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Department of Sociology/Anthropology
Ebonyi State University Abakaliki
Ebonyi State - Nigeria.

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OR

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FACTORS INFLUENCING ATTITUDES TOWARDS STIGMATIZATION AND
DISCRIMINATION AMONGST PEOPLE LIVING WITH HIV/AIDS

ADEUSI, SUSSAN OLUFUNMILOLA

Department of Psychology,
Covenant University, Ota
e-mail:funmiswayas@yahoo.com
+2348066202909

&

ADEKEYE, OLUJIDE A.

Department of Psychology,
Covenant University, Ota
e-mail:jikeye@yahoo.com
+2348035956630

&

AMODU, LANRE

Department of Mass Communication,
Covenant University, Ota.
e-mail:olaoluamodu@yahoo.com
+2347034737394

Abstract

This research study was designed to explore stigmatization and discrimination related to people living with HIV/AIDS. The study employed the descriptive survey of By means of a self 116 participants. A research questionnaire elicited information on demography and stigmatization and discrimination amongst the people living with HIV/AIDS and the general population. Two hypotheses were formulated and tested. The result confirmed a significant combined contribution of family and workplace attitude, towards people living with HIV/AIDS. ($r = .408, r^2 = .166; F_{(2, 113)} = 11.261; p < 0.005$). The second hypothesis showed that there is no significant difference between male and female respondents in their workplace attitude towards people living with HIV/AIDS ($t = 0.200, df = 114, p > 0.05, one-tailed$). The study concludes that the society should be encouraged to have a change of attitude towards people living with HIV/AIDS. Empathy, support and care should be demonstrated to victims of HIV/AIDS in place of stigmatization and discrimination.

Keywords: - Attitude, Stigma, Stigmatization, Discrimination, HIV, AIDS, Transmission.

Introduction

HIV-related stigma and discrimination remain highly prevalent across the globe. In the Declaration of Commitment on HIV/AIDS (2001) governments throughout the world made commitments to reduce stigma and discrimination against people living with HIV and groups vulnerable to HIV infection. In 2005-2006, country and regional consultations on universal access to HIV prevention, treatment, care and support showed that stigma and discrimination against people living with HIV were major barriers to universal access and undermined the effectiveness of national responses to HIV. There is no doubt that the greatest health problem threatening the

human race in contemporary times is the HIV/AIDS pandemic (UNAIDS 2008), and the societal response to the scourge is labeling, which discourages people from HIV counseling and testing. Stigma is generally accepted to be an attribute that deeply reduces the bearer "from a whole and usual person to a tainted and discounted one" (Goffman, 2004). Stigma and discrimination are everyday constructs that manifest themselves wherever there are human beings, making it inherent in social structures that make up society.

Stigmatization often leads to discrimination, which refers to any form distinction, exclusion, restriction affecting a person by virtue of personal characteristics (Link & Phenlan, 2005). Stigma is not unique to HIV/AIDS. It has been documented with other infectious diseases like tuberculosis, syphilis, and leprosy (Herek, Mitnick, Burris et al., 1998). Stigma is most frequently associated with diseases that have severe, disfiguring, incurable, progressive outcomes, especially when modes of transmission are perceived to be under the control of individual behaviour. It is common in diseases that are perceived to result from the transgression of social norms, such as socially unsanctioned sexual activity (Crandall & Moriarty, 2005). Discrimination is a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations, or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits, and advantages available to other members of society (Lee, Kochman & Sikkema, 2002; Weitz, 1990). Stigmatizing attitude is amplified by the tendency of people to be judgmental. A significant portion of the public blame people living with HIV/AIDS (PLWHA) for their illness, since the acquisition is perceived to be as a result of immoral and voluntary actions, for example in homosexual and promiscuous sex and the sharing of infected needles among injection drug users (Herek, Mitnick, Burris et al., 1998).

HIV/AIDS stigma and discrimination as complex social processes that interact with and reinforce preexisting stigma and discrimination associated with sexuality, gender, race, and poverty (Parker and Aggleton, 2002) and as reported by Herek, Mitnick, Burris et al (1998), AIDS shares many characteristics with other diseases that are highly stigmatized, such as its perception to be unalterable, degenerative, and fatal, its contagiousness and transmissibility, and the repellent, ugly, and upsetting appearance of the afflicted in the advanced stages of the disease. Stigma and discrimination related to HIV/AIDS appears to be more severe than that associated with other life threatening conditions. It also extends beyond the disease itself to providers and even volunteers involved with the care of people living with HIV disease. Often, HIV/AIDS-related stigma and discrimination is expressed in conjunction with one or more other stigmas, particularly those associated with homosexuality, bisexuality, and injection drug use. People with certain religious beliefs and less educated people may be more likely to harbour HIV/AIDS-related stigma. Those less educated people about the disease believe that kissing someone with the virus, sharing public toilets, being sneezed on or donating blood, increases the rate which one can contaminate the virus. Stigma also affects the care of HIV-positive individuals. After a person tests positive, he or she faces decisions that include how to enter and adhere to care and whether to disclose HIV positivity to partners, friends, family, colleagues, employers, and health care providers (Chesney & Smith, 1999).

Stigma may be conceptualized as both external (public stigma) and personal (felt stigma). Public stigma, as described by Corrigan and Watson is the stigmatizing attitudes or reaction that the general population holds toward persons with HIV and their family members. Felt stigma, on the other hand, refers to an individual's anticipated fear of societal attitudes and potential discrimination if they were to have a particular undesirable attribute, such as HIV infection (Corrigan & Watson, 2002; Brown, Macintyre & Trujillo, 2003). Persons with HIV infection living in a society that widely endorses stigmatizing ideas will internalize these ideas and believe

that they should be blamed and stigmatized. Stigmatized individuals suffer diminished self-esteem and self-efficacy (Scambler, 1998; Jacoby, 1994).

Stigma directed at people living with HIV/AIDS not only makes it more difficult for people trying to come to terms with and manage their illness on a personal level, but it also interferes with attempts to fight the AIDS epidemic as a whole. On a national level, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care. Stigma can have significant negative health effects and disease transmission by delay in seeking care, in failing to disclose one's condition due to fear of isolation or rejection, and by refusing to follow medical advice. Stigma is particularly relevant to prevention and treatment in the global HIV/AIDS pandemic. Stigma surrounding HIV and AIDS has been shown to act as barrier to HIV prevention, treatment, and care, including voluntary counselling and testing (VCT) (Adekeye, 2010; Kalichman & Simbayi, 2004; Kalichman, Simbayi, Jooste, Toefy, Cain, Cherry, et al., 2005); Lieber, Li, Wu, Rotheram-Borus, & Guan, 2006).

Discrimination is the ultimate effect of HIV stigma, and with regard to the HIV/AIDS epidemic, HIV related stigma refers to "prejudice, discounting, discrediting, and discrimination directed at people perceived to have HIV/AIDS, as well as the individuals, groups, and communities with which they are associated" (Herek & Capitanio, 1997). As noted by Herek, Capitanio & Widaman (2002), fear of causal contagion and worry of HIV infection as a result of misconceptions about acquiring HIV infection may lead to avoidance (e.g., persons without HIV infection do not want to be proximate to persons with HIV because they fear disease spread).

Experts have described stigma as a quality that "significantly discredits" an individual in the eyes of others, it is generally considered to be "an attribute used to separate affected individuals from the normalized social order." (Goffman, 1963; Gilmore & Somerville, 1994). HIV stigma is a ubiquitous phenomenon that the Joint United Nations Programme on HIV/AIDS (UNAIDS) suggests is "universal, occurring in every county and region of the world. Based on the work of Goffman (1963), HIV-related stigma has been defined as prejudice, discounting, discrediting, and discrimination that are directed at people perceived to have HIV or AIDS. Rutledge & Abell (2005) noted that UNAIDS has well-documented cases from throughout the world of persons being stigmatized and discriminated against and denied services due to their serostatus. A plethora of studies (Goffman, 1963; Green & Platt, 1997; Herek, 1999; Emler, 2006) have found HIV stigma to be associated with various interpersonal and psychosocial issues such as feelings of shame, guilt, fear and anger, mental strain, and feelings of self loathing.

Since HIV/AIDS-related stigma and discrimination acts at both the societal and at the individual level, there is an urgent need in many contexts to address stigma and discrimination to promote adequate, accessible and acceptable HIV/AIDS programs and services. HIV/AIDS-related stigma and discrimination has been shown to be inversely related to knowledge of HIV transmission, access to antiretroviral treatment (Castro & Farmer, 2005) and disclosure of HIV status (Maman, 2003). This study is an attempt to explore stigmatizing and discriminatory attitude of family members and the work-place environment on PLHA. To achieve the objective of this study, two hypotheses were formulated:

Research Hypotheses

1. There will be a combined contribution of the family and workplace on attitude towards people living with HIV/AIDS.
2. There will be a significant difference in the workplace attitude of male and female participants

Methods

Research Design

This study employed descriptive survey method. Verma & Beard (1981) states that descriptive method of research have the advantage of being an effective way of collecting data from a large number of sources and in a short time. is primarily concerned with portraying the present. Descriptive method helps the researcher to describe an existing phenomenon by using numbers to characterize individuals or respondents. It was adopted because of its flexibility and effectiveness in information gathering.

Sample and Sampling Procedure

A total of 116 respondents were involved in this study. 50 participants from each support groups were randomly selected meaning that all HIV/AIDS participants have equal chances of being selected. Participants were selected from the National Hospital Abuja (25), the General Hospital Garki, Abuja (25), health care services (22), from organizations (22) and institutions (22) such as secondary, primary and tertiary institutions. A stratified random sampling was employed in selecting people living with HIV/AIDS.

Instruments

The instrument used for data collection was a questionnaire titled "Questionnaire on stigmatization and discrimination of people living with HIV/AIDS". The questionnaire was divided into four sections. Section A was based on demographic data with includes age, sex, marital status, number of children and education qualification. Section B was based on attitude of the family while Section C elicited information on attitudes of health care professionals and the workplace. Section D was based on attitudes towards people living with HIV/AIDS. The second, third and fourth sections was structured as a Likert-type rating scale. The instrument has a Cronbach alpha at the pre-test 0.78 and at the post-test .80.

Procedure for Administration of Questionnaire

The researcher personally administered the questionnaire with some assistance from colleagues and counsellors in the support group who helped to interpret to those that could not speak and understand English. Each participant in the support group responded to the items immediately and the researcher did the collection because it was administered on their clinic days. Other respondents filled the items at their work place and collection was also done immediately.

Data analysis

All statistical analyses were performed using SPSS (SPSS version 17 for Windows, SPSS Inc., Chicago, IL).

Hypothesis One: There will be a combined contribution of the family and workplace on Attitude towards people living with HIV/AIDS

Table 1: Relative Contribution of the Independent Variables to Attitude towards People Living with HIV/AIDS

Model	Predictor Variables	Unstandardized Coefficients		Standardized Coefficients	t-ratio	Sig
		B	Std. Error	Beta		
1	constant	14.919	6.446		2.314	.022
	Family Attitude		.217	.306		
	Workplace Attitude	.758	.280	.214	3.493	.001
		.682			2.437	.016

a. Dependent Variable: Attitudes to PLHA

Table 2: Model Summary of Multiple Regressions

Predictors	R	R ²	R ² Adjusted	Std. Error
Family Attitude, Workplace Attitude	.408a	.166	.151	10.56461

Predictors: (Constant), Family Attitude, Workplace Attitude

Table 3: Regression Analyses on Attitude towards People Living with HIV/AIDS

Sources of Variations	Sum of Squares	Df	Mean Square	F	Sig.
Regression	2513.785	2	1256.893	11.261	.000a
Residual	12612.042	113	111.611		
Total	15125.828	115			

a. Predictors: (Constant), HCTOTAL, FRTOTAL

b. Dependent Variable: PLHTOTAL (ANOVA)

In testing hypothesis one, regression analysis was carried out on family and workplace as predictor variables and attitude towards people living with HIV/AIDS as the criterion variable. The model summary table as presented in Tables 2 and 3 reveals that when all the predictor variables were entered into the regression model at once, there was a significant combined contribution of family and workplace ($r = .408$, $r^2 = .166$; $F_{(2, 113)} = 11.261$; $p < 0.005$).

As indicated in Table 2, the model summary table provides useful information about the regression analysis. First, the "multiple R" column is the correlation between the actually observed independent variables and the predicted dependent variables (i.e. predicted by the regression equation). "R square" also known as the "coefficient of determination" states the proportion (percentage) of the variation (sample) in the dependent variable that can be attributed to the independent variables. In this study, 16.6% of the variation in attitude towards people living with HIV/AIDS appears to be accounted for by the combination family and workplace.

The "adjusted R square" refers to the best estimate of R square for the population from which the sample was drawn and the "standard error of estimate" indicates that on the average, observed attitude towards people living with HIV/AIDS deviate from the predicted regression line by a score of 10.56461. Table 1 reveals that both family ($\beta = .758$; $t = 3.493$; $p < 0.05$) and workplace ($\beta = .682$; $t = 2.437$; $p < 0.05$) were strong predictor of the attitude towards people living with HIV/AIDS. The hypothesis which states that there will be a combined contribution of the family and workplace on attitude towards people living with HIV/AIDS was accepted.

Hypothesis Two: There will be a significant difference in the workplace attitude of male and female participants.

Table 4: Means, Standard Deviations and t-values of Participants by Gender

Variables	No of Cases	Mean	Std. Dev.	Df	t-value	Sig.
Male	55	21.200	3.663	114	0.200	0.42
Female	61	21.065	3.563			

The resulting difference between male and female respondents in their workplace attitude towards people living with HIV/AIDS as presented in Table 4 reveals that there was no significant difference between male and female respondents in their workplace attitude towards people living with HIV/AIDS ($t = 0.200$, $df = 114$, $p > 0.05$, one-tailed). Hypothesis two was therefore rejected.

Discussion

Hypothesis one shows that when all the predictor variables were entered into the regression model at once, there was a significant combined contribution of family and workplace attitude, towards people living with HIV/AIDS. Tables 2 and 3 reveals that when all the predictor variables were entered into the regression model at once, there was a significant combined contribution of family and workplace ($r = .408$, $r^2 = .166$; $F_{(2, 113)} = 11.261$; $p < 0.005$). This result confirmed the hypothesis. Herek (1990) found that people with AIDS are evaluated more negatively than people diagnosed with other incurable diseases, even by health care workers.

Herek (1990) also reported that it was common for caregivers to avoid people with AIDS and to overestimate the risks of casual contact with people living with HIV/AIDS. HIV/AIDS-related stigma extends beyond individuals living with HIV/AIDS to volunteers, caregivers, co-workers, and professionals who provide HIV/AIDS services or advocacy. For example, some patients will switch medical providers when they learn that their provider is HIV positive or cares for HIV positive patients. Individuals who had direct contact with an HIV positive person were less likely than those who had no contact with an HIV positive person to switch health care providers on the basis of the HIV status of the provider or the provider's patients (Gerbert, 1991, cited by Herek, 1997).

Some researchers have suggested that disclosure of HIV positivity may provoke violence in intimate relationships (Gielen, O'Campo, Faden & Eke, 1997). Evidence from Kenya suggests that quality of care by family members is improved when stigma is low. Less expressed stigmatizing attitudes were associated with greater care and support knowledge and insights into the needs of children under their care (Hamra, 2005). While provision of care activities within the home is sometimes an explicit attempt to avoid potential discrimination at formal services, families caring for an HIV positive family member cite fear of stigma from community members as a dominant concern. Home-based care professionals also report stigma to feature strongly as a barrier to introducing home-based care services (Waterman, 2007).

Hypothesis two shows that there was no significant difference in the workplace attitude of male and female participants ($t = 0.200$, $df = 114$, $p > 0.05$, one-tailed), and based on this result, the hypothesis was rejected. Gender inequality especially women's lack of economic empowerment is an important factor in the spread of HIV/AIDS. Social and economic relations between women and men, the role of power in sexual relations, and physiological differences between males and females determine their respective risk levels for infection, their respective ability to protect themselves effectively, and their respective share of the HIV/AIDS burden. In sub-Saharan Africa, 55 percent of those infected are women, and in some African countries, females aged 15-24 have prevalence rates up to six times that of males of the same age (UNAIDS, 2001). Therefore, as companies operate in an increasingly diverse workplace and draw their workforce

from very wide risk pools, they need to take into account the differing attitudes of men and women towards other employees living with HIV/AIDS.

Implication of Study

HIV/AIDS has severely undermined the development of many countries, in terms of individual sufferings and loss as well as knock out effects on the families, communities, economies, medical services, business, public services and society as a whole (UNDESA, 1998). To bring down the ravage of this disease in people's attitudes towards the individuals living with HIV/AIDS must have to change. This becomes necessary when the impact of continued spread of the disease and the role of attitude of people to those already infected are taken into consideration.

The family, which is the agent of socialization, will be dissolved due to the presence of the disease within the households, as parents die and children are sent to relatives. Children are also faced with problem of infection, become orphans and suffered untold psychological effects because of the abuse, alienation, stigma and discrimination. Many of the children drop out from school and are forced to become providers for themselves and their families. The elderly are also likely to bear an increasing burden as a result of care of infected people, orphaned children and remaining in the work place for longer period. Thus, the number of vulnerable children and orphans will increase. Child labour and street children will become the order of the day if the impact of the disease is not properly addressed. Extraordinary efforts are therefore needed to provide for children orphaned by the epidemic, especially in the form of measures that afford them the access to education, food, health care and other social support. However, people living with HIV/AIDS also need information and education on how to access medical services and drug provision and on how to find appropriate emotional and practical support and help. People living with HIV/AIDS must overcome socio-cultural and economic barriers to get the care and support they need.

Conclusion

For years, experts, researchers and people living with HIV have identified stigma and discrimination as major drivers of the HIV epidemic. In 1987, Jonathan Mann, then director of the World Health Organization's Global Programme on AIDS, forecast three components to the HIV epidemic: the first would be HIV, the second AIDS, and the third would be stigma, discrimination, and denial. He predicted that stigma, discrimination, and denial would be as central as the illness itself. It is tragic that twenty years later, stigma and discrimination would continue to be major problems, even in an era where treatment for HIV is more and more accessible, and prevention of HIV is not only more and more possible, it is critical. As national AIDS programmes and the international community mount an ambitious effort to make universal access to HIV prevention, treatment, care and support a reality, all stakeholders in the AIDS response must work together to address major obstacles to reaching this goal.

Greater leadership is needed to raise awareness and spur concrete action to address the obstacle of HIV stigma and discrimination, building on what has been learned through programmatic experience to date. Donors, UNAIDS and United Nations Joint Teams on AIDS can work together to support countries to include programmes to reduce stigma and discrimination as a central part of effective national responses to HIV. Not only will these efforts help countries achieve critical HIV programme and Millennium Development Goal (MDGs) targets, they will also help to protect the human rights of people living with HIV and other affected groups, will enable people to utilize information and services to reduce the transmission of HIV, and will reduce the impact of HIV on individuals, communities.

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