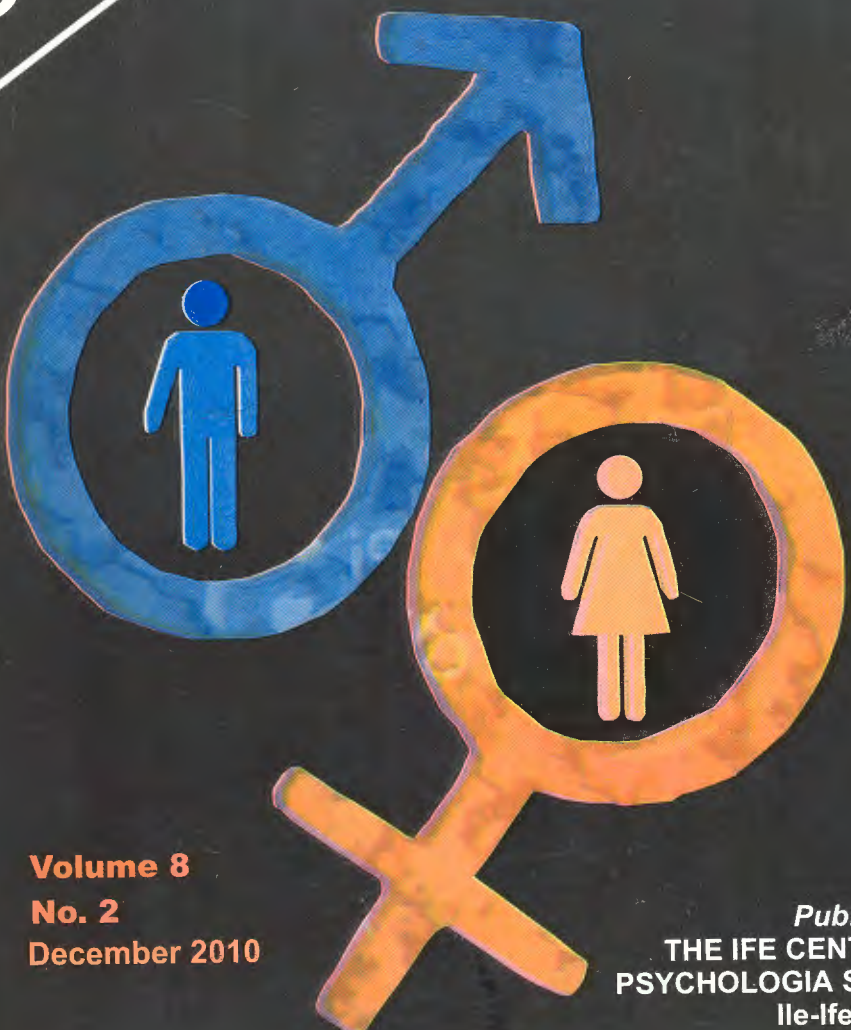
Gender & Behaviour



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SOCIO-DEMOGRAPHIC FACTORS INFLUENCING HIV/AIDS STIGMATIZATION AND DISCRIMINATION AMONGST WOMEN IN LAGOS STATE

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The study empirically examines socio-demographic factors influencing HIV/AIDS Stigmatization and Discrimination amongst women in Lagos State. Two hundred and thirty respondents (Female respondents only) who have positive status of HIV/AIDS were interviewed through administration of questionnaires in Lagos State, Nigeria. Frequency tables and regression model were used in the analysis of data collected from the field. The two hypotheses were tested in this study. However, socio-demographic factors which include age and educational attainment indicated a negative influence on HIV/AIDS stigmatization and discrimination amongst sampled women in the study. In addition, the result from Analysis of Variance (ANOVA) clarified that those women who disclose their HIV/AIDS status are gossiped about, verbally harassed and neglected by the Nigerian society. The study presents evidence that once a woman discloses her HIV/AIDS status, she is immediately stigmatized by the society and then discriminated.

The paper thus recommends that any form of gossip, verbal harassment and neglect should be stopped against women, who disclosed their HIV/AIDS status to the Nigerian society. Lastly, women with HIV/AIDS positive should apply their educational skills in taking all drugs that will foster their long-living in Nigerian society.

Key Words: Stigmatization, Discrimination, HIV/AIDS Status, ANOVA and Socio-demographic factors.

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Introduction

Background of the Study

Sexually transmitted infections have always been imbued with stigma due to their association with behaviours considered deviant or immoral (Goldin, 1994). Similarly, societies have historically reacted with fear to disfiguring, debilitating, and fatal diseases and have translated this aversion into discriminatory actions against the infected (Alonzo, 1995). The Human Immunodeficiency Virus (HIV) was unknown until the early 1980's but since that time, it has infected millions of persons in a worldwide pandemic. At the end of the 20th century, over 21 million persons worldwide had died from AIDS; another 34 million were living with HIV infection whilst the majority 95% of HIV infected persons were residents of developing nations (UNAIDS, 2006). The HIV/AIDS pandemic has presented the world with a condition that combines these characteristics – and it has frequently been met with stigma and discrimination, a reaction dubbed "the second epidemic" (Somerville and Orkin, 1989).

Despite the high prevalence of HIV/AIDS that exists in many Sub-Saharan African countries, very little is known of the prevalence and context of HIV-related stigma in these settings. In nearly 20 sub-Saharan African countries, an estimated 5% or more of young women 15–24 years are HIV positive, and more than one half of those newly infected with HIV today are between 15 and 24 years old, such that an estimated 11.8 million young people are now living with HIV/AIDS (USAID, 2008).

'Stigma' is a Greek term denoting a mark that, in ancient times, was burned or cut into the flesh of an unsavoury character — a traitor, criminal, or slave (Harvey, 2001). Goffman (1963) defined stigma as 'an attribute that is deeply discrediting within a particular social interaction', as a 'spoiled social identity' and 'a deviation from the attributes considered normal and acceptable by society' (Harvey et al; 2001).

There are few definitions of stigma according to some erudite scholars. Firstly, Alonzo and Reynolds (1995) defined stigma as a 'powerful and discrediting social label that radically changes the way individuals view themselves and are viewed as persons'. Secondly, Inside-out Research (2003) describes a large collaborative study on stigma in South Africa and reports that stigma 'can be felt (internal stigma), leading to an unwillingness to seek help and access resources, or enacted (external stigma), leading to discrimination on the basis of HIV status or association with someone who is living with HIV/AIDS'. Thirdly, 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."(Nyblade, 2009). Fourthly, According to Alonzo and Reynolds (1995), stigma is 'a construction of deviation from some ideal or expectation'. Stigmatised groups include women; minorities, such as people of colour, homosexuals, and substance abusers, and people who are physically and/or mentally disabled (Harvey et al, 2001). It is interesting as of today to note that Goffman's concept of stigma is the one most widely acceptable one (Harvey et al, 2001).

People with HIV/AIDS may not have any visible signs of the disease, yet they are more likely to be stigmatised because others may view them 'as contributors to their own problems and unworthy of the care directed to more legitimate victims of illness' (Jillings & Alexus, 1991).

Heterosexual intercourse remains a major route of HIV/AIDS transmission in three-quarters of HIV cases in developing countries (D'Cruz-Grote, 1996) and this is also applicable in Nigeria. With the prevalence rates being highest among young adults aged 20 -24 years in Nigeria, it implies that a significant proportion of adults and young people in Nigeria engage in unprotected and risky sexual acts and also exists, exploitative sexual relationships particularly between adult males and younger females who may not be able to negotiate for safer sexual encounters (Orubuloye, Caldwell; and Caldwell; 2001).

Stigmatized individuals may suffer discrimination that can lead to loss of employment and housing, estrangement from family and society, and even increased risk of violence. HIV/AIDS-related stigma also fuels new HIV infections because it can deter people from getting tested for the disease, make them less likely to acknowledge their risk of infection, and discourage those who are HIV-positive from discussing their HIV status with their sexual and needle-sharing partners.

Stigma still remains one of the most significant challenges in developing countries for all HIV and AIDS programs, which involve the prevention and care continuum. Stigma increases vulnerability to HIV and worsens the impact of infection. Fear of being identified with HIV keeps people from learning about their status, changing behaviour to prevent infecting others, caring for people living with HIV and AIDS, and accessing HIV and AIDS services (UNAIDS/WHO; 2006). Additionally, stigma intensifies the emotional pain and

suffering of people living with HIV and AIDS, their families and caregivers (Castro, 1998a; Castro et al; 1998b).

AIDS stigma and discrimination have been seen all over the world, although they manifest themselves differently between countries, communities, religious groups and individuals. They are often seen alongside other forms of stigma and discrimination, such as racism, homophobia or misogyny and can be associated with behaviours often considered socially unacceptable such as prostitution or drug use. An understanding of the factors associated with attitudes toward HIV/AIDS is essential for the creation of community-based interventions HIV/AIDS-related stigma compromises the well-being of people living with the disease. However, those who experience stigma view it differently than those who stigmatise (Herek, Capitanio & Widaman, 2002). In health care, stigma is often described in the literature in relation to chronic illness and visible physical disability. One description of stigma in this context is 'a factor influencing the response of others to the chronically ill' (Jillings & Alexus, 1991). AIDS-related stigma is not static. It changes over time as infection levels, knowledge of the disease and treatment availability vary. Much work has been done on the stigma and discrimination that surrounds HIV/AIDS in Sub-Saharan Africa, and the barriers this creates in the effective delivery of HIV testing and prevention efforts (Link and Phelan, 2001). Although, there has been little consideration of the role of the wider community in shaping the attitudes of young people (Oyediran, Oladipo and Anyanti, 2005), however, it is estimated that as many as one-third of the HIV-positive population do not know their HIV status (Kaiser Family Foundation, 2004). Even in countries where studies have documented high rates of HIV infection, many individuals are reluctant to get tested and often slow to access care (Mbonu, Van Den Borne and De Vries, 2009).

Globally, 40 million people were estimated to be living with HIV and AIDS at the end of 2001. Sub-Saharan Africa is clearly the worst-affected region. With 28.5 million People Living with HIV and AIDS (PLHA) in 2001, Sub-Saharan Africa accounts for more than 70 percent of all HIV and AIDS cases in the world. Over two million of the three million deaths due to AIDS in 2001 occurred in sub-Saharan Africa. AIDS is now the leading cause of death in sub-Saharan Africa and the cause of a 15- year drop in life expectancy in the region, from 62 to 47 years. New HIV infections are highest among young people, and young women have consistently been found to have higher (in some cases as much as six times as high)

prevalence rates of HIV than men of the same age (Joint United Nations Programme on HIV/AIDS; 2004).
Nigeria, being the largest and most populous country in sub-Saharan Africa, is one of the countries highly affected by the HIV/AIDS scourge. HIV/AIDS have spread rapidly since the first case was diagnosed 1986 with the adult HIV prevalence which has been increasing from 0 percent in 1986 to 1.8 percent in 1991 to 4.5 percent in 1996 to 5.4 percent in 1999 to 5.8 percent in 2001 (Nnedum, 2006). Mann, (1987), in his studies identified three phases of the epidemic, the HIV epidemic, the AIDS epidemic and the epidemic of Stigma, Discrimination and Denial of which the later is least understood part of the epidemic. Nigeria appears to be in between the full AIDS epidemic phase and the Stigma and discrimination phase.
The problematic situation of this study is that of the stigmatization and discrimination of those women with HIV/AIDS and the challenges they usually encounter in the Nigerian society. The discrimination and stigmatization are measured in the context of negative attitudes of the people of Nigeria towards People living with HIV/AIDS, that is, whether or not people are willing to care for a family member (male or female) with HIV/AIDS.

This research is significant in many ways because it will greatly benefit the government, the academic society, social scientists and policy makers for the following reasons: Firstly, since discrimination and stigmatization is a major challenge all over the world that has not received adequate attention up till date. Secondly, there are not much work recently done by Scholars on stigmatization and discrimination amongst women especially in Lagos state. However, many studies were carried out in order to curb and to reduce discrimination and stigmatization as a whole among people living with HIV/AIDS that are not comfortable living in the Nigerian society as well as in the workplace. Despite the aforementioned background, this study tries to answer this bothering issue of concern: Are there socio-demographic factors influencing HIV/AIDS stigmatization and discrimination amongst women in Lagos State as well as in Nigerian society as a whole?

Essentially, the main focus of this paper was to identify socio-demographic factors influencing HIV/AIDS stigmatization and discrimination in the Nigerian society by using Lagos State as a case study.

Methodology: A total sample size of 230 women with HIV/AIDS positive were randomly selected from the three public hospitals in Lagos state (80 in Lagos University Teaching Hospital, Idi-Araba (LUTH), 80 in Ikeja General Hospital and 70 in EKO Hospital respectively). A multi-stage random sampling technique was used to select the female respondents with HIV/AIDS positive. Purposive sampling method was employed due to the fact that this research was a very sensitive one and in order to carry out the study effectively, female respondents were randomly selected from these three public hospitals. A randomly selected sample of female HIV/AIDS patients in the survey constituted the sample. Information about socio-demogaphic factors, knowledge of HIV/AIDS, form of stigmatization and the extent of discrimination were collected from the respondents with the help of questionnaire instrument.

Analysis of this recent study was based on 230 female HIV/AIDS patients aged 15-49 years. The data were analyzed with the aid of Statistical Packages for Social Scientists (SPSSversion15.0).

After checking for incorrect responses, and missing values, descriptive statistics were calculated for all variables. Cross-tabulations and Regression were performed on the stigmatization and discrimination and the results were interpreted. The data for the study was analysed by using the information obtained through questionnaires and personal interviews. The variables of consideration on the frequency tables for this study includes: age, marital status, educational attainment, employment status, religion and ethnicity respectively.

The study was carried out in Lagos State due to the proximity or closeness to the researcher, highly populated, one of the major centres of business, commerce and industry as well as being former capital of Federal Republic of Nigeria.

Tables and Interpretations

Demographic and Socioeconomic Characteristics of females with HIV/AIDS positive

Table 1: Age of females with HIV/AIDS positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	15-19	3	1.3	1.3	1.3
	20-24	12	5.2	5.2	6.5
	25-29	46	20.0	20.0	26.5
	30-34	71	30.9	30.9	57.4
	35-39	46	20.0	20.0	77.4
	40-45	42	18.3	18.3	95.7
	45 and above	10	4.3	4.3	100.0
	Total	230	100.0	100.0	

Source: field study, April 2010

The above reflected that the age group (30-34) has the highest number of respondents which accounts for 30.9% of the total respondents. This was followed by the age groups (25-29) and (35-39), (40-45), (20-24), (45+) and (15-19) which accounted for 20.0, 20.0, 18.3, 5.2, 4.3 and 1.2 percents respectively. It could be discovered that that the age group 30-34years are the major respondents of the study.

Table 2: Marital status of females with HIV/AIDS positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Single	74	32.2	32.2	32.2
	Married	114	49.6	49.6	81.7
	Separated	36	15.7	15.7	97.4
	Divorced	5	2.2	2.2	99.6
	No Response	1	.4	.4	100.0
	Total	230	100.0	100.0	

Source: field study, April 2010

From table 2 above, 32.3% of the respondents are singles, 49.6% are married, 15.7% are separated, 2.2% are divorced and 0.4% reported as non-response (a widow). We can deduce that the HIV/AIDS was more amongst married women than others.

Table 3: Educational attainment of the females with HIV/AIDS positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Primary	22	9.6	9.6	9.6
	Secondary	124	53.9	53.9	63.5
	Tertiary	69	30.0	30.0	93.5
	others, specify	15	6.5	6.5	100.0
	Total	230	100.0	100.0	

Source: field study, April 2010

Table 3 shows that 9.6% female respondents only had primary school education, while 53.9% acquired secondary school education. 30.0% of females with HIV/AIDS positive while 6.5% of respondents indicated other category e. g Masters, OND.

Table 4: Employment status of the females with HIV/AIDS positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Student	30	13.0	13.0	13.0
	Employed	118	51.3	51.3	64.3
	Unemployed	82	35.7	35.7	100.0
	Total	230	100.0	100.0	

Source: field study, April 2010

From table 5 above, 13.0% of the respondents are students, 51.3% are employed and 35.7% are unemployed. We can therefore say that most of the females with HIV/AIDS positive in this study are gainfully employed (51.3%).

Table 5: Religion of the females with HIV/AIDS positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Christian	154	67.0	67.0	67.0
	Islamic	76	33.0	33.0	100.0
	Total	230	100.0	100.0	

Source: field study, April 2010

The distribution of the female respondents by religion from the table 5 shows that 154 (67.0%) out of the total respondents are Christians and the remaining 33.0% are Muslims. There were no traditional worshippers amongst the respondents.

Table 6: Ethnicity of the females with HIV/AIDS positive

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yoruba	131	57.0	57.0	57.0
	Igbo	76	33.0	33.0	90.0
	Hausa	23	10.0	10.0	100.0
	Total	230	100.0	100.0	

Source: field study, April 2010

The distribution of the female respondents by ethnicity from the above table showed that majority of the respondents interviewed are Yoruba people with 131 (57.0%) out of a total of 230. The Igbo were 76 (33.0%) and 10% were Hausa people.

Respondents' Nature of HIV/AIDS Stigmatization

Table 7: knowledge on whether people know about respondent's status

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	153	66.5	66.5	66.5
	No	69	30.0	30.0	96.5
	No Response	8	3.5	3.5	100.0
	Total	230	100.0	100.0	

Source: field survey, April 2010

The table 7 above shows that majority of the female respondents have disclosed their HIV/AIDS status to people. About 66.5% of the respondents have disclosed their HIV/AIDS status to the public while 30.0% of females with HIV/AIDS positive refused to disclose their status to people.

Table 8: knowledge on whether respondent finds it difficult to secure a job

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	109	47.4	47.4	47.4
	No	101	43.9	43.9	91.3
	No Response	20	8.7	8.7	100.0
	Total	230	100.0	100.0	

Source: field survey, April 2010

From table 8, it can be observed that 47.4% of the females with HIV/AIDS positive find it difficult to secure job opportunities due to their HIV/AIDS status while 43.9% of the female respondents did not find it difficult to secure job opportunities.

Socio-demographic factors and HIV/AIDS Stigmatization and Discrimination

Table 9 **Model Summary**

(a) Predictors: (Constant), religion, marital status, age group, educational attainment

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.125(a)	.016	-.002	21.74369

Table 10 **ANOVA (b)**

(a) Predictors: (Constant), religion, marital status, age group, educational attainments. (b)Dependent Variable: if people avoid close contact.

Model		Sum of Squares	D f	Mean Square	F	Sig.
1	Regression	1688.037	4	422.009	.893	.469(a)
	Residual	106377.285	225	472.788		
	Total	108065.322	229			

Coefficients (a)

Table 11: (a) Dependent Variable: Response on whether people avoid close contact

Model		Un-standardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	11.856	8.952		1.324	.187
	age group of the respondent	-.536	1.131	-.032	-.474	.636
	marital status of respondent	.006	.224	.002	.029	.977
	educational attainment of the respondent	-2.911	2.038	-.099	-1.428	.155
	religion of the respondent	2.927	3.137	.064	.933	.352

Hypothesis 1

- H_0: socio-demographic factors of females with HIV/AIDS positive are not significantly related to the level of stigmatization and discrimination they experienced.
- H_1: socio-demographic factors of females with HIV/AIDS positive are significantly related to the level of stigmatization and discrimination they experienced.

Community Attitudes and HIV/AIDS Stigmatization and Discrimination

Model Summary

Table 12: (a) Predictors: (Constant), feels neglected, feels verbally harassed, people gossip about the respondent's HIV/AIDS status, avoid close contact.

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.332(a)	.110	.095	17.07448

ANOVA

Table 13: (a) Predictors: (Constant), feels neglected, feels verbally harassed, people gossip about the respondent's HIV/AIDS status, people avoid close contact
b) Dependent Variable: Responses on whether people know about respondent's status

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	8141.465	4	2035.366	6.981	.000(a)
	Residual	65596.018	225	291.538		
	Total	73737.483	229			

Coefficients (a)

Table 14: (a) Dependent Variable: if people know about respondent's status

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	3.084	1.187		2.598	.010
	whether people avoid close contact with respondent	-.014	.124	-.017	-.112	.911
	whether people gossip about the respondent's HIV/AIDS status	-.026	.124	-.030	-.209	.834
	whether the respondent usually feels verbally harassed	-.013	.108	-.017	-.124	.901
	whether the respondent usually feels neglected	.367	.173	.387	2.117	.035

Hypothesis 2

H_0: there is no strong relationship between community attitudes and HIV/AIDS stigmatized and discriminated victims.

H_1: there is a strong relationship between community attitudes and HIV/AIDS stigmatized and discriminated victims.

Discussion of Results

From the above table 9, 10 and 11 respectively, the following deductions are evident: the 'b' coefficient shows that both positive and negative relationship exists between socio-demographic factors and HIV/AIDS stigmatization and discrimination. The variables, age and educational attainment of the respondents is negatively related to the study hypothesis, while marital status, employment status of the respondent and religion of the respondents are positively related to the hypothesis.

Overall, these predictor variables above are not statistically significantly related to the outcome variable (HIV/AIDS stigmatization and discrimination), i.e. there are other variables that are outside the socio-demographic factors that can determine the phenomenon.

However, the R square indicated a very weak relationship (1.6%) which confirms that socio-demographic characteristics are not the only factors influencing HIV/AIDS stigmatization and discrimination. It shows that 1.6% of the dependent variable is explained by the independent variable in the regression model; therefore, this is not a good fit. Since **F cal > F tab (0.893 < 2.09) at 0.05 level of significance,** therefore, we reject the alternative hypothesis (H_1) and accept the null hypothesis (H_0), concluding that socio-demographic factors influencing HIV/AIDS victims are not significantly related to the level of stigmatization and discrimination experienced. Socio-demographic characteristics (age and educational attainments) have a negative impact on HIV/AIDS stigmatization and discrimination.
With reference to table 12, 13 and 14 above, the following are the findings derived from them: the 'b' coefficient of if the respondent usually feels neglected shows that a positive relationship exists in the above listed variable and HIV/AIDS stigmatization and discrimination. The 'b' coefficients of if people avoid close contact with respondent, if people gossip about the respondent's HIV/AIDS status, if the respondent usually feels verbally harassed shows a negative relationship exists also in the above listed variables and HIV/AIDS stigmatization and discrimination. Overall, only one predictor variable above is statistically significant to the outcome

variable which is HIV/AIDS stigmatization and discrimination and the variable is if the respondent usually feels neglected. This just shows that there are other variables outside the community attitude variables used that can help to determine the phenomenon. Although, the other variables are positively related to the determined outcome, they are not statistically significant to the phenomenon. The R square (11%) shows a weak relationship between the variables and the phenomenon, it confirms that community attitudes is not a major factor influencing HIV/AIDS stigmatization and discrimination. It shows that only 11% of the dependent variable is explained by the independent variable in the model, thus indicating that the model use is not a good fit. In the analysis of the F ratio, if the F calculated is greater than the F tabulated (F cal >F tab), then we reject the null hypothesis and accept the alternative hypothesis. In this case, since F cal > F tab (6.981>2.09) at 0.05 level of significance, we will therefore reject our null hypothesis (H_0) and accept our alternative hypothesis (H_1). Therefore, we can conclude that there is a strong relationship between community attitudes towards HIV/AIDS stigmatization and discrimination of victims. Community attitudes have a positive impact on HIV/AIDS stigmatization and discrimination, it is expected that HIV/AIDS positive women that are stigmatized and discriminated have community attitudes surrounding and influencing them.

Conclusion

The primary concern of this study is to identify the nature and socio-demographic factors influencing HIV/AIDS stigmatization and discrimination amongst women in Lagos state of Nigeria. The study is hereby concluded with the following facts from findings: firstly, the result from Analysis of Variance (ANOVA) indicated that those women who disclosed their HIV/AIDS status are gossiped about, verbally harassed and neglected by the Nigerian society.

Secondly, socio-demographic factors identified from this study are age and educational attainments influencing HIV/AIDS stigmatization and discrimination experienced by women. Socio-demographic factors (age and educational attainments) have a negative influence on HIV/AIDS stigmatization and discrimination. The two hypotheses were tested based on the HIV/AIDS stigmatization and discrimination amongst women. The hypothesis testing for the first hypothesis indicated that there is a weak relationship which confirms that community attitude is not a major factor influencing HIV/AIDS stigmatization and discrimination that

other factors could also serve as factors aggravating HIV/AIDS stigmatization and discrimination.

The hypothesis testing of the second hypothesis indicated a very weak relationship which confirms that socio-demographic factors is not a major factor influencing HIV/AIDS stigmatization and discrimination that other factors could also aggravate HIV/AIDS stigmatization and discrimination. This confirms the result derived from the study.

The paper thus recommends that any form of gossip, verbal harassment and neglect should be stopped against women, who disclose their HIV/AIDS status to the Nigerian society. Lastly, women with HIV/AIDS positive should apply their educational skills in taking all prescribed drugs that will foster their long-living in Nigerian society.

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