

Exploring HIV Self-Stigma In Enugu State Nigeria

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Abstract

World Health Organization cites fear of stigma as the main motive behind people's reluctance to get tested for HIV/AIDS, disclose their HIV status, take ARV drugs and access other ART services. This study explored self-stigma and factors influencing it among persons living with HIV/AIDS in Enugu State. This was a cross-sectional study, involving eight hundred and forty adults living with HIV/AIDS accessing care across eight health facilities. Data was done using interviewer-administered questionnaires. Frequencies and proportions were generated. Chi square test of statistical significance was used to determine the factors that influenced self-stigma. Multivariate analysis using binary logistic regression was utilized to predict the probability of the occurrence of the outcome variable. 69.2% of respondents were classified as having high self-stigma. 95.2% had disclosed their HIV status. Residence in rural areas (AOR 0.807, 95% CI: 0.580 - 1.122) and socio-economic status (AOR 1.415, 95% CI: 1.0- 1.9) predicted high self-stigma. As low socio economic status and area of residence were found to influence self-stigma among respondents in the study, there is a call for persons living with HIV/AIDS to be economically empowered by the government with more emphasis on those residing in rural areas.

KEYWORDS: Self-stigma, PLWHA, Enugu state, Nigeria

INTRODUCTION

HIV-related stigma and discrimination is universal, occurring in every country, at different levels and manifest in different forms. This has accompanied the AIDS epidemic from the very beginning. Over three decades after the advent of the HIV infection and despite substantial advances in its treatment, the stigma related to this condition continues, providing a barrier for patients to access prevention, treatment and care services. (Otur, 2011; Chávez et al. 2011; NEPWHAN, 2011). People living with HIV/AIDS (PLHWA) are occasionally shunned by family and the wider community, while others face poor treatment in healthcare and educational settings, erosion of their human rights, and psychological damage. (AVERT, 2018)

Contrary to assertions that stigma may no longer be relevant in the face of a mature HIV

epidemic and widespread antiretroviral access, it is wide spread in Sub-Saharan Africa including Nigeria due to the weak health system and litigation services. (Dahlu et al. 2015) A study carried out in Uganda reveals that stigma remains a concern among PLWHA. (UNAIDS, 2007) In Nigeria, stigma exists with an index ranging from 2% - 25.8%. (Nigeria Stigma Index, 2015) This is a significant challenge in this setting as the stigma and discrimination attached to being diagnosed with HIV/AIDS is more than that linked to being diagnosed with other illnesses such as leprosy, epilepsy and psychiatric disorder. Being primarily transmitted through sexual intercourse, people speciously associate HIV infection with promiscuity and unfaithfulness. (Aransiola et al. 2014) People tend to distance themselves from them for fear of being tarred with the same brush. The adage, "birds of the same feather flock together" springs to mind. Hence, a PLWHA is

already condemned from the onset and end up with little or no sympathy from others.

Stigma can be experienced internally (self-stigma) or externally (as in discrimination). Self-stigma refers to the state whereby a patient feels that everyone is aware of his/her disease and attempts to isolate him/herself. (Otur, 2011) This can result invariably to reluctance to be tested for HIV, non-disclosure to partners and poor engagement in biomedical prevention approaches. (Stangl et al. 2013) Though PLWHA while accessing care are encouraged to confide in or disclose to someone, there is still some forms of reluctance in disclosing to family members and friends. Upon disclosure, PLWHA are expected to receive social and psychosocial support to enable them cope with their health condition. In a qualitative study in Ethiopia, (Bezabhe et al. 2014) patients who disclosed their HIV status to relatives and close friends did not fear stigma and discrimination. However, review of the consequences of HIV disclosure found that about 4% of HIV-positive women experience violence after disclosure. (Neuman et al. 2013) In some instance, they are blamed for bringing the disease into communities. (Dahlui et al. 2015) This makes disclosure of HIV diagnosis a difficult resolution.

This study was conducted to determine the level of self-stigma among PLWHA in Enugu state. Since there is paucity of information on self-stigma among PLWHA in Enugu state, findings from this study will contribute to strengthening evidence for advocacy and provide possible directions for future research in a bid to reduce self-stigma among PLWHA.

MATERIALS AND METHOD

Enugu State is one of the five states in the southeast geopolitical zone of Nigeria. Most of the urban dwellers are civil servants, traders or artisans while rural dwellers are largely subsistent farmers or petty traders. The inhabitants are mainly of Igbo ethnic nationality with mixture of other tribes and are predominantly Christians. Enugu state operates the District Health System with the distribution of health facilities based on the population and disease burden of the areas. The study utilized cross-sectional study design involving adult PLWHA enrolled in care in health facilities that

provide ART services. ART services in Enugu are currently provided by PERPFAR agencies in partnership with the Federal Ministry of Health. The services offered include HIV testing and counseling, prevention of mother-to-child transmission of HIV, HAART, and social support for PLWHA.

The study instrument was developed by the researchers in both the local dialect 'Igbo' and English language with questions adapted from a previous study. (Simbayi et al. 2007) Data was collected using interviewer-administered questionnaires with sections on socio-demographic characteristics, self-stigma and disclosure. This instrument assessed if patients agreed with statements including; "It is difficult to tell people about my HIV infection;" "Being HIV positive makes me feeling dirty" and "I hide my HIV status from others." Participants responded to each question by strongly agree = 5, agree = 4, undecided = 3, disagree = 2 or strongly disagree = 1. The total scores ranged from 6 to 30. Score of 6 - 18 indicates low stigma, while 19 - 30 indicates high self-stigma.

Data entry and analysis were done using Statistical Package for Social Sciences version 22. Chi square test of statistical significance was used to find out the factors that influenced self-stigma. Multivariate analysis using binary logistic regression was utilized to predict the probability of the occurrence of the outcome variable. Variables that had a p-value of <0.2 in the bivariate analysis were entered into the logistic regression model to determine the predictors of self-stigma with the level of significance set at p-value of <0.05.

Ethical approval for the study was requested from the Health Research and Ethics Committee of Enugu State University Teaching Hospital Enugu, Nigeria. Approval was also obtained from Enugu State Ministry of Health and the management of the selected health facilities. Written informed consents with detailed account of the study objectives, procedures, risks and benefits were obtained from the participants. Confidentiality was emphasized and all study materials stored in a place accessible only to the study team.

RESULTS

Eight hundred and forty adult PLWHA

participated in this study. Tables 1 below shows the socio-demographic characteristics of respondents. The mean age of respondents was 38.5 ± 9.8 years. Also, the highest proportion of the respondents was in the age group 30-39 years while the least proportion was those less than 30 years.

Table 1: Socio-demographic characteristics of PLWHA in Enugu State

Variable	Frequency (N = 840)	Percentage
Age of respondents		
Mean \pm (SD)	38.5 \pm 9.8	
Age in groups		
<30 years	136	16.2
30 – 39 years	353	42.0
40 – 49 years	228	27.1
\geq 50 years	123	14.6
Gender		
Male	199	23.7
Female	641	76.3
Level of Education		
No formal education	44	5.2
Primary education	312	37.1
Secondary education	362	43.1
Tertiary education	122	14.5
Employment status		
Self-employed	623	74.2
Salary earners	119	14.2
Unemployed/Student	98	11.7
Area of Residence		

Table 2: Self-stigma of PLWHA in Enugu State

Variable	Frequency	Percentage
Difficult to tell people about my HIV status		
Yes	746	88.8
No	94	11.2
Being HIV positive makes me feel contaminated		
Yes	168	20
No	672	80
Feel guilty that I am HIV positive		
Yes	267	31.8
No	573	68.2
Ashamed that I am HIV positive		
Yes	306	36.4
No	534	63.6
Feel worthless because I am HIV positive		
Yes	184	21.9
No	656	78.1

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Table 2 above shows the level of self-stigma among PLWHA in Enugu State. Majority (88.8%) of the respondents have difficulty disclosing their HIV status to others. 83.9% hide

their status from others. Upon categorization, 69.2% of respondents were classified as having high self-stigma.

Table 3: Disclosure of PLWHA in Enugu State

Variable	Frequency	Percentage
Disclosed HIV status		
Yes	800	95.2
No	40	4.8
Disclosure of HIV status to others		
	n=800	
Partner	348	43.5
Sibling	176	22
Child	98	12.3
Relative	87	10.9
Parents	65	8.1
Friend	21	2.6
Religious leader	5	0.6

Table 3 above shows the disclosure of HIV status disclosed. Majority of the respondents disclosed of respondents to others. When asked if their HIV status to their partners (43.5%) while respondents had disclosed their status to the least proportion disclosed to religious leaders significant others, a high proportion (95.2%) had (0.6%).

Table 4: Factors affecting Self-stigma among PLWHA in Enugu State.

Variable	Self-Stigma	Self-Stigma	x ²	p value*	AOR[95%CI]**
	Yes	No			
Age in groups***					
<40 years	154 (31.5)	335 (68.5)	0.239	0.625	NA
-	105 (29.9)	246 (70.1)			
Gender					
Female	199 (31.0)	442 (69.8)	0.057	0.811	NA
Male	60 (30.2)	139 (69.8)			
Level of Education					
Primary education and less	114 (32.0)	242 (68.0)	0.410	0.522	NA
Secondary education and more	145 (30.0)	339 (70.0)			
Employment status					
Self employed	197 (31.6)	426 (68.4)	1.487	0.475	NA
Salary employment	31 (26.1)	88 (73.9)			
Unemployed	31 (31.6)	67 (68.4)			
Area of residence					
Urban	76 (26.5)	211 (73.5)	3.873	0.049	0.807 (0.580-1.122)
Rural	183 (33.1)	370 (66.9)			
Socio-economic status					
Low socio-economic status	149 (35.1)	276 (64.9)	7.202	0.007	1.415 (1.041-1.924)
High socio-economic status	110 (26.5)	305 (73.5)			

Table 4 above shows the factors affecting self-stigma. A higher proportion of the respondents residing in the rural area, (33.1%) were self-stigmatized when compared with those who had their residence in the urban area, (26.5%) and the difference in proportions was found to be statistically significant, ($\chi^2=3.873$, $p=0.049$). A significantly higher proportion of respondents who were on low socio-economic status (SES) were self-stigmatized when compared with those who were on the high SES, ($\chi^2=7.202$, $p=0.007$). When modeled in multiple logistic regression, respondents whose residence were in the urban area were 0.807 times less likely to be self-stigmatized when compared with those whose residence were in the rural area (95% CI: 0.580 - 1.122), $p=0.049$. Likewise, respondents who were had low SES were 1.415 times more likely to be self-stigmatized when compared with those with high SES (95% CI: 1.0- 1.9), $p=0.007$.

DISCUSSION

The mean age of respondents in this study was lower than the mean age (34.2 ± 8.2 years) of respondents in South Africa. (Madiba et al. 2013) This difference in the mean ages of respondents in the two studies may be due to lower access and uptake of HIV services in Nigeria. (UNAIDS, 2013) Females were of higher proportion in this study and similar Nigerian (66%) and South African (62.9%) studies. (Tumwikirize et al. 2015; Madiba et al. 2013) This disparity in gender distribution could be attributed to poor involvement of men in HIV prevention, care and support programmes, reflecting gender-differences in health-seeking behaviors. (Madiba et al. 2013; Mburu et al. 2013)

In this study, the prevalence of self-stigma among PLWHA (69.2%) was higher than 9.6% in Malawi and 45.0% in Burkina Faso. (Neuman et al. 2013) In South Africa, 33 – 66% of men and 23 – 61% of HIV positive women have self-stigma. (Neuman et al. 2013) Disclosure in this study was mainly to partners, parents, children and siblings. Hence the closer the relationship, the more likely respondents were to disclose their status. Similar to other studies, participants more often than not disclosed their status to their partners or spouses.

(Forouzan et al. 2013; Madiba et al. 2013; Sasaki et al. 2012) In Ekurhuleni District South Africa, disclosure to partner (43.5%) was relatively lower than in Zambia where over 80% of the study participants had disclosed to their spouses. (Madiba et al. 2013; Sasaki et al. 2012) This higher rate of disclosure in this Zambian study could be attributed to the fact that the study was conducted among married couples only. (Sasaki et al. 2012)

Self-stigma is influenced by factors which differ from region to region. Factors shown to significantly influence HIV self-stigma in the region of study are; area of residence and SES. Findings from this study reveal that the effect of self-stigma is experienced more in the rural areas with a significantly higher proportion of respondents in the rural area (33.1%) having self-stigma than those in the urban areas (26.5%). A multivariable binary regression showed that respondents whose residence were in the urban areas had 1.239 times the odds of being self-stigmatized when compared with those in the rural areas. Adult literacy level and access to media are higher in the urban than the rural areas in Nigeria. (NPC, 2013) Also there is a higher chance of those in urban areas being of higher SES than those in the rural areas. These factors combined may equip the urban residents more in boosting their self-image than their counterparts in the rural areas. Similarly, PLWHA in Kenya and Puerto Rico who reside in rural areas have exhibited higher levels of self-stigma than those in the urban areas. (Yebei et al. 2008; Chavez et al. 2011)

Poverty influences self-stigma (Mburu et al. 2013). Self-stigma was higher among respondents with low SES than in their counterparts with high SES. Furthermore, when the result was logged into regression model, findings reveal that respondents belonging to low SES were more likely to be self-stigmatized when compared with those who belong to high SES. Findings from a PLWHA HIV stigma index survey in Nigeria reveals that 34.8% of the participants earn US\$50 or less per month and food insecurity (higher in rural areas) was a major factor. (NEPHWAN, 2011) In Uganda, (Mburu et al. 2013) being wealthy appeared to cushion stigma, especially among the men. Involvement of PLWHA in income- generating

ventures reduces poverty and indirectly counter stigma. (Mburu et al. 2013)

CONCLUSION

As low socio economic status and area of residence were found to influence self-stigma among respondents in the study, there is need for PLWHA to be economically empowered by the government with more emphasis on those residing in rural areas. There is need for consistency and intensification of stigma reduction programmes in Nigeria as this has the potential to reduce self-stigma among PLWHA in Enugu state, Nigeria.

REFERENCES

- Aransiola J, Imoyera W, Olowookere S, Zarowsky C. (2014). Living well with HIV in Nigeria? Stigma and survival challenges preventing optimum benefit from an ART clinic. *Global Health Promotion*. 21(1): 13-22
- Averting HIV and AIDS (AVERT). (2018). HIV Stigma and Discrimination. 2018. Available at <http://www.avert.org/professionals/hiv-social-issues/stigma-discrimination>. Accessed on 20/10/18
- Bezabhe WM, Chalmers L, Bereznicki LR, Peterson GM, Bimirew MA, Kassie DM. (2014). Barriers and Facilitators of Adherence to Antiretroviral Drug Therapy and Retention in Care among Adult HIV-Positive Patients: A Qualitative Study from Ethiopia. *PLoS One*. 9(5):e97353.
- Chávez JJ, Morales M, Sala A, Puig M, Deliz L, Castro E, Santiago L, Zorrilla C. (2011). HIV-related felt stigma among Puerto Ricans living with HIV/AIDS: A focus group study. *Inter-American Journal of Psychology*. 45(3): 331-338.
- Dahlu M, Azahar N, Bulgiba A, Zaki R, Oche OM, Adekunjo FO, et al. (2015). HIV/AIDS Related Stigma and Discrimination against PLWHA in Nigerian Population. *PLoS ONE* 10(12):e0143749.
- Forouzan AS, Shushtari JZ, Sajjadi H, Salimi Y, Dejman M. (2013). Social Support Network among People Living with HIV/AIDS in Iran. *AIDS Research and Treatment*. 2013: 715381.
- HIV Leadership through Accountability Programme: GNP+, Network of People Living with HIV and AIDS in Nigeria (NEPWHAN). (2011). *PLHIV Stigma Index Nigeria Country Assessment*. Amsterdam: GNP+
- Joint United Nations Programme on HIV/AIDS. UNAIDS. (2007). The greater involvement of people living with HIV (GIPA): UNAIDS policy brief. 2007. Assessed on 2/9/18. Available at: http://data.unaids.org/pub/BriefingNote/2007/jc1299_policy_brief_gipa.pdf.
- Madiba S, Kekana O. (2013). Factors Associated with Attendance and Non-Attendance of Support Groups among HIV Positive Adults Attending an Antiretroviral Community Clinic at Ekurhuleni District, South Africa. *World Journal of AIDS*. 3: 111-118.
- Mburu G, Ram M, Skovdal M, Bitira D, Hodgson I, Mwai GW, Stegling C, Seeley J. (2013). Resisting and challenging stigma in Uganda: the role of support groups of people living with HIV. *Journal of the International AIDS Society*. 16(s2): 18636.
- National Population Commission (NPC) Nigeria, ICF International. (2013). *Nigeria Demographic and Health Survey (2013)*. Abuja, Nigeria, Rockville Maryland USA. 2014. NPC and ICF International.
- Neuman M, Obermeyer CM, Cherutich P, Desclaux A, Hardon A, Ky-Zerbo O, et al. (2013). Experiences of stigma, discrimination, care and support among people living with HIV: A four country study. *AIDS Behaviour*. 17(5): 1796–1808.
- Nigeria 2015 Stigma Index. (2015). *Recent Interventions to Reduce Stigma & Discrimination in Nigeria*. Available at www.stigmaindex.org/nigeria. Accessed 3/9/15.
- Oturu K. (2011). Stigma in Access to HIV Treatment in African Settings: The importance of social connections. *Grounded Theory Review: an International Journal*. 2(10): 63.
- Sasaki Y, Kakimoto K, Dube C, Sikazwe I, Moyo C, Syakantu G, et al. (2012). Adherence to antiretroviral therapy (ART) during the early months of treatment

- in rural Zambia: influence of demographic characteristics and social surroundings of patients. *Annals of Clinical Microbiology and Antimicrobials*. 11:34.
- Simbayi LC, Strebel A, Cloete A, Henda N, Mqeketo A. (2007). Details for Manuscript Number SSM-D-06-00290R2 “Internalized Stigma, Discrimination and Depression among Men and Women Living with HIV/AIDS in Cape Town, South Africa.” *Social Science & Medicine*. 64(9): 1823-1831.
- Stangl AL, Lloyd JK, Brady LM, Holland CE, Baral S. (2013). A systematic review of interventions to reduce HIV-related stigma and discrimination from 2002 to 2013: how far have we come? *Journal of the International AIDS Society*. 16(s2):
- Tumwikirize S, Torpey K, Adedokun O, Badru T. (2015). The Value of Support Group Participation in Influencing Adherence to Antiretroviral Treatment among People Living with Human Immunodeficiency Virus (HIV). *World Journal of AIDS*. 5: 189-198.
- UNAIDS (2013). Report on the Global AIDS epidemic 2013. Joint United Nations Programme on HIV/AIDS (UNAIDS). Available at: http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf Accessed on 2/2/2018.
- Yebei VN, Fortenberry J, Ayuku DO. (2008). Felt stigma among people living with HIV/AIDS in rural and urban Kenya. *African Health Sciences*. 8(2):97-102