

Stigma and Discrimination- HIV and Aids Context: (A Case Study of University Community)

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Abstract- The study investigated the impact of HIV/AIDS related stigma and discrimination among Pwani University Community. The research design used was a baseline survey. To ensure equal representation, simple random sampling was done of 196 participants from nursing students department and academic and non-academic technical staffs who were on session during the long vacation. The Tools used to collect data included questionnaires, Focus Group Discussions and interview schedules. Both qualitative and quantitative data analysis methods were employed. The study established that members living with HIV infection suffer isolation, rejection and forms of non-physical abuse. The Rights of students to educational activities were found to be infringed through isolation and peer formations during practical and various student activities. Quite a number of interviewees had at least experienced or observed cases of HIV/AIDS related stigma and discrimination in their interaction with others within the university community. Study recommended intervention strides at three levels; individual, community and organization but concluded that individual responsibility and positive perception was key in coping in a stigmatized environments to help build self esteem which may reduce discrimination mind set in individuals.

Index Terms- HIV and AIDS, Stigma and discrimination, behavior change, university community.

I. INTRODUCTION

Stigma has been perceived as a social construct long before Goffman (1963) provided a concrete definition. However, in his book *Stigma: Notes on the management of spoiled identity*, Goffman (1963) defined stigma as “an attribute that is deeply discrediting”. Therefore, an individual possessing a characteristic that appears different may be considered undesirable in the eyes of the society, particularly when the person is perceived as “bad, or dangerous, or weak.” Consequently, the person with this attribute is “reduced in our mind from a whole and usual person to a tainted, discounted one” (Goffman, 1963).

Apparently, since the onset of Human Immunodeficiency Virus (HIV) and Acquired Immunodeficiency Syndrome (AIDS) in Kenya in the 1980s, a similar social construction of stigma has been directed at People Living with HIV and /AIDS (PLWHA), who by virtue of possessing HIV or AIDS are perceived to be different, and therefore undesirable. Owing to their HIV/AIDS status, PLWHA have often been associated with immorality and other demeaning behavior and practices in society. This perceived “difference has been manifested in various acts of discrimination that often accompanies stigma, thereafter directed

towards specific groups or individuals, who are perceived to be living with HIV/AIDS” (Parker & Aggleton, 2003).

Stigma and discrimination of PLWHA is exacerbated by ignorance about the disease, misconceptions about how HIV is transmitted, limited access to treatment, irresponsible media reporting, incurability of the disease and fears and prejudices relating to socially sensitive issues, including sexuality (www.avert.org). These differences in perception hinge on the belief that HIV virus is a life-threatening disease, with the commonly held view by the society that “PLWHA are sometimes perceived as invasive agents in a healthy society” (Sontag cited in Varas-Diaz et al., 2005, p. 170). These social differences have evoked various forms of negative treatment including social exclusion, rejection and denial of much needed support from members of a given community who should support one another.

It is worth noting that White, & Carr, (2005) attested to the fact that AIDS stigma and discrimination have severe consequences on the physical, emotional and psychological well-being of PLWHA. Consequently, stigma and discrimination negatively affect how well PLWHA adapt to the disease and adjust to their status, thus making them susceptible to further stigmatization and affects their psychological well-being.

Governments and stakeholders including the universities have taken stringent measures to reduce the spread of HIV and decrease stigma and discrimination. In these efforts, Pwani University has initiated and implemented a policy on HIV to safeguard educational programmes that involve PLWHA as a way of creating awareness, clarifying misconceptions and providing accurate information about HIV/AIDS in order to facilitate positive attitude and acceptance of PLWHA in the institution. The present survey therefore sought to evaluate the extent to which stigma and discrimination is felt and practiced among members of the Pwani University community with a view to mitigate the problem.

Study Objectives

The Specific objectives of the survey were to:

1. Establish stigma and discrimination prevalence rate within the University
2. Find out the root causes of stigma and discrimination.
3. Assess the effect of stigma and discrimination.
4. Identify and recommend strategies on stigma and discrimination mitigation

Statement of the Problem

The VCT clinic data surveillance report retrieved from District Aids and STI Control Office Kilifi (MOH, DASCO Kilifi report, 2013) revealed that Pwani University HIV

prevalence rate was at 1.2% among a population of about 3500, (DASCO, 2013). The Coast Province HIV prevalence rate stood at 8%, while the national prevalence rate was at 5.6%. Despite concerted efforts by the government and National AIDS Control Council (NACC) towards HIV and AIDS prevention, reports on stigma and discrimination experiences were high at 67% in almost monthly returns. This reports necessitated the need for this study and mitigation strategies.

II. METHODOLOGY

The study employed a cross-sectional survey design among a sample population of 196 from a total population of about 3500. Pilot study was conducted for validity and reliability of the study instruments. Data was collected using interviews with key informants, Focus Group Discussions, structured Interview Schedules and document analysis as secondary data. Purposive sampling technique was used to cover all student nurses who were on session while simple random sampling technique covered the staff who were equally on session. The sample size

was calculated using the Krejcie & Morgan, (2004) formula for sample size calculation. The calculation was obtained at 95% confidence level with a margin of error of 5%. Qualitative and quantitative data analysis technique was used to analyze data. Quantitative data from structured survey interviews with open ended responses were coded. Data was then entered into the computer using the Statistical Package for Social Sciences (SPSS) program. Frequency tables, descriptive statistics, graphs and charts were used to present the findings.

III. RESULTS AND DISCUSSIONS

Prevalence Rate of Stigma and Discrimination among the University Community

The HIV prevalence rate was at 1.2% among a population of about 3500. This population of PLWHA perceived stigma and discrimination from those they interacted with almost at 74%. For example, students and staff reported cases of having witnessed colleagues or fellow students discriminated against each other.

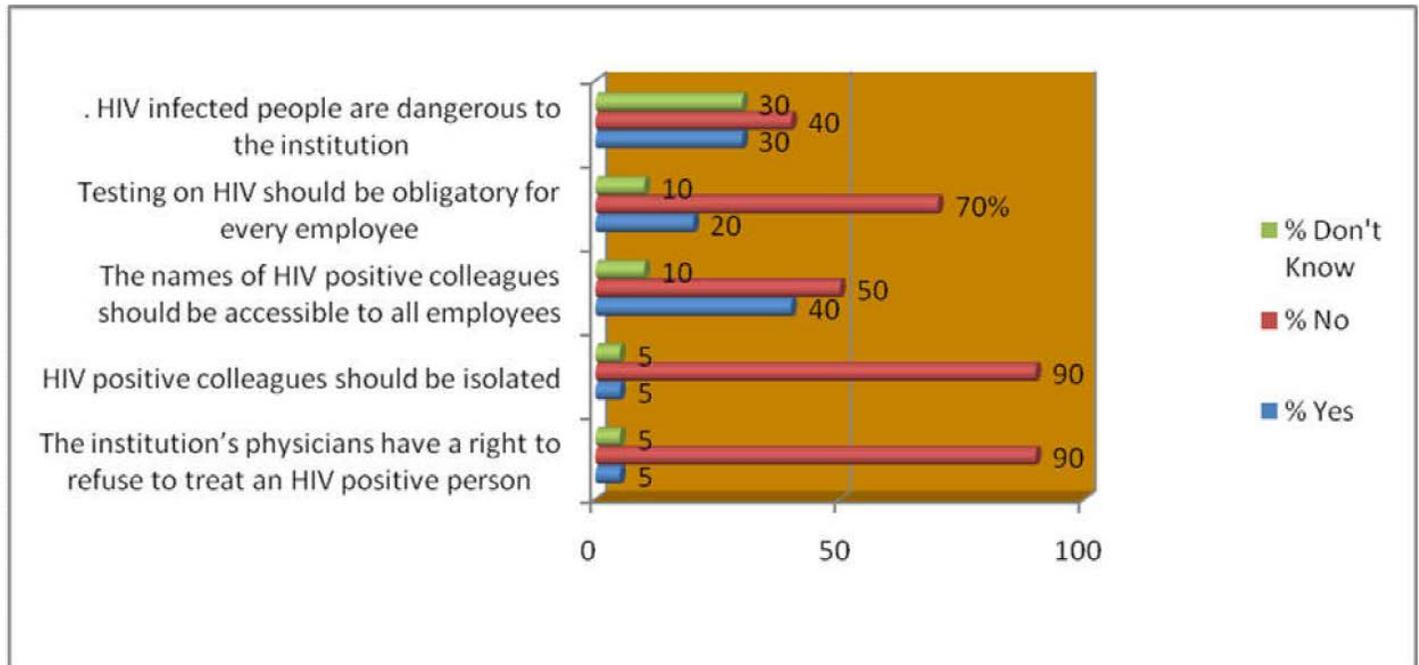


Figure 1.0: Attitude about HIV Positive Members of staff

From Figure 1.0, the degree of discrimination is very clear from how people perceive those suffering from HIV infection. 90% of the participants were of the opinion that HIV positive people should be isolated from non positives at work place and

the university's physician has a right to refuse to attend to them. 70% suggested that testing for HIV status among the working staff should be an obligatory exercise done to all workers.

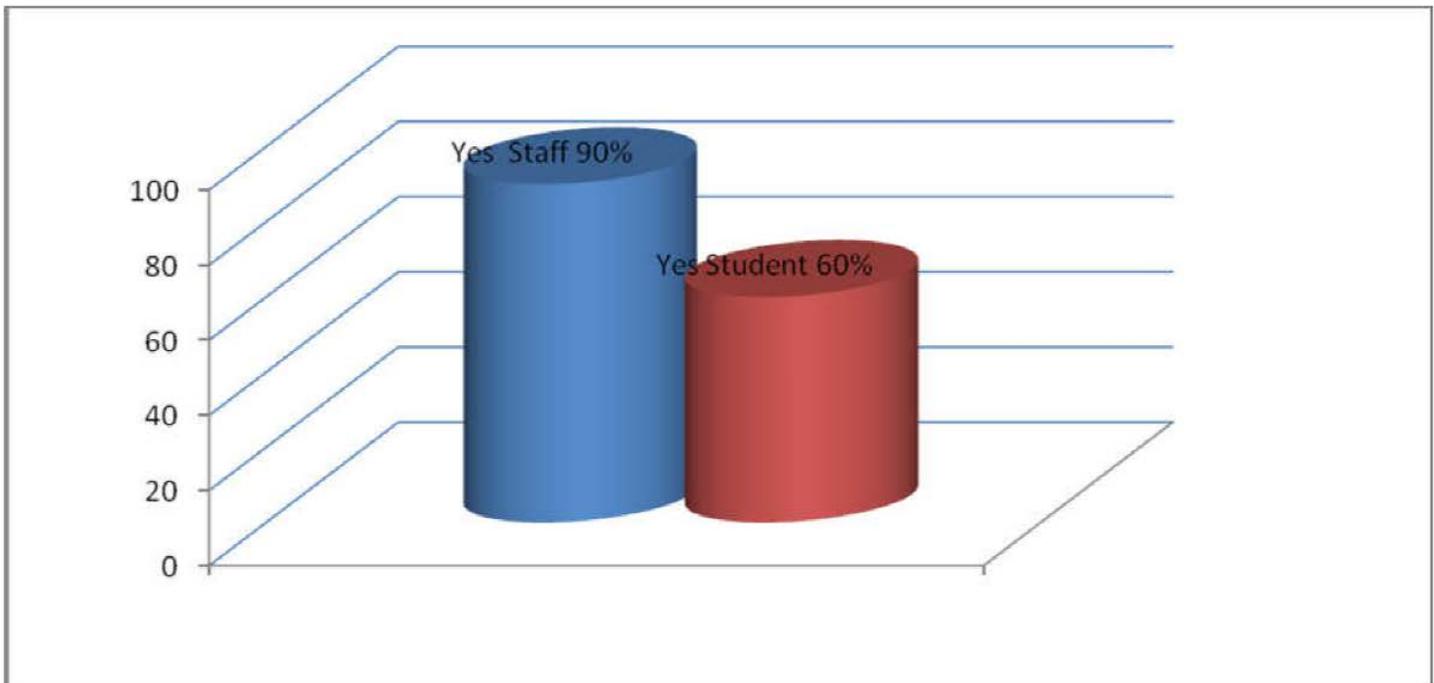


Figure 2.0: Association with HIV Positive People or Friends

Figure 2 revealed that 90% of staff felt that they found it most hard to associate with HIV positive people while 60 % of students were also of the same opinion. Though to some extent,

fear was not observed among the student’s nurses on the association as much as it was among the staff, probably due to their medical background.

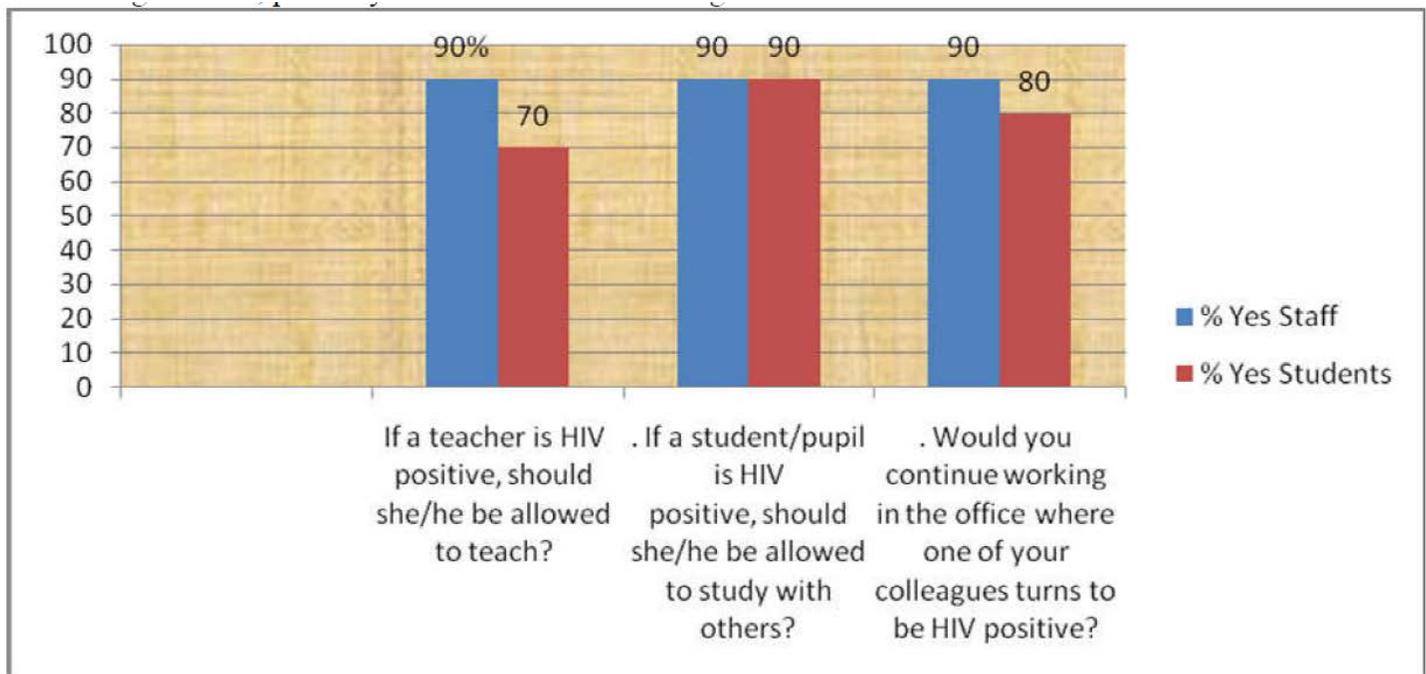


Figure 3.0: Interaction with HIV positive student/teacher

Figure 3.0 revealed the level of interaction with those suffering from HIV infection. 90% of staff agreed that the lecturer who is HIV positive should just be allowed to teach, both staff and students consented that students should be allowed to study despite their HIV status and they also embraced positively

that they could work or study with whoever happened to turn HIV positive in the course of work or study. This results report mixed feelings from participants. In figure 2.0, the study revealed that participants found it most difficult to work with those infected with HIV virus but on the other hand, they don’t mind them continuing to work in their jurisdiction of duty. This

implies that, the individual participant views those infected but and there is no individual contacts. happen to be their colleagues as distant from personal interaction

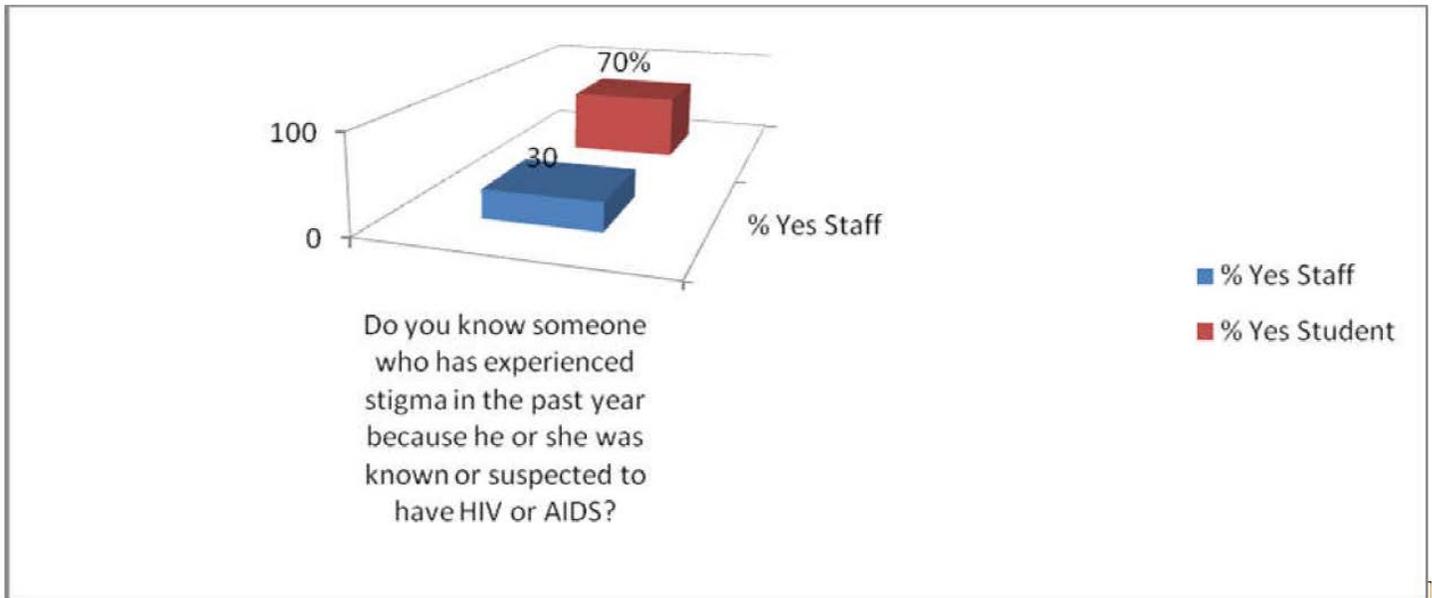


Figure 4.0 : Knowledge of stigma and discrimination at work place

Figure 4.0 reveals the reality of stigma and discrimination practices among the university community. 70% admitted to have experienced stigma because of being suspected by fellow colleagues to have HIV virus. At the health clinic, results shows that people experience stigma and discrimination even more. According to the participants opinion and perception, if client is suspected to suffer HIV infection, then from figure 5.0 results,

majority felt that the clients received less care and attention than other patients, extra precaution to treat them was taken when they are being handled such as use of gloves, even HIV test is performed without their consent and health providers gossip about the clients.

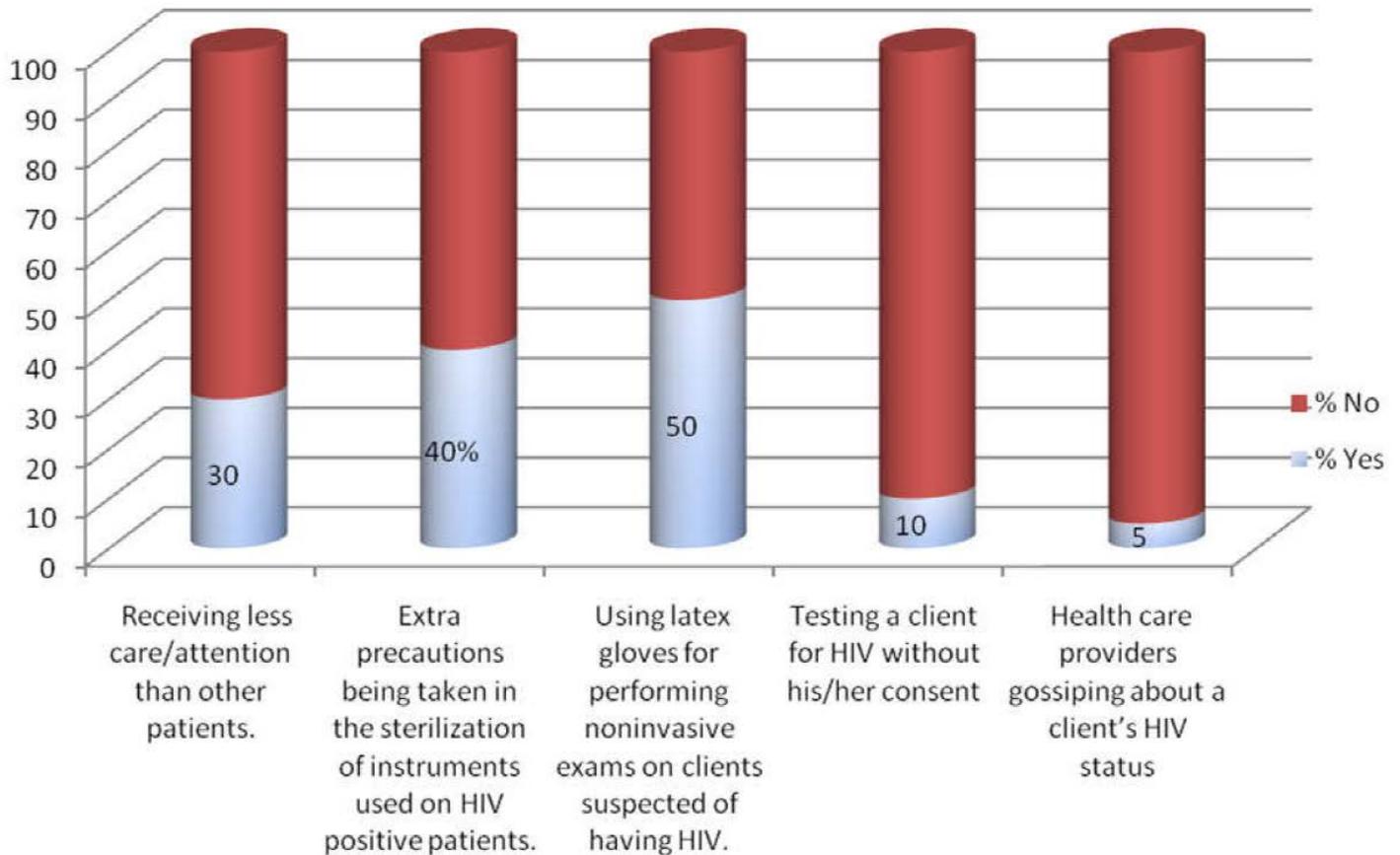


Figure 5.0: Observation from the health unit.

Most members of the University community consented that they would not disclose their HIV status to any one at all cost. This was due to stigma and discrimination. Figure 6.0 below results revealed that participants were most at ease with the medical personnel's the physician, friends and relative but very

low to a sexual partner. This implied the causes of high HIV infection prevalence increase among the married couples (KAIS, 2012). See response from figure 6.0 and 7.0 below. Some reasons which makes people not disclose their HIV status include shame 40% fear 40% and violation of rights 20%

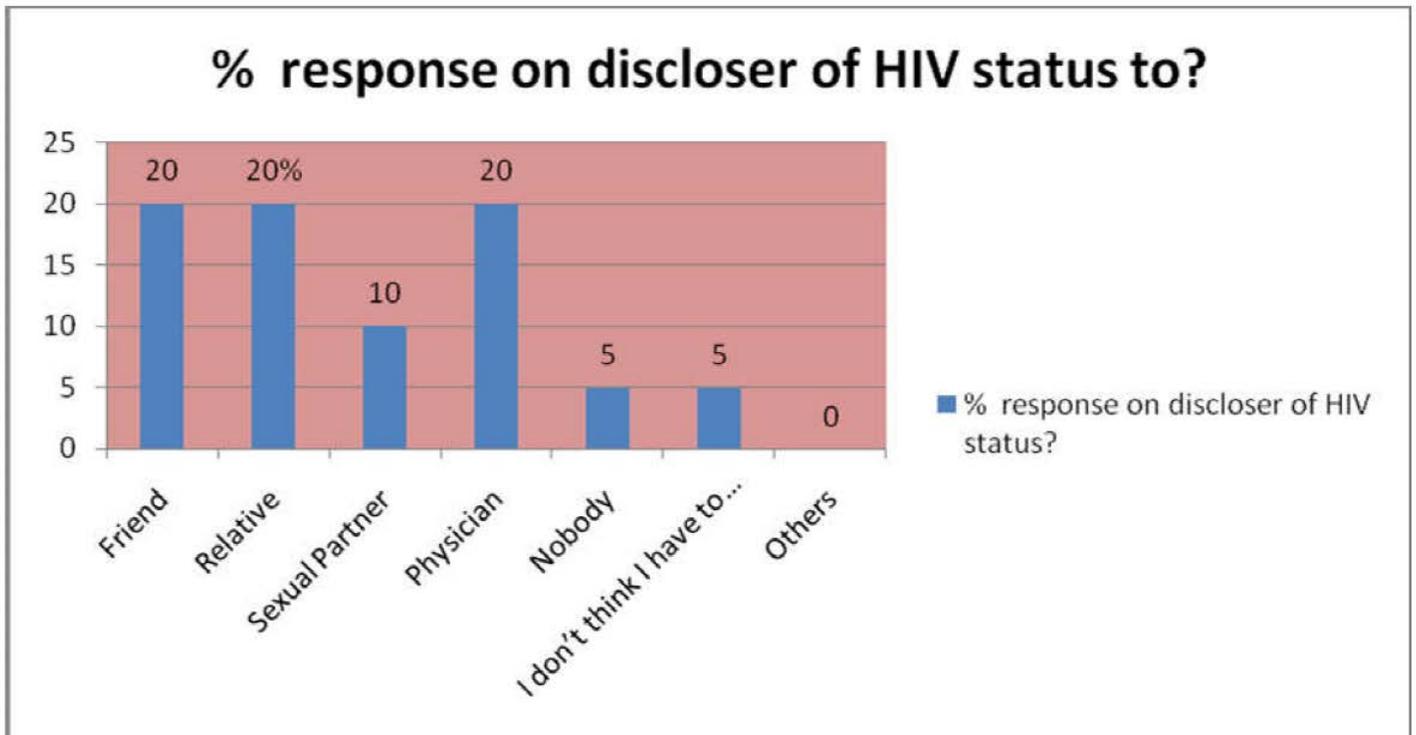


Figure 6.0: Disclosure of HIV Status to Different People

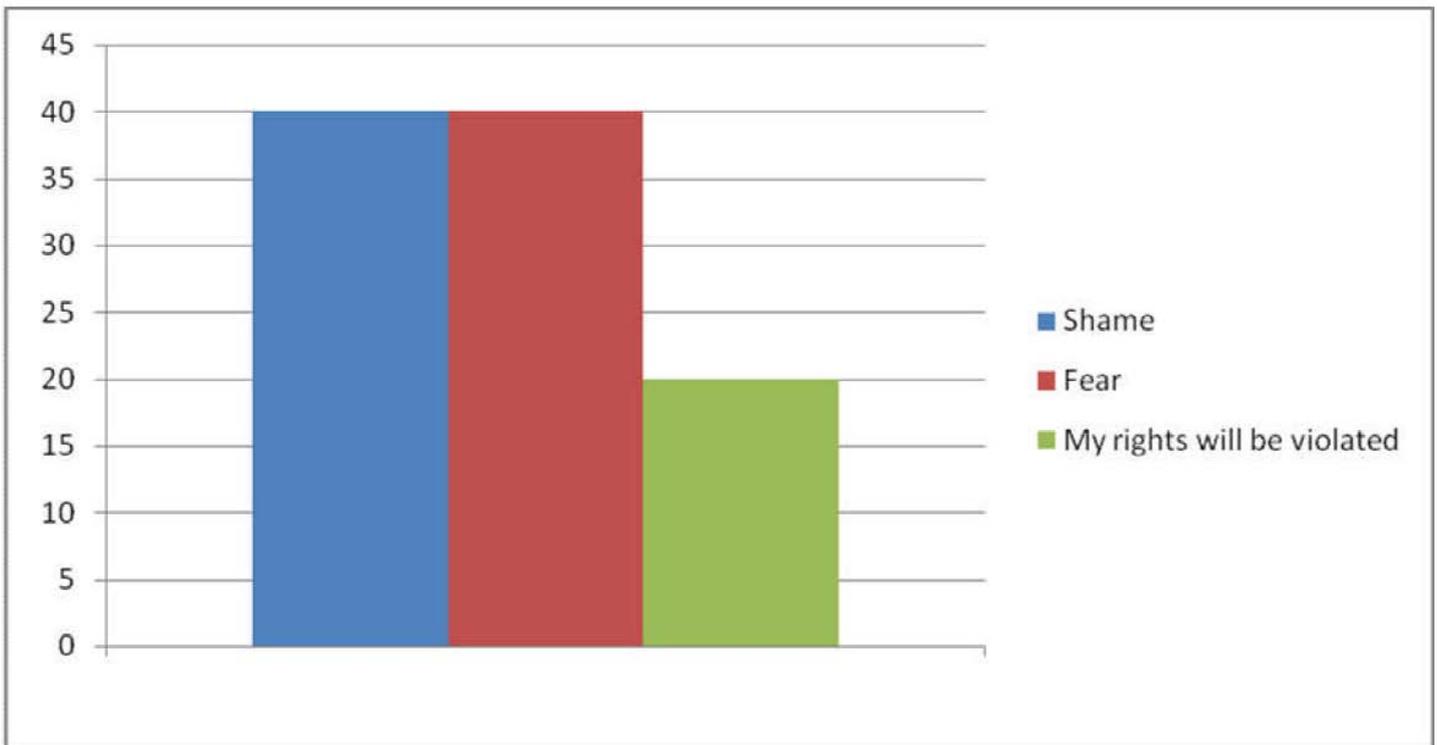


Figure 7.0: Reasons for not disclosing Status

Objective Two: To establish the Root Causes of Stigma and Discrimination

From the focused group discussions, the following reasons emerged as the root causes of stigma and discrimination; Fear, HIV infection, a disease being associated with sex, prostitution,

drugs use and punishment from God. Others felt that, the side effect of ARVs was disgusting experience. Some people gained questionable weight all over sudden with unpleasant appearances. It makes people form opinions about the individuals. Religious beliefs and moral judgment were also causes cited as causes of stigma and discrimination. This is

because religion places standards on humanity hence the need to follow strict codes of conducts and therefore associating HIV and AIDS with immorality. Society's perception is quite indifferent on HIV and AIDS effects on individuals. Certain practices scored

highly as the major causes of stigma and discrimination as shown in the Table 2.0 and 3.0.

Table 1.0: Percentage Score for Causes of Stigma

S/No.	Causes of Stigma	Percentage Score (%)
1	Association with certain lifestyles	60%
2	Societal Value systems and norms	20%
3	Religious beliefs and moral judgment	20%

Table 2.0: Lifestyle Scores

S/No.	Lifestyles	Percentage Score (%)
1	Unprotected sex by commercial sex workers, truck drivers, the youth and married couples	70%
2	Men Who Have Sex with Men, Rape, Inject able Drug Users, Anal Sex	25%
3	Contact with contaminated blood through accidental handling	05%

Objective Three: Effect of stigma and discrimination among University community

Interviewees showed mixed reactions on how PLWHA are treated. Figure 8.0 revealed the varied treatment experienced by HIV positive people.

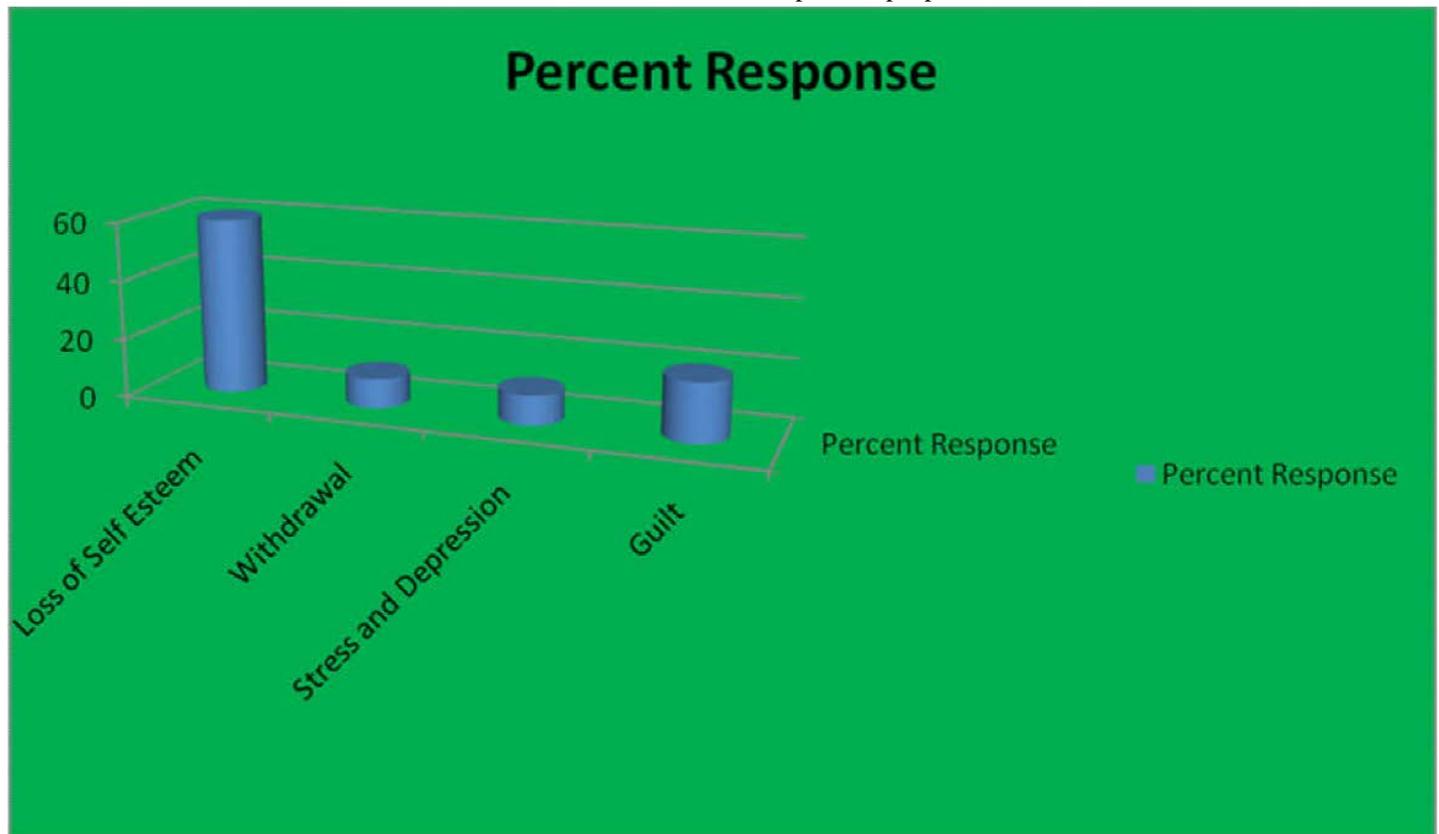


Figure 8.0: Effect of Stigma and Discrimination on Staff

The study established that loss of self esteem 59% was one of the worst effects of stigma and discrimination among others such as guilt 20% withdrawal 11%, stress and depression 10%.

The stigmatized groups are therefore not in a position to defend themselves as they are robbed of the energy and their self worth.

Other effects of stigma and discrimination which were highlighted included; constant fear, loneliness and rejection, under production, loss of jobs, suicide attempts as well as alcohol and drug abuse dependency. Those who are stigmatized feel discouraged, unwanted or rejected stressed and depressed as supported in Castro, 2005 study. Such people are usually bitter,

demoralized, and suicidal and often develop negative attitudes towards others as contended in Deacons, (2006) study. Some related stigma and discrimination experiences were also pointed out to include being gossiped about in gatherings, abandoned by spouse among other factors as was pointed out in Table 1.0.

Table 3.0: Other Sigma and Discrimination Related Experiences

S/N	Experiences	% No	% Yes
1	Been excluded from a social gathering.	80	20
2	Been isolated in class or abandoned by classmates	70	30
3	Been abandoned by spouse/partner.	40	60
4	Been isolated by colleagues and friends	50	50
5	Had a health care worker refuse to treat /denied access to medical treatment or care.	90	10
6	Forced to pay additional charges for medical services (e.g., dental care, surgery).	80	20
7	Lost or been denied private insurance.	90	10
8	Been forced to change place of residence because of being HIV-positive.	40	50

Objective Four: To establish strategies on stigma and discrimination prevention

The participants suggested the following strategies to reduce stigma and discrimination in the focused group discussion. That the response could be handled at three different levels. These included;

i) Personal Level

That is taking personal responsibility to seek correct information, access psycho-social support group, change psychological mindset and separate HIV infection from death. Change individual life style and healthy habits which could bring about longevity.

ii) Strategies at Community Level

Continuous education and awareness creation was key to discourage cultural practices related to HIV infection such as sleeping with a virgin or a baby cures one from HIV infection, addressing issues on Prevention of Mother to Child Transmission (PMTCT), provide quick referral services and getting rid of myths

iii) Institutional Levels

This involves availing the right education or information to members of the institution, hence creating awareness among the students and staff. Giving support to those affected and infected and giving knowledge on healthy living or living with HIV/AIDS positively.

Other institutional strategies suggested included, a policy on non discrimination of PLWA, putting in strict measures on those who discriminate others, empowering people living with HIV and AIDs in positions of leadership and establishing legal mechanisms to address issues related to stigma and discrimination.

One limitation in this study was noted to be the selection biased. The students who participated in this study were all medical students who are familiar with HIV issues and therefore their perception may not adequately represent all the university students' opinion. Similarly, most members of staff were also on leave even though accurate sampling procedure was used upon those who were on session.

The study confirms other studies (Goffman 1963; Parker 2003; Varas-Diaz et al 2005 and White 2005) that discrimination fuels anxiety and prejudice against groups most affected, as well as those living with HIV or AIDS. It goes without saying that HIV and AIDS are as much about social phenomena as they are about biological and medical concerns. Across the world the global epidemic of HIV/AIDS has shown itself capable of triggering responses of compassion, solidarity and support, bringing out the best in people, their families and communities on the other hand, the disease is also associated with stigma, repression and discrimination, as individuals affected. This rejection cuts across the world, the rich countries and poorer nations of Africa in the South, Uganda and more closer- Kenya, around the lake regions where prevalence remains high (11% regional distribution - KAIS 2012).

Students scored highly on knowledge of people living with HIV and AIDS. This was probably due to the medical background of the participants whose orientation had a positive impact in terms of attitude towards the disease, the affected and the infected population. The staff had a lower score perhaps due to their style of interaction. However, despite the levels of academic individual may poses, study reveal that stigma exists among the university population. Stigma can be a powerful tool of social control as was observed by (Gostin & Lazzarini, 1997). This is seen not only in the manner in which such groups are denied access to the services and treatment as revealed in this study but the participants perception on social interactions with PLWHA.

IV Discussions:

On the other hand, disclosure to friends, relative and physician showed mixed reactions on disclosure to sexual partner. A small percentage of respondents would not want to keep their HIV status secretive. This means intervention strategies should take into consideration the disclosure categories. If infected people shy away from seeking counseling services and getting relevant drugs, then reduction of HIV infection remains a milestone of achievements (UNAIDS report 2014).

V Conclusion

A comprehensive package of interventions, tailored to the local context with the university environments for different categories of groupings may address the multiple causes of stigma and discrimination identified in the study. Personal responsibility is key in individual's liberations towards discrimination more than stigma. Further studies is necessary

VI Recommendations

The study recommended;

1. Creation of an enabling environment for interaction but with increase of sensitization on the negative impacts of stigma and discrimination among University Communities.
2. Other activities should include participatory methods such as quality discussions on the betterment of human improvement as opposed to stereotyping cultural perception on such issues.
3. Provision of VCT clinics, to enhance greater understanding in effects of stigma and discrimination to individuals

4. More training for all categories of staff and students on stigma and discrimination
- Further researches on prevention strategies.

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