



EVALUATION OF THE EXPERIENCES OF STIGMA AND DISCRIMINATION AMONG HIV-POSITIVE MEN AND WOMEN LIVING WITH HIV IN OWERRI NORTH LOCAL GOVERNMENT AREA, IMO STATE, NIGERIA

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ABSTRACT

The study was carried out to analyse experiences of stigma and discrimination among HIV positive men and women getting HIV care in Owerri North Local Government Area, Imo State, Nigeria. The facility-based cross-sectional study enrolled a total of 400 persons living with HIV, comprising 200 males and 200 females. A structured questionnaire was used to collect data. The questionnaire had items modified from a validated HIV Stigma Scale. Descriptive statistics were used to summarise responses and variations in the aspects of perceived, expected, internalised and performed stigma by gender. Respondents reported high levels of HIV-related stigma. On the whole, 96.0% of females and 91.0% of men agreed that people living with HIV are commonly discriminated against. Fear of unequal treatment based on HIV status was reported by 91.5% of females compared with 54.0% of males. Seventy-six percent of females and 19.5% of males indicated perceived social avoidance. 77.5% of females and 37.0% of males experienced shame about their HIV status. Almost all the women respondents (99.5%) and a large percentage of men respondents (91.5%) stated that society has negative perceptions about people living with HIV. 62.5% of females experienced loneliness linked with HIV status compared to 11.5% of males. Concern about disclosure of HIV status was highly high for both genders: 98.5% of females and 97.0% of males. In total, 92.8% of respondents indicated that they had been discriminated against because of their HIV status. Discrimination was most frequently reported in family contexts (42.0%) and health care institutions (35.7%), followed by community settings (10.5%) and workplaces (4.5%). HIV-related stigma and discrimination are still quite common among people living with HIV in Owerri North.

KEYWORDS: HIV/AIDS, stigma, discrimination, gender differences, persons living with HIV, psychosocial health, public health, Nigeria.

INTRODUCTION

Despite tremendous breakthroughs in prevention, diagnosis and treatment, Human Immunodeficiency Virus (HIV) infection remains one of the most important global public health concerns. Since the beginning of Acquired Immunodeficiency Syndrome (AIDS) in the early 1980s, millions of people worldwide have been infected with HIV and it continues to be a major health, social and economic burden. Despite the widespread availability of antiretroviral therapy (ART) that has transformed HIV infection from a fatal disease to a manageable chronic condition, people living with HIV (PLWH) continue to experience numerous psychosocial challenges, among which stigma and discrimination remain particularly prominent.^[1]

HIV-related stigma is negative attitudes, beliefs and behaviours towards people because of their real or perceived HIV status. It can take several forms including perceived stigma, anticipated stigma, internalised stigma and executed stigma.^[2] Perceived stigma refers to the belief that society has negative attitudes towards HIV. Anticipated stigma is the expectation of future discrimination, while internalised stigma is when individuals internalise society's unfavourable judgements and apply it to themselves. Enacted stigma means actual experiences of discrimination and social rejection. Such stigma may have a negative impact on mental health, self-esteem, social relationships, health care seeking behaviour, compliance to treatment, and quality of life.^[3]

HIV-related stigma remains a major barrier to efforts to control the epidemic. Fear of discrimination prevents

many people from being tested for HIV, reporting their status, starting treatment and staying engaged in care. Stigma thus remains a major barrier to attaining worldwide targets for HIV prevention and treatment. Despite considerable success in reducing HIV incidence and AIDS-related mortality, the psychosocial sequelae of HIV remain severe, especially in low- and middle-income countries.^[4]

Sub-Saharan Africa bears the highest burden of the HIV epidemic and is home to the majority of persons living with HIV worldwide. Nigeria is one of the worst hit countries in Africa by HIV with about 1.9 million individuals living with the infection. Although there has been significant progress in HIV service delivery and ART coverage, HIV-related stigma is pervasive and continues to severely effect health outcomes. Many living with HIV endure rejection, social isolation, discrimination in health care settings, marginalisation in the job and damaged family relations. These experiences have been linked to psychological discomfort, low levels of treatment adherence, poor health-seeking behaviour and poor quality of life.^[5]

Gender is an essential factor in the experiences of persons living with HIV. Social constructions of gender affect how men and women perceive, experience and respond to HIV-related stigma and discrimination. Women living with HIV are likely to experience various and intersecting kinds of stigma related to gender inequity, reproductive expectations, economic dependency and cultural norms around sexuality.^[6] They may be blamed, abandoned, excluded from society, discriminated against by their families, spouses and healthcare providers. On the other hand, males living with HIV can face barriers linked with societal norms of masculinity, which typically restrict emotional expression, disclosure of illness and healthcare seeking.^[7]

Previous research have shown that gender differences can have an impact on psychosocial outcomes of persons living with HIV, including social support, treatment adherence, coping strategies, mental health and quality of life.^[8] However, most studies on HIV in Nigeria have concentrated on epidemiological trends, clinical outcomes and treatment effectiveness, with very limited emphasis to gender-specific psychosocial experiences. As such, there is little evidence of differential experience of stigma and prejudice between men and women in many Nigerian communities.^[9]

Empirical data on gender variations in HIV-related stigma and discrimination in Owerri North Local Government Area of Imo State are not readily available. Understanding these experiences is crucial to designing effective, gender-sensitive interventions that can reduce stigma, improve psychosocial well-being, enhance treatment results and promote overall quality of life for persons living with HIV.^[10]

This study was therefore carried out to assess the experiences of stigma and discrimination among the HIV positive men and women living with HIV in Owerri North Local Government Area, Imo State, Nigeria and to assess gender disparities in the experiences. The results are expected to provide evidence to guide public health policy, psychosocial support programmes and stigma reduction strategies for persons living with HIV.

MATERIALS AND METHODS

This chapter describes the methodology employed in conducting the study. It covers the study design, study area, study population, sample size determination, sampling technique, study variables, instrument for data collection, validity and reliability of the instrument, data collection procedures, data processing and analysis, and ethical considerations.

Study Design

This study employed a cross-sectional survey design to investigate the lived experiences of adults living with HIV who were enrolled in HIV care and treatment services in Owerri North Local Government Area (LGA), Imo State, Nigeria. The design enabled the assessment of stigma and discrimination, healthcare access, treatment adherence, social support, sexual intimacy, coping strategies, and quality of life among respondents at a specific point in time.

Study Area

The study was conducted in Owerri North Local Government Area of Imo State, located in the South-East geopolitical zone of Nigeria. Owerri North shares boundaries with Owerri Municipal and several surrounding local government areas. The area comprises urban, peri-urban, and rural communities, making it socio-demographically diverse and representative of different population groups.

The inhabitants are predominantly of Igbo ethnicity, although migrants from other parts of Nigeria also reside within the area. The local economy is driven largely by trading, artisan work, civil service employment, agriculture, and small-scale enterprises. Owing to its proximity to Owerri, the state capital, Owerri North experiences substantial population movement and commercial activities.

The study was conducted in three healthcare facilities that provide HIV testing, treatment, and care services:

1. Holy Rosary Hospital, Emekuku;
2. Primary Health Centre, Akwakuma; and
3. Primary Health Centre, Ihitta-Ogada.

Holy Rosary Hospital, Emekuku, is a major secondary healthcare facility and referral centre for HIV/AIDS management within the area. HIV services in these facilities are supported through collaborations involving governmental and non-governmental organizations,

including Caritas Nigeria and international HIV/AIDS support programmes.

Study Population

The study population comprised adults living with HIV who were receiving treatment and care services at the selected healthcare facilities in Owerri North LGA.

Inclusion Criteria

Participants were eligible for inclusion if they:

- Were aged 18 years or older;
- Had a confirmed HIV-positive diagnosis;
- Had been enrolled in HIV care for at least six months; and
- Provided informed consent to participate in the study.

Exclusion Criteria

Participants were excluded if they:

- Were younger than 18 years of age;
 - Were too ill to participate at the time of data collection; or
 - Declined participation in the study.
- The study examined the following variables:
- Stigma and discrimination;

Sample Size Determination

The sample size was determined using Cochran's formula for estimating sample size in cross-sectional studies:

$$n = Z^2 p(1-p) / e^2$$

Where:

- n = minimum required sample size;
- Z = standard normal deviate corresponding to a 95% confidence level (1.96);
- p = estimated proportion of the population possessing the attribute of interest (0.5);
- e = margin of error (0.05).

Substituting the values:

$$n = (1.96)^2 \times 0.5 \times (1-0.5) / (0.05)^2$$

The calculated minimum sample size was approximately 385 participants. To improve representation and facilitate gender-based comparisons, a total sample size of 400 respondents was adopted, comprising 200 males and 200 females.

Ethical Considerations

Ethical approval for the study was obtained from the Department of Public Health, Imo State University, Owerri. Additional permission was obtained from the management of Holy Rosary Hospital, Emekuku, and the Department of Health and Social Services, Owerri North Local Government Area.

Participation was entirely voluntary. The objectives and procedures of the study were explained to all respondents before participation. Informed consent was obtained from each participant prior to data collection.

Interviews were conducted in private settings to ensure confidentiality and privacy. No identifying information was collected, and all responses were treated anonymously and used solely for research purposes.

Sampling Technique

A stratified random sampling technique was employed. The sampling frame consisted of registers of adults receiving HIV care in the selected healthcare facilities. Participants were first stratified by gender (male and female). Thereafter, simple random sampling was used to select respondents from each stratum until the required sample size was attained.

Instrument for Data Collection

Data were collected using a structured questionnaire developed from validated psychometric instruments and relevant literature. HIV-related stigma and discrimination were assessed using items adapted from the Short HIV Stigma Scale.

The instrument measured four dimensions of stigma

- Anticipated stigma;
- Internalized stigma;
- Enacted stigma; and
- Perceived stigma.

Validity of the Instrument

Instrument validity refers to the extent to which an instrument measures what it is intended to measure. The psychometric scales used in this study have been previously validated and demonstrated satisfactory construct and criterion validity in diverse populations. To ensure contextual relevance, the questionnaire was subjected to face and content validation by two senior academics in Public Health. Their recommendations were incorporated into the final version of the instrument before data collection commenced.

Reliability of the Instrument

Reliability refers to the consistency of an instrument in measuring the intended constructs under similar conditions.

A test-retest reliability assessment was conducted among 50 respondents who were not included in the final study sample. The questionnaire was administered on two separate occasions at an interval of 7–10 days.

Reliability was assessed using the Intraclass Correlation Coefficient (ICC) based on a two-way mixed-effects model with absolute agreement. The psychometric scales demonstrated satisfactory reliability, with a mean ICC of 0.853, indicating excellent stability and consistency of the instrument.

Data Collection Procedure

Data collection was conducted with the assistance of two trained research assistants over a three-month period.

Eligible participants were approached during clinic visits and invited to participate in the study. After obtaining informed consent, questionnaires were administered in either English or Igbo, depending on the respondent's preference.

Participants completed the questionnaires independently where possible. Assistance was provided when clarification was required. Each interview lasted approximately 15 minutes.

Prior to data collection, the research assistants received training on study objectives, ethical procedures, questionnaire administration, and respondent engagement. Quality control measures included periodic supervision and random verification of completed questionnaires to ensure consistency and accuracy.

RESULTS

Table 1: The experience of stigma and discrimination among HIV positive men and women living with HIV in Owerri North.

Statement/response	FEMALE		MALE		TOTAL	
	NUM	PERC	NUM	PERC	NUM	PERC
I feel that people with HIV are often discriminated against.						
Strongly disagree	0	0	0	0	0	0.0
Disagree	1	0.5	1	0.5	2	0.5
Neutral	7	3.5	17	8.5	24	6.0
Agree	52	26.0	119	59.5	171	42.8
Strongly agree	140	70.0	63	31.5	203	50.7
I worry about being treated differently because of my HIV status.						
Strongly disagree	1	0.5	0	0.0	1	0.3
Disagree	4	2.0	23	11.5	27	6.7
Neutral	12	6.0	69	34.5	81	20.2
Agree	63	31.5	91	45.5	154	38.5
Strongly agree	120	60.0	17	8.5	137	34.3
People often avoid me when they learn about my HIV status.						
Strongly disagree	0	0.0	0	0.0	0	0.0
Disagree	3	1.5	17	8.5	20	5.0
Neutral	45	22.5	144	72.0	189	47.2
Agree	59	29.5	37	18.5	96	24.0
Strongly agree	93	46.5	2	1.0	95	23.8
I feel ashamed of my HIV status.						
Strongly disagree	0	0.0	0	0.0	0	0.0
Disagree	2	1.0	26	13.0	28	7.0
Neutral	43	21.5	100	50.0	143	35.8
Agree	40	20.0	53	26.5	93	23.2
Strongly agree	115	57.5	21	10.5	136	34.0
I believe that society views people with HIV negatively.						
Strongly disagree	0	0.0	0	0.0	0	0.0
Disagree	0	0.0	1	0.5	1	0.2
Neutral	1	0.5	16	8.0	17	4.3
Agree	31	15.5	117	58.5	148	37.0
Strongly agree	168	84.0	66	33.0	234	308.5
I have felt lonely because of my HIV						

Statistical Analysis

Data were coded and entered into Statistical Package for Social Sciences (SPSS) version 27 for analysis. Descriptive statistics were used to summarize respondents' socio-demographic characteristics and study variables. Continuous variables were summarized using means and standard deviations, while categorical variables were presented as frequencies and percentages.

To determine gender differences in stigma and discrimination independent-samples t-tests were performed.

status						
Strongly disagree	0	0.0	0	0.0	0	0.0
Disagree	7	3.5	69	34.5	76	19.0
Neutral	68	34.0	108	54.0	176	44.0
Agree	54	27.0	18	9.0	72	18.0
Strongly agree	71	35.5	5	2.5	76	19.0
I am concerned about disclosing my HIV status to others.						
Strongly disagree	0	0.0	0	0.0	0	0.0
Disagree	0	0.0	1	0.5	1	0.2
Neutral	3	1.5	5	2.5	8	2.0
Agree	13	6.5	83	41.5	96	24.0
Strongly agree	184	92.0	111	55.5	295	73.8
Have you experienced discrimination related to your HIV status?						
No	13	6.5	16	8.0	29	7.2
Yes	187	93.5	184	92.0	371	92.8
In what settings have you experienced discrimination?						
No experience	13	6.5	16	7.2	29	7.3
Workplace	9	4.5	9	4.5	18	4.5
Healthcare	78	39.0	65	35.8	143	35.7
Community	21	10.5	21	10.5	42	10.5
Family	79	39.5	89	42.0	168	42.0

Table 1 analyzes responses to 7 questions of the psychometric scale for stigma plus 2 others. Each question and response was analyzed to determine the differences between females and males.

Analyzes responses to the statement, "I feel that people with HIV are often discriminated against." On this, 96% of female respondents <agreed + strongly agreed> with the question. Of the males, 91% <agreed + strongly agreed> to the question.

To the statement, "I worry about being treated differently because of my HIV status.", of the females, 91.5% <agree + strongly agree> with this. Of the males, 80% are <neutral + agree> with the statement. Therefore, females are more in agreement with the statement.

To the statement, "People often avoid me when they learn about my HIV status." 98.5% females responded <neutral + agree + strongly agree>. Of the males, 90.5% responded <neutral + agree>. Therefore, females are more in agreement with the statement.

To the statement, "I feel ashamed of my HIV status." 77.5% of the females, <agree + strongly agree> with this. Of the males, 76.5% are <neutral + agree> with the statement. Therefore, females are more in agreement with the statement.

To the statement, "I believe that society views people with HIV negatively." 99.5% of the females, (agree + strongly agree) with this. Of the males, 88.5% (agree + strongly

agree) with the statement. Therefore, females are more in agreement with the statement.

To the statement, "I have felt lonely because of my HIV status." 96.5% of the females are <neutral + agree + strongly agree> with this. Of the males, 88.5% <disagree + neutral> with the statement. Therefore, females are more in agreement with the statement.

To the statement, "I am concerned about disclosing my HIV status to others," 98.5% of the females <agree + strongly agree> with this. Of the males, 97% <agree + strongly agree> with the statement. Though a substantial proportion of both females and males are in agreement with the statement, females are more in disagreement.

To the question, "Have you experienced discrimination related to your HIV status?" 93.5% of the females and 92.0% of the males replied yes. Therefore, females are more in agreement with the statement.

To the statement, "In what settings have you experienced discrimination? The table shows that both females and males have experience discrimination similarly in diverse settings.

DISCUSSION

This study findings show that HIV-related stigma and prejudice still exist among people living with HIV in Owerri North Local Government Area. Both men and women reported stigma^[11], with women reporting

consistently higher levels of perceived, internalised, expected, and enacted stigma than males.

Almost all female respondents said that persons living with HIV are often discriminated against, and an overwhelming majority thought that society had negative attitudes towards people living with HIV.^[12] Similar tendencies were identified among male respondents, although the strength of these views was weaker. These results imply that HIV continues to be substantially related with social judgement and exclusion, despite greater awareness, wider access to treatment, and improved survival outcomes.^[13]

Women reported higher levels of fear of disclosure, guilt, and loneliness connected with their HIV status. These findings are in line with earlier studies in sub-Saharan Africa, where women have been found to incur a disproportionate cost of HIV-related stigma due to prevailing social norms around sexuality, marriage and reproduction. In many societies, women diagnosed with HIV may be blamed for bringing the infection into relationships, seen as morally irresponsible or regarded unsuited for marriage and childbearing.^[15] Thus, women are more able than men to internalise unfavourable social attitudes.

The study also found that discrimination was happening in many social settings including health institutions, family, job and community settings. The most common source of discrimination was family settings, closely followed by health care settings.^[16] This is especially troubling because family and health care providers are expected to serve as the primary sources of support for those living with HIV. Psychological distress, treatment adherence and health care utilisation are also affected by discrimination in these settings.^[17]

The documented high frequency of prejudice within the healthcare settings corroborates the findings from earlier Nigerian and African studies showing stigmatising attitudes among health care personnel. Such attitudes can be demonstrated through breaches of confidentiality, delays in treatment, differential care, inappropriate referrals, judgemental behaviour or refusal to offer services. Experiences of prejudice within health care settings may deter patients from attending clinics routinely, disclosing health issues, or adhering to long-term HIV care.^[18]

The observed gender discrepancies can be explained using the Health Belief Model, Gender and Power Theory and Intersectionality Theory. From these theoretical viewpoints, women are usually located in more vulnerable social situations, characterised by economic reliance, limited decision-making power and a greater susceptibility to social punishments. Consequently, women may perceive greater risks of HIV status disclosure and may experience more serious effects when stigma occurs.^[19]

Intersectionality theory further emphasises how HIV-related stigma intersects with other types of social disadvantage. Women living with HIV may face prejudice based on gender, marital status, economic vulnerability and social expectations at the same time. Vulnerabilities intersect in a way that compounds the psychological and social impacts of HIV stigma.^[20,21]

The data also indicate that stigma contributes significantly to the emotional suffering experienced by those living with HIV. Higher levels of stigma were associated with increased fears over disclosure, loneliness, and social isolation among respondents. HIV-related stigma has been associated consistently with sadness, anxiety, decreased self-esteem, poorer adherence to treatment and lower quality of life.^[22] Thus, stigma reduction should continue to be a key component of HIV care and support programs.

CONCLUSION

The results show that both men and women experience HIV-related stigma, but women are more affected. This gender difference underlines the need for gender-sensitive interventions that target the structural and social causes of stigma. Community education projects, stigma reduction campaigns, psychological support services, family-centred counselling, and health worker training are important techniques to eliminating discrimination and enhancing the wellbeing of persons living with HIV.

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