclosed their status to their family members and health care providers. Three female respondents said respectively;

“I told only my older sister and asked her not to tell anybody and most especially my children so that they will not run away from me”.

“I didn’t disclose it to anybody only me and my husband. My husband is not on drugs, but he is my treatment partner”.

“I disclosed to my husband because he will not understand if I don’t breast feed the new baby while I had always breast fed my children but my husband did not believe and he said I should go and tell the doctor that it is not my blood”.

However, respondents implied that disclosure can be promoted by empowerment, awareness and support. Support group helps because some people come out because of the benefits they will get from the groups.

4. Stigma and Social Interaction

Stigma and sexual partner

Respondents expressed their experiences with stigma in their interactions with sexual partners, particularly on rejection by their sexual partners, following the disclosure of their sero-positive

status and by other partners they met afterwards. Most people feel bad when they know their partner's HIV status, and some go as far as keeping their partners in confinement or even leaving them for the fear of being infected. Others are sympathetic and tend to encourage their partners and even follow them to support groups. A woman said her husband never disclosed his status to her and she only found out after his death. A female respondent said;

"I was dating somebody for 6 years when I discovered my status, when I disclosed my status to him, he ran away from me claiming that he doesn't want me to infect him meanwhile I later discovered that he was already taking drugs before I knew my status because I was not inquisitive I didn't know what the drugs were for".

A male respondent said;

"It was not easy to disclose to my wife because of the fear of breaking up but thank God I was able to disclose it, and nothing happened to my marriage".

Stigma and Family

Most respondents stated that they had not disclosed their status to either family members or friends. Some disclosed their status to just their siblings without disclosing to the entire family members. Possible rejection by family members led respondents to practice self-imposed isolation to avoid tense interactions. Also, respondents opined that family members living with HIV/AIDS and of low economic status were more stigmatized than family members living HIV/AIDS with high economic status.

A female respondent said;

"I have disclosed my status to only my family members. My older sister knows but she doesn't discriminate against me but when her children got to know they started running away from me and never agreed to visit me anytime my sister suggested. They made me and my sister

separate from each other. I didn't tell my children, and nobody told them".

Two male respondents said respectively;

"I was abandoned when my older brother learnt that I was HIV positive. When I became better, they were surprised because they were expecting my death".

"When I was sick at the hospital and my father got to know about my status at the hospital bed, he disowned me".

Stigma and Friends

The responses about friends are both of rejection and encouragement. A female respondent said;

"They will not want to hear about it. Even your calls, they will not pick it, some of them will start going about telling people about your status. Gossiping about your status meanwhile they themselves they don't know their own status".

"In my own case, some of my friends who were accusing me of bad behaviour that I have AIDS and that I am going to die soon, died before me and I am still living and some others when they got infected they came to me to seek counselling and when I showed them the way and they get healthy along the line, they will run away from me again and start saying that they have been healed; that they went to pastors who prayed for them and they are healed".

Stigma and Workplace

Most respondents reported not disclosing their status to their work colleagues because of fear of sack. A female respondent said;

"Being that my co-workers don't know my status. Most often the co-workers look at the person suspiciously and gradually withdraw while the employer or boss find a flimsy excuse to relieve the person of his/her job".

An Engineering company sacked a man because of his status when his brothers disclosed to his boss calling him unclean. A man was sacked from a private transportation firm. A lady was denied employment with Nigeria Navy, Nigeria Army three times due to her status.

A male respondent said;

“I lost my job in Chevron because of my HIV status” while another female respondent said, *“My boss encouraged me when I disclosed to him”*.

Stigma and Health Care Providers

Respondents reported that interactions with health care professionals include refusal of health services and lack of effective communication though not all manifestations of stigma resulted in denial of services. Although some stigmatization by health professionals seemed to be blatant most times, in other instances, it was described as subtle and was perceived through body language and the avoidance of interaction. Two female respondents said;

“Even a doctor that gave me my test result said to me; these days you just go and prepare for death”.

“The laboratory attendant that gave me my result said to me that I have gotten what I was looking for in this world so I should just go and prepare for my death and I told him that he was very stupid and that he will die before me”.

Stigma and Community

In most cases there is rejection which is usually accompanied by hostility from the community members, but as more people are becoming aware that stigmatization is not the best solution to help the PLWHA, they now tend to pity the person living with HIV and await the news of the victim's death. Two male respondents said;

“A woman in the community beats her children anytime they play with my children because of my status”.

“Community members are the worst, they will just run away from you. They won't want to come close to you for anything. They will not share toilet with you even where you spread your cloths, they will not use it again, they don't even want anything to do with you”.

Coping Mechanisms by PLWHAs

Respondents expressed measures they have taken to live positively with HIV/AIDS to include: Living positively, be close to God, strict adherence to antiretroviral ARV prescriptions, eating balanced diet, be hygiene conscious, avoid high risk behaviour, join a support group, share experiences with fellow PLWHA and create awareness by educating others.

Discussion

Stigma and discrimination have been identified as being among the foremost barriers to HIV prevention, treatment, care and support^{15,16}. Findings of this study showed that 67% of PLWHA experienced stigma and discrimination in various forms of social interaction while the narratives of study respondents demonstrated that stigma plays into and reinforces social inequalities as described in the focus groups. At some point or the other in their daily lives, respondents suffered rejection by sexual partners, family members and friends, dismissal from work, decreased quality of health care services and sometimes outright denial of services. The experience of stigma has also been reported in other studies and is nearly universal among a sample of women in Vietnam¹⁷⁻¹⁸. Even in the US the prevalence is as high as 8 out of 10 families¹⁹ but can also be as low as 17%²⁰. A large household-based study in Kenya, East Africa, found that 75% of HIV-positive respondents had experienced stigma²¹. Tables 2, 3, and 4 showed the distribution of the socio demographic characteristics of the respondents and correlation between stigma and age/gender. The mean age was 33.01years (SD=5.94) with a minimum of 20 years and maximum of 51 years. Panel 1 in Table 2 showed that the respondents in the 30-34-year age group had the highest proportion 33 (33%) of participation in the study

indicating consistency with earlier studies that found HIV prevalence more in younger people. The mean age of the males was higher than that of females (36.8 vs 31.2) years. The difference in the mean ages between the males and females was statistically significant ($p=0.000$). Although, there was a female preponderance of 69 (69%) compared to 31(31%) of males among the respondents in our study there was no statistically significant association between HIV/AIDS stigma and gender and age of respondents. Previous studies had shown that women experienced more stigma²², but older females, with low perceived stigmatization, but with good HIV cognition were most likely to disclose their status²³. A Kenyan study showed that being female may be associated with less stigma as males were always seen as culprit because of multiple sexual partners^{24,25}. With women empowerment and gender equality, stigma is likely going to be un-associated with gender as shown in our study. As shown in table 4, 77% of clients reported that “people find flaws in one’s character following disclosure of one’s HIV positive status”. Also 71% reported that “people don’t want me around their children”. Various other levels of discriminations were also very common. Negative consequences included stigma, rejection by sexual partners and others, loss of intimacy, and threats to personal well-being²⁶. The consequences of stigma and discrimination are wide-ranging. Some people are shunned by family, peers and the wider community, while others face poor treatment in healthcare and educational settings, erosion of their rights, and psychological damage. These all limit access to HIV testing, treatment and other HIV services^{27,28}. Positive rewards resulting from disclosure included increased social support and intimacy with partners, reaffirmation of one’s sense of self, and the opportunity to share personal experiences and feelings with sexual partners²⁶. Indeed, findings from this study revealed a wide range of issues around stigma and discrimination as experienced by PLWHA in AMAC, FCT-Abuja Nigeria including HIV/AIDS situation in AMAC, legislations/policies on HIV/AIDs in the country, factors that promote the spread of HIV/AIDs, voluntary counselling and testing services, effects of knowing one’s sero-

status, disclosure of sero-status, factors that have facilitated people to disclose their HIV status, effects of disclosure of sero-status, factors to promote disclosure of sero-status, factors that make people not to disclose their status and social interaction. Policies and legislation to curb these ugly stigma experiences exist in the country but it is not well harnessed and implemented to achieve the desired results.

Conclusion

In conclusion, this study has shown a high but comparable proportion of stigma and discrimination among HIV seropositive individual relative to other studies, and age and gender are not significantly associated with stigma and discrimination. The consequences of stigma and discrimination identified in the study such as regret for disclosure of status and ending social interaction by PLWHA hinder disclosure and lead to the continuous spread of the virus thereby frustrating intervention efforts. HIV/AIDs stigma and discrimination in AMAC-FCT is no different from experiences of PLWHA around the world therefore, findings of this study as documented will contribute to the growing literature around stigma and discrimination in AMAC-FCT and Nigeria at large. Lack of documented experiences and evidence has been a major gap in intervention measures in Abuja FCT. Further studies are also necessary to investigate other predictors and reasons for stigma and discrimination in this population.

Ethical Approval

A written approval was obtained for the study from the network of people living with HIV/AIDs in Nigeria (NEPWHAN) in Abuja FCT while ethical clearance was obtained from the Institutional Review Board of Staffordshire University, United Kingdom. Every probable apprehension by PLWHA was addressed and clarified using respondent’s information sheet and written informed consent duly obtained before commencement of the study. Also, participation was voluntary, and respondents had the choice to give or withdraw consent freely at any stage of the study.

Recommendations by PLWHA

- Empower PLWHAs to be self-dependent so that even when they are discriminated against, they won't care so long as they are able to feed themselves.
- Government should pass into law the discrimination bill and this will help HIV/AIDS work place policies to be effective. Anybody caught discriminating against a person living with HIV/AIDS should be penalised.
- Government should establish more health centres in the rural areas for VCT services and create more awareness through campaign on radio and television. The VCT centres should be operated by PLWHA.
- People should be encouraged to join support groups where they will be encouraged and see other PLWHA living healthily and positively.
- More orientation should be given to the health providers who discourage PLWHA from taking the ARV to stop discouraging people living with HIV from taking their drugs because the drugs are essential.

Study Limitations

The major study limitation was sample selectivity because the ethical way to contact PLWHA for a survey is with a request for participation through the networks of PLWHA, service organizations, and health care providers, which precludes the possibility of obtaining a random sample of all PLWHA. Another limitation was the small sample size due to resources (time and financial) constraint. However, this study provides evidence for interventions focusing HIV/AIDS related stigma and discrimination for PLWHA. Also, the study relied completely on PLWHA self-reported stigmatizing and discriminating attitudes of others towards them giving room to possible bias by respondents and no guarantee of absolute truth from the respondents.

Acknowledgment

Special thanks to Professor Tony Stewart who supervised this study as a Master of Public Health

thesis in the Faculty of Health and Sciences, Staffordshire University Stoke on Trent, United Kingdom. We also acknowledge the tireless efforts of Anuli, Peter, Ginika, Patience, David, Ndubuisi and Umar who worked as research assistants. Dr. Shehu Umar, Dr. Ibrahim Yisa, Dr. D. Oyedeji are all well appreciated for their expert support during the development and implementation of the research. Mr. Peter Ikifi for his unflinching support throughout the process of preparation and implementation of the study. Finally, we appreciate Dr. Pat Matemilola who facilitated NEPWAN's written approval for us to conduct this study in AMAC, FCT-Abuja.

Contributions of Authors

Chioma Oduenyi: Conceptualized the study, collected and analyzed the data and prepared the manuscript

Emmanuel Ugwa: Reviewed the results and the manuscript

Zimako Ojukwu: Collected and analyzed data during the research, and reviewed the manuscript

Jachike Ajasigwe: Reviewed results and the manuscript.

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