THE STIGMA OF BEING HIV PATIENTS IN NORTH CENTRAL NIGERIA: SOCIO-ECONOMIC AND CULTURAL FACTORS

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THE STIGMA OF BEING HIV PATIENTS IN NORTH CENTRAL NIGERIA: SOCIO-ECONOMIC AND CULTURAL FACTORS

by

NALAH AUGUSTINE BALA

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LIST OF ABBREVIATIONS

ABC	Abstinence, Being Faithful, and Using Condoms
AIDS	Acquired Immunodeficiency Syndrome
AIHA	American International Health Alliance
APA	American Psychological Association
ART	Anti-Retroviral Treatment/Therapy
ARV	Anti-Retro-Viral
BBC	British Broadcasting Corporation
CAQDAS	Computer-Assisted Qualitative Data Analysis Software
CBHG	Community-Based HIV Groups
CBT	Cognitive Behavioral Therapy
CCA	Community Cultural Associations
CDC	Centers for Disease Control and Prevention
CDCC	Computer Data Capturing Card
CFM	Close Family Members
CHEW	Community Health Extension Workers
CSOs	Civil Society Organizations
CYPA	Children and Young Persons Act
DASH	Dalhatu Araf Specialists Hospital
DFID	Department for International Development
FCT	Federal Capital Territory
FGM	Female Genital Mutilation
FLHE	Family Life and HIV Education
FMC	Federal Medical Centers
FMOE	Federal Ministry of Education
FST	Female Sex Traders

GHA	General Hospitals Akwanga
HAART	Highly Active Antiretroviral Therapy
HCP	Health Care Providers
HCWs	Health Care Workers
HEAP	HIV/AIDS Emergency Action Plan
HIV	Human Immunodeficiency Virus
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
HND	Higher National Diploma
IAS	International AIDS Society
ICD	International Condom Day
IDP	Internally Displaced Persons
IMF	International Monetary Fund
INGOs	International Non-Governmental Organizations
IRBC	Immigration and Refugee Board of Canada
JAAADS	Journalists Against AIDS Nigeria
LGA	Local Government Area
LGBT	Lesbian, Gay, Bisexual, and Transgender
MSM	Men who have Sex with other Men
MTCT	Mother-To-Child Transmission
NACA	National Agency for the Control of AIDS
NACAs	National Action Committee on HIV/AIDS
NARHS	National HIV/AIDS Reproductive Health Survey
NBHAAD	National Black HIV/AIDS Awareness Day
NBS	National Bureau of Statistics
NCE	National Certificate in Education
NGOs	Non-Governmental Organizations

NHAAD	National HIV/AIDS and Aging Awareness Day
NHREC	National Health Research Ethics Committee
NIH	National Institute of Health
NSP	National HIV/AIDS Strategic Plan
NWGHAAD	National Women and Girls HIV/AIDS Awareness Day
NYHAAD	National Youth HIV and AIDS Awareness Day
OVC	Orphans and Vulnerable Children
PCA	Presidential Council on AIDS
PEPFAR	President's Emergency Funds for AIDS Relief
PHC	Primary Health Care
PI	Principal Investigation
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission
RVF	Recto-Vaginal-Fistula
SDGs	Sustainable Development Goals
SES	Socio-Economic Status
SMOH	State Ministry of Health Lafia
SSS	Social Support System
STDs	Sexual Transmitted Diseases
STEER	Systems Transformed for Empowered Action and Enabling Responses for Vulnerable Children and Families
STIs	Sexual Transmitted Infections
THIS	Twinning for Health Support Initiative Nigeria
UAA	United Against AIDS
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV and AIDS
UNESCO	United Nations Educational, Scientific and Cultural organization

UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations International Children's Emergency Fund
USD	United State Dollar
USM	Universiti Sains Malaysia
UTIs	Urinary Tract Infections
VCT	Voluntary Counselling Therapy
VVF	Vesico-Vaginal-Fistula
WEF	World Economic Forum
WENR	World Education News and Review
WHO	World Health organization

LIST OF APPENDICES

STIGMA SEBAGAI PESAKIT HIV DI UTARA TENGAH NIGERIA: FAKTOR-FAKTOR SOSIOEKONOMI DAN BUDAYA

ABSTRAK

Stigma HIV terdiri daripada sikap diskriminatif dan tidak berperikemanusiaan yang dialami oleh pesakit HIV, sehingga mempengaruhi kesejahteraan sosial, fizikal, mental dan psikologi. Kajian ini bertujuan memberikan analisis deskriptif terperinci mengenai pengaruh pemboleh ubah sosiodemografi seperti sosiobudaya, sosioekonomi, pendidikan, agama dan ketaksamarataan gender sebagai faktor-faktor penentu stigma terhadap pesakit HIV. Kajian ini menumpukan pada pesakit luar yang didiagnosis dan dimasukkan ke dalam wad dari hospital terpilih iaitu Pusat Kesihatan Persekutuan Keffi (FMC), Hospital Besar Akwanga (GHA) dan Hospital Pakar Dalhatu Araf, Lafia (DASH) yang dikhaskan untuk penjagaan pesakit HIV di negeri Nasarawa, Utara Tengah Nigeria. Sampel kajian terdiri daripada remaja lelaki dan perempuan berumur 18 tahun yang telah distigma sebagai pesakit HIV dan bersetuju menyertai kajian. Kajian eksplorasi dan kualitatif ini mengadaptasi teknik persampelan bukan rawak iaitu kaedah persampelan bertujuan dengan memilih 20 sampel dari hospital-hospital terpilih untuk menangani kes-kes HIV di negeri Nasarawa, Utara Tengah Nigeria. Proses pengumpulan data menggunakan teknik temu bual mendalam menerusi rakaman audio dan catatan lapangan. Perisian Analisis Data Kualitatif Berkomputer (CAQDAS) menerusi ATLAS.ti8 digunakan untuk menganalisis data tidak berstruktur melalui rakaman audio, nota catatan dan lain-lain data lapangan. Perisian ATLAS.ti8 menganalisis dan mengekod transkrip temu bual secara sistematik dengan menukar, mengtranskrip dan mempersembahkan data kepada bentuk teks menerusi analisis tematik. Data yang dikod dipersembahkan secara grafik

menggunakan analisis jaringan tematik untuk memaparkan tema, subtema dan petikan kata-kata menerusi reka bentuk model psikososial stigma HIV berdasarkan hasil kajian. Hasil kajian menunjukkan patriarki dan poligami adalah kunci pemboleh ubah sosio-budaya yang menyumbang kepada stigma terhadap pesakit HIV, contohnya ketaksamarataan gender, penolakan sosial dan amalan budaya tidak sihat seperti pemotongan alat kelamin wanita dan hubungan seks semasa haid tanpa perlindungan sebagai perjanjian darah. Hasil kajian juga menemukan bahawa sesetengah ibu bapa menggalakkan perkahwinan bawah umur bagi anak perempuan dan hubungan tidak matang akibat daripada kadar kemiskinan yang tinggi, malnutrisi, buta huruf, kekurangan makanan, ketidakseimbangan ekonomi dan status sosioekonomi yang rendah. Selain itu, kajian ini juga mendapati bahawa remaja perempuan dan wanita takut untuk mendedahkan status HIV, penceraian, penderaan seksual dan perkahwinan paksa berikutan ketaksamaan gender, seterusnya meningkatkan lagi stigma dan jangkitan HIV. Kajian ini mencadangkan agar pekerja sosial dan saintis tingkah laku menggunakan strategi intervensi tingkah laku termasuk sokongan sosial, mekanisme daya tindak, latihan kemahiran vokasional, melatih pekerja kesihatan, dan menjalankan kempen kesedaran awam terhadap stigma dan HIV/AIDS.

THE STIGMA OF BEING HIV PATIENTS IN NORTH CENTRAL NIGERIA: SOCIO-ECONOMIC AND CULTURAL FACTORS

ABSTRACT

HIV stigma constitutes a discriminatory and dehumanizing attitude experienced by HIV patients, affecting the social, physical, mental, and psychological well-being. This study aims to provide a detailed descriptive analysis of the influence of socio-demographic variables like socio-cultural, socioeconomic, education, religion, and gender inequality as determinants of the stigma of being HIV patients. The population centered on diagnosed and admitted outpatients from selected Federal Medical Centers (FMC) Keffi, General Hospitals Akwanga (GHA), and Dalhatu Araf Specialists Hospital (DASH) Lafia, all designated for the HIV care across Nasarawa State, North Central Nigeria. The sample comprises male and female aged 18 consented to be stigmatized for being HIV patients. In this qualitative phenomenological based study, a non-randomize technique using a purposive sampling technique to select 20 samples from hospitals designated to handling HIV cases in Nasarawa State, North Central Nigeria. Data collection utilized an in-depth face to face interview using an audio recorder and field notes. A Computer-Assisted Qualitative Data Analysis Software (CAQDAS) using ATLAS.ti8 to analyze the unstructured data collected through audiotape, note-taking, and all other field data. The ATLAS.ti8 analyzes and code interview transcripts by systematically converting, transcribing, and presenting data into a textual form using thematic analysis. The coded data were presented graphically through thematic network analysis to visualize the themes, sub-themes, and quotations by designing the psychosocial model of HIV stigma from the findings. The findings indicate that the patriarchal and polygamous

are key socio-cultural variables contributing to the stigma of being HIV patients by encouraging gender inequality, social rejection, and harmful cultural practices such as female genital mutilation, and sexual intercourse during menstruation without protection as blood covenant. Also, the finding found that some parents encourage girl-child early marriage and premature relationships due to a high poverty rate, malnutrition, illiteracy, food insecurity, economic inequality, and low socioeconomic status. The finding also indicates the perceived fear of disclosing HIV status, divorce, sexual violence, and forced marriage among young girls and women due to gender inequality, thereby increase stigmatization and HIV infection. The study recommends that the social workers and behavioral scientists employ behavioral-based intervention strategies including social support, coping mechanisms, vocational skills training, training health personnel, public awareness campaigns against stigmatization and HIV/AIDS.

CHAPTER 1

INTRODUCTION

1.1 Background of the Study

The Human Immunodeficiency Virus (HIV) is an infected disease that damage and sabotage the effective functioning of the human organ responsible for protecting infection from attacking the human body. The presence of HIV disease in the human body system creates a range of conditions that caused severe loss of body fluids leading to a more complicated situation called Acquired Immunodeficiency Syndrome (AIDS). Bhatti, Usman, & Kandi (2016) maintained that medical science had provided medications on Anti-Retro-Viral (ARV) drugs for the control and treatment of infection of HIV. However, ARV medications have not been effective due to the psychosocial problem of stigmatization among people living with HIV/AIDS.

Stigmatization is a challenging psychosocial problem affecting the smooth health care services of people living with HIV/AIDS (PLWHA). HIV/AIDS is transmitted through vertical or Mother-To-Child Transmission (MTCT), unprotected Sex by female sex traders (FST), Men who have Sex with other Men (MSM), and people who inject drugs (Shaw & Hunter, 2012). HIV stigma deteriorates the physical, mental, and social well-being. Medical health has been useful in providing medical treatment to sustain the human immune system against HIV (Oyekale, 2017). HIV stigma is influenced and determined by the socio-cultural, socio-economic, educational, and religious factors (Walcott, Kempf, Merlin, & Turan, 2016). However, the general quality of life of HIV patients requires medical treatment and psychological services to determine the patients' physical and mental health (Thurman, Kidman, Carton, & Chiroro, 2016).

Stigma and discrimination are negative perceptions that are fighting against the quality of life of HIV patients. The culture influences the individual, educational, economic, religious, and political system that collaborates in sustaining every member of the city (Addo-Atuah & Lundmark, 2015; Kontomanolis, Michlopoulos, Gkasdaris, & Fasoulakis, 2017). Okorie (2017) asserts that women were restricted from attending formal education and asking questions about their husbands' health status. In a study, King (2016) confirmed that in most communities, women are under locked and control with total restriction from going outside or possibly going to attain formal education. According to Saadat, Behboodi, and Saadat (2015), the health problems necessitated male and female victims to develop depression and anxiety. Adeloye et al. (2017) added, deteriorating health problems occur due to frustration, discrimination, rejection, and stigmatization by members of the community, including Close Family Members (CFM), Healthcare Providers (HCP), and place of work and schools.

Globally, Nigeria, as an HIV prevalence of 3.2%, is a country with the second-largest population of 3.4 million PLWHA, among whom 30% were accessing ARV (Awofala & Ogundele, 2018). The HIV prevalence in Nigeria increased drastically in 2016 with the most prevalence population of sex workers 14.4%, men who sleep with men 23%, and people who inject drugs 3.4%. Nigeria’s epidemic is generalized with prevalence across the country. In 2012, the prevalence data analysis of the National HIV/AIDS Reproductive Health Survey (NARHS) across the six geopolitical zones showed that the incidence is an increase of 5.5% to the South-South and decrease of 1.8% to the South East Zone (NACA, 2014).

Recently, as shown in Table 1.1, the UNAIDS (2018) distribution of new HIV infections and AIDS-related deaths by countries of the western and central Africa revealed Nigeria to be accounted for 55% new HIV infections and 53% HIV-related

deaths. As shown in Figure 1.1, Nigeria accounted for more than half of AIDS-related death across western and eastern African countries in 2018 (UNAIDS, 2018a). A study by the National HIV/AIDS Strategic Plan (NSP, 2015) from 2010 to 2015 recorded that HIV stigma influenced the spread of HIV/AIDS (National Bureau of Statistics [NBS], 2014). Also, according to the Director-General, National Agency for the Control of AIDS, Dr. Sani Aliyu, about 1.1 million people in Nigeria are receiving antiretroviral drugs as of October (UNAIDS, 2018a). HIV stigma and discrimination do not only hinder the chances of prevention options for early detection and treatment; it increases vulnerability to exposure and possibly death in most cases of concealments of HIV positive status (Odimegwu, Alabi, Wet, & Akinyemi, 2018).

The Nigerian government, however, has set up multi-sectoral strategies to handling the rising incidence of HIV and provide treatment options for the PLWHA who require health care services and most importantly by aggressively implementing treatment as a prevention option (Odimegwu, Akinyemi, & Alabi, 2017; Oladele et al., 2018). PLWHA now accesses Anti-Retroviral Treatment/Therapy (ART), and fewer babies are being born with HIV thanks to the innovation of the Prevention of Mother to Child Transmission (PMTCT) and technologies. This scientific invention has clear the risk for children of HIV positive mothers from being infected with HIV during pregnancy, labor, delivery, and breastfeeding (Kassa, 2018).

Table 1.1 AIDS-related death by country, western and central Africa

Country	**HIV Prevalence**
Central African Republic	1
Congo	2
Togo	2
Mali	2
Guinea	2
Ghana	6
Democratic Republic of Congo	6
Cameroon	8
Rest of the region	9
Cote d'Ivoire	9
Nigeria	53

Source: UNAIDS 2018 Estimate

HIV stigma continues to deteriorate the health and psychological well-being of HIV positive persons. Nnko et al (2019) wrote on the fear of stigma and HIV testing as a determinant factor to efficient HIV treatment, and supported by Chan, Operario, and Mak (2020). The global initiative suggested an increased Antiretroviral Therapy among PLWHA, which demonstrated a tremendously positive influence on the treatment response (Oladele et al., 2018). Another survey on the increased ART on HIV positive mothers revealed an advanced modification of antiretroviral drugs for the prevention of mother to child transmission of HIV during pregnancy, labor, delivery, and breastfeeding (Black et al., 2013; Oyeledun et al., 2017). The international community gained recognition for effective healthcare interventions against HIV stigma (UN, 2005).

Additionally, the global strategic program for the challenges of PLWHA was initiated with a 90% agenda to reduce the prevalence of HIV/AIDS infection (WHO, 2018). Its objective was to decrease the risk factor of HIV death by 80% in 2010. Also, it targeted zero HIV/AIDS (UNAIDS, 2016). Though Nigeria signed into law in 2014 the Anti-Discrimination Acts, however, Nigeria needs to specifically address the problem of stigma and discrimination through national policy on HIV/AIDS (Odimegwu et al., 2017; Onyemelukwe, 2017). Further, at the 2018 World International Workers' Day, the Director-General of NACA calls for the implementation of HIV workplace, anti-discrimination law.

The healthcare services have not enjoyed effective practices lately on the treatment and prevention of HIV stigma (Adeloye et al., 2017). Medical treatment has gained progress with the introduction of an antiretroviral drug (Bhatti et al., 2016). Peoples' attitude towards attending HIV hospital clinic season has been frustrated by stigmatization (Li et al., 2017). The poor attitude of HIV positive persons towards antiretroviral therapy (Mhode & Nyamhanga, 2016) and HIV testing (Lorenz et al., 2016; Meade et al., 2016) calls for health psychologists and social workers to provide cognitive and behavioral interventions (Garofalo, Kuhns, Reisner, & Mimiaga, 2016; Tobin et al., 2017).

There is an ongoing HIV cure research studies globally, adding that, of the 36.9 million people with HIV/AIDS, there are approximately 100 documented cases of HIV remission and one case of complete "HIV cured" of the "Berlin Patient," who remains HIV negative by all measures despite several years without ART. Recently, researchers at the Hebrew University in Jerusalem have identified a protein called "*Gammora*" that could eliminate HIV in infected patients by 99 percent. Dr. Esmira Naftali, head of development at Israeli biotech company "*Zion Medical*," reported

findings of HIV cure from the Investigational Medicinal Product (IMP) called "Gammora" through the ten weeks Phase 1/2a human clinical trial between July and August 2018 (Zion Medical, 2018). In Part I of the study randomly assigned nine HIV-infected patients from Dr. Ronald Bata Memorial Hospital in Entebbe, Uganda received either 0.05-0.2mg/kg, or 0.1-0.3mg/kg, or 0.2-0.4mg/kg of Gammora for up to 4-5 weeks. Most patients showed a baseline reduction of the viral load of up to 90% during the first four weeks. In Part II of the trial, two weeks after conducting the first, and patients received Gammora 0.2-0.4 mg/kg twice a week with the combined additional retroviral treatment of "lopinavir" 800mg and "ritonavir" 200mg (LPV+r) for another 4-5 weeks. The result showed up to a 90% reduction in viral load from baseline within four weeks, as patients established sustained viral suppression and achieved HIV-1 RNA <300 copies/mL (Zion Medical, 2018). This recent study brought hope to the cure of the extended managing health care pandemic.

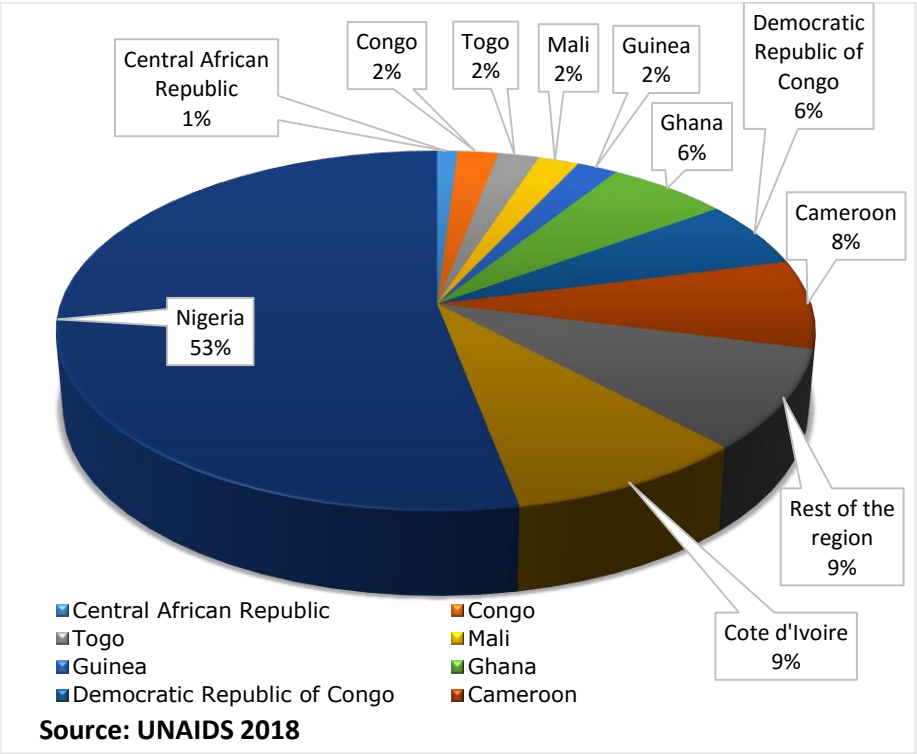


Figure 1.1 AIDS-related death by country, western and central Africa

1.2 Problem Statement

The issue of HIV stigma recorded significant public health challenges for the people living with HIV/AIDS (PLWHA) in Nigeria (Odimegwu et al., 2017; Stockton, Giger, & Nyblade, 2018). It resulted in mental and psychological trauma to PLWHA, their close family members (CFM), and the healthcare providers (HCP) (O'Donnell, Corrigan, & Gallagher, 2015). Studies confirmed that HIV stigma leads to discrimination, rejection, and isolation of PLWHA from the immediate society (AVERT, 2019; Famoroti, Fernandes, & Chima, 2013; Srithanaviboonchai, Chariyalertsak, Nontarak, Taneepanichskul, & Aekplakorn, 2017) with negative implications to general welfare (Biraguma & Mutimura, 2018; Wabiri & Taffa, 2013). CFM and HCP stigmatized PLWHA, which is necessitated by poor health policies and the implementation of legal Acts in Nigeria (WHO, 2018).

The Nigeria Anti-Discrimination Act was passed into law in 2014. However, the lack of implementation has posed a severe challenge to Nigeria's effective health care services (Odimegwu et al., 2017). Further, the socio-cultural and traditional spiritual values have considerable influence on the individual's perception and the society's belief on health issues (Anugwom & Anugwom, 2016; Udeh, Emelumadu, Nwabueze, Adimma, & Ogbonna, 2016; N. U. Ugwu & De Kok, 2015). Society teaches values and belief systems on every individual whose perception is directly or indirectly controlled by this belief system. PLWHA personally feel guilt, shame, and fear (AVERT, 2019; Hutchinson & Dhairyawan, 2018). The social culture already marked them as '*gawa mai rai*' meaning '*living death corpse*,' '*ashawo*' meaning '*sex workers*,' '*dan kwaya*' meaning '*drug addicts-injecting drugs*,' and '*dan daudu*' meaning '*men who have sexual intercourse with men*.' Cultural belief suggests that HIV positive is a punishment from God or ancestors for the atrocities committed by

the person, his parents, or grandparents (Olaore & Olaore, 2014; Pantelic, Boyes, Cluver, & Thabeng, 2018). The society built a negative attitude in every member of the city towards PLWHA (Odimegwu et al., 2017). Fatoki (2016) stated that it has negatively increased stigmatization on HIV patients.

Additionally, the socio-cultural traditional beliefs encourage homophobia and discrimination towards gay due to the doctrinal rejection of homosexuality (Szaflarski, 2017). It influences attitude towards HIV testing and adherence to ARV and Highly Active Antiretroviral Therapy (HAART) (Afe, Olanrewaju Motunrayo, & Ogungbade, 2018; Agam, Ndifreke, & Abraham, 2017). In other studies, religion/spirituality is a significant facilitator to the management and prevention of stress, diagnosis, and treatment of HIV/AIDS (Ghaempanah, Memaryan, Kochakzaei, Atoof, & Ebrahim, 2018). In general, the negative consequences of cultural and traditional beliefs make HIV prevention a challenging public health issue in Nigeria (Udeh et al., 2016). It invokes self and internalized-stigma (Turan et al., 2017; Zarei & Joulaei, 2018) and encourages high-risk behavior (Okafor, Crutzen, Ifeanyi, Adebajo, & Van Den Borne, 2017) among HIV positive patients. It leads to an identity crisis, low self-concept, personality disorders, and psychological distress (Sebastian, Subathra, & Sadath, 2018).

According to Fagbamigbe, Adebayo, and Idemudia (2016), Sub-Sahara Africa accounted for 60% of the world's HIV infections, two-thirds among women. The socio-cultural values encourage the ascription of gender roles (Girum, Wasie, & Worku, 2020). In particular, HIV prevalence in Nigeria is predominantly among female sex workers and men who have sex with men (Awofala & Ogundele, 2018). There is an increased prevalence of 23% in 2016 among men who have sex with men, which accounted for 55% of all new HIV infections in the country (UNAIDS, 2019a).

For example, the reported case of July 2017 mass arrests of 40 suspected gay men at a private house party by the Police confirmed the rising HIV prevalence in Nigeria. The socio-culture influences gender inequality in promoting HIV-related stigma (AVERT, 2018b) making women vulnerable to HIV infection (Anugwom & Anugwom, 2016). Also, society's belief has marked female sex workers as the most vulnerable group who transmit HIV/AIDS (Awofala & Ogundele, 2018). Culture, therefore, define HIV as women's problem (Girum et al., 2020).

Another study in 2013 supported the assertion (Ramjee & Daniels, 2013), and Odiachi et al (2018) confirmed the fear of divorce and intimate partner violence affecting early HIV diagnosis and disclosure rate among Nigerian women. It leads to a poor attitude of women to follow-up and completes the entire PMTCT care during the antenatal, delivery, and postnatal follow-up visits (Adetokunboh & Oluwasanu, 2016; Omonaiye, Kusljic, Nicholson, & Manias, 2018; PRB, 2014; Rawizza et al., 2017). The HIV prevalence rate in Nigeria recorded higher among women (Odimegwu et al., 2017) who experienced HIV stigma and discrimination compared to the men (Paudel & Baral, 2015).

There is also variation in HIV prevalence rates by geopolitical zones in Nigeria. As shown in Table 1.2 and Figure 1.2, the North-Central zone had 27.5% HIV prevalence, and North-East had 24.1% while North-West had 20.9% and the Southern region, South-East had 9.2%, South-South had 30.3 while South-West had 15.5%. Also, as shown in Figure 1.2, the 2015 national state statistics on HIV prevalence revealed Nasarawa state among the four states with high HIV prevalence with Rivers (15.2%), Taraba (10.5%), Kaduna (9.2%), and 8.1% Nasarawa (NACA, 2015). Further, the implication to research problem centered on the proximity and vulnerability of Nasarawa in sharing boundaries with the most prevalence states in

North Central Nigeria having Taraba (10.5%) on the east, Kaduna (9.2%) on the north, FCT (7.5%) on the west, and Benue state (5.6%) on the south.

Table 1.2 Nigerian HIV Prevalence by Zone

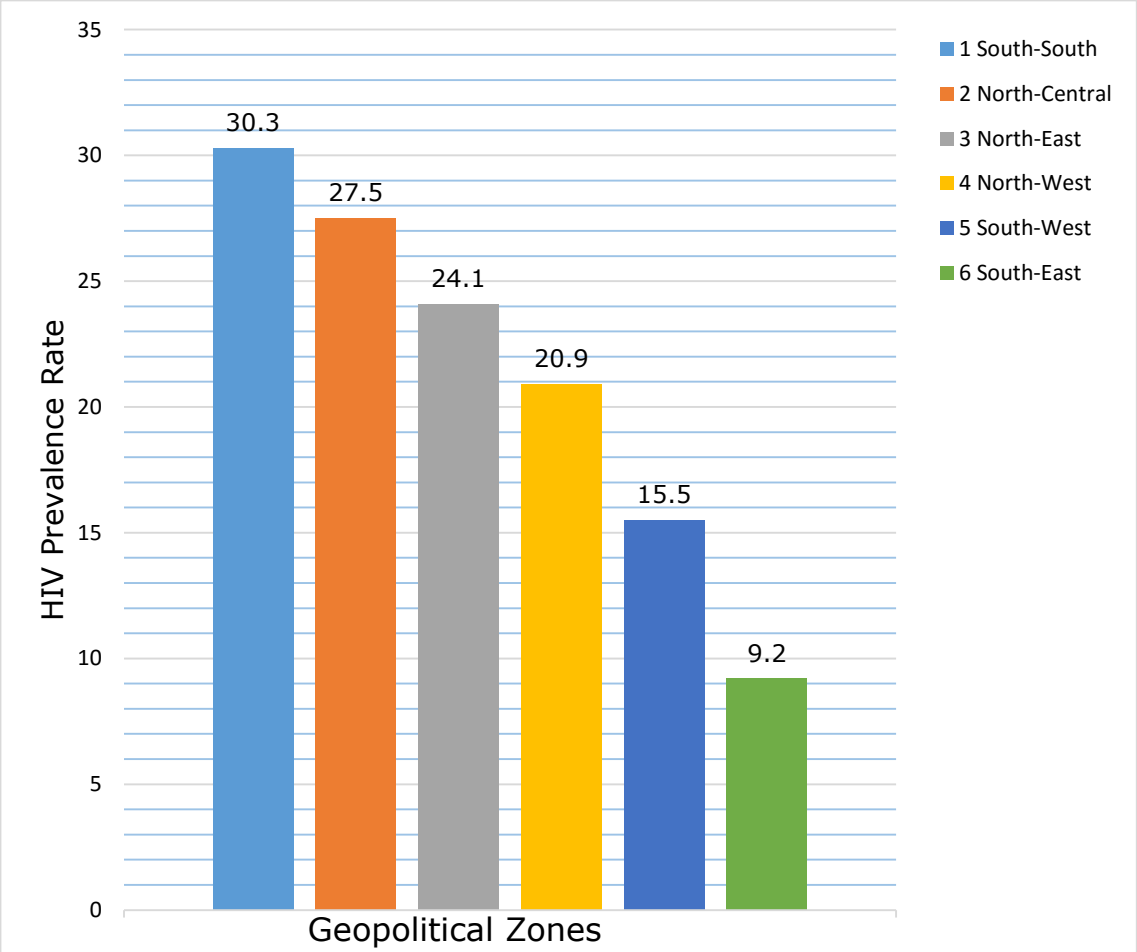
Zone	HIV Prevalence
South-East	9.2
South-West	15.5
North-West	20.9
North-East	24.1
North-Central	27.5
South-South	30.3

Source: NACA 2015 Nigerian HIV prevalence statistics by Geopolitical Zone

Additionally, another important consideration for this research is the implication of socio-economic status as a determinant factor to HIV prevalence in the Sub-Saharan African country, Nigeria, inclusive (Brodish, 2016; NACA, 2015). Low economic resources affected the level of education and HIV-related knowledge in Nigeria (Faust, Ekholuenetale, & Yaya, 2018). Other studies also revealed an association between economic inequality and socio-cultural prevalence of HIV/AIDS (Brodish, 2016; Faust, Yaya, & Ekholuenetale, 2017; Udeh et al., 2016; Wabiri & Taffa, 2013).

Most of the researches with behavioral-based intervention for HIV/AIDS pandemic centered on developed industrialized countries (Asad, Najib, Mussawar, & Farooq, 2017; Faust et al., 2017; Girum et al., 2020; Pantelic et al., 2018; Ssewanyana, Mwangala, Baar, Newton, & Abubakar, 2018). Few studies which captured developing countries like Nigeria employ the quantitative approach with no reference to the phenomenological theoretical approach of the qualitative studies (Odimegwu et al., 2018; Okafor et al., 2017; Udeh et al., 2016; Uzochukwu et al., 2015). However,

this study employs a qualitative approach using the face-to-face in-depth interview to understand the psychosocial analysis of stigmatization among HIV patients in Nigeria. Also, this study adopts a Computer-Assisted Qualitative Data Analysis Software (CAQDAS) using ATLAS ti.8 for qualitative data analysis that enables the development of HIV stigma intervention strategies from the findings.



Source: Extracted and designed Barchart indicating the Nigeria Geopolitical Zone Statistics 2015

Figure 1.2 Nigeria HIV Prevalence by Zone

1.3 Research Questions

Below are the research questions:

1. What are the influence of socio-cultural value on HIV stigma, health and well-being of the HIV positive?
2. How can socio-economic status determine healthcare service, early diagnosis, and antiretroviral among HIV positive?
3. How can gender contribute to HIV stigma, vulnerability, and prevalence of HIV among HIV positive?
4. How can this study generate the development of HIV stigma intervention strategies from the findings?

1.4 Research Objectives

Below are the research objectives

1. To explore the influence of socio-cultural on HIV stigma, health and well-being of the HIV positive.
2. To explore the influence of socio-economic status in determining the access to healthcare service, early diagnosis, and antiretroviral therapy among HIV positive.
3. To explore gender as a contributing factor to HIV stigma, vulnerability and prevalence among HIV positive.
4. To generate the development of HIV stigma intervention strategies from the findings.

1.5 The Scope of the Study

The research scope is an ongoing HIV stigma-oriented cohort of twenty (20) HIV infected patients aged 18 and above both men and women receiving care at hospitals designated in handling HIV/AIDS cases in Nasarawa State, North Central Nigeria. The principal goal is to provide a platform for linking the medical condition with the health and social well-being of the patients in the hospital. The research assembles a cohort of well-characterized HIV infected persons of diverse demographic and clinical background within some selected hospitals in Nigeria. Intensive face-to-face interviews with the selected HIV persons cover areas of gender, socio-economic, socio-cultural, and educational status as it influences the perception of stigmatization and general well-being.

1.6 Significance of the Research

The study contributes to the improvement of society, taking into account the physical, mental, social, and psychological consequences of HIV stigma that are detrimental to the sustainability of society. The recorded challenges of stigmatization and discrimination necessitated by socio-cultural, socio-economic, educational, and gender inequality against people living with HIV justifies the need for collaborative psychosocial intervention towards modifying and changing the orientation, perception, attitude, and behaviors of people towards HIV positive society. Thus, the recommendations derived from the result of this study can benefit the social workers and the health care providers in handling effective health care services to the HIV positive individuals, their spouse and close family members, their employers, and the entire community.

Importantly, the relevant authorities including religious and community leaders, civil society, government agencies and Non-Governmental Organisations (NGOs), school and health administrators, legal and social activists, employers of labor, educators, and policymakers guided on the power of using the cognitive-behavioral therapy (CBT) as an effective intervention technique to HIV stigmatization and HIV/AIDS prevention. For the researcher, the study will help to explore critical areas in HIV stigmatization and discrimination that many researchers were not able to cover. Thus, a new foundation for the development of new context-specific theory on HIV stigmatization grounded on the data may be achieved.

Further, this research identifies social workers' understanding of the stigma of being HIV patients among diagnosed HIV/AIDS. The contribution of this study is imperative to the social work practice as it brings awareness to social workers on professional training and educational workshops that prepare social workers in service delivery on stigma-related behaviors among HIV/AIDS population in North Central Nigeria. This study is beneficial to social work practice as it helps the social workers to explore social variables such as culture, education, economic, religion, political, and gender disparity in understanding stigma and HIV/AIDS. The professional training and educational workshops help social workers with intervention strategies and knowledge to address HIV/AIDS prevention, coping mechanisms, social support systems, early diagnosis, HIV education, and HIV-related stigma. Hence, it will help the students with the techniques to cope with the challenge of HIV-related stigma within the individual and the community level.

1.7 Organization of the Research Project

The thesis is arranged into five chapters. **Chapter one** introduces an understanding of stigmatization among HIV patients focusing on the problem statement, research questions and objectives, the scope, and research significance. **Chapter two** reviewed the relevant literature with emphasis on the empirical, theoretical, and conceptual framework on psychosocial variables like socio-cultural, gender inequality, socio-economic, and education as determinants of stigmatization and discrimination among people living with HIV/AIDS in Nigeria. **Chapter three** covers the methodological processes through research design, population, sample, study location, research instrument, the procedure in data collection and analysis, pilot study and result of the pilot study, and ethical consideration in research. **Chapter four** presents a descriptive analysis of the data provided by the participants during the interview session. The presentation covers the participant's descriptive information, pseudonyms, brief biographic descriptions of participants, qualitative data analysis, and summary of the findings. Finally, **Chapter five** provides a detailed discussion of the findings through the following headings; discussion, implications of findings (practical and theoretical), limitation of the study, recommendations, suggestions for future research, conclusion, and summary of findings.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

This chapter aims to give a detailed overview of the HIV stigma literature, including the theoretical and conceptual framework and empirical findings. Various research engines, Google Scholar, and the University's website have been used to find previous literature on stigmatization and HIV/AIDS, challenges, coping mechanisms, and intervention strategies reviewed. This chapter includes discussion on HIV/AIDS and stigmatization, coping mechanisms, and intervention strategies that the HIV patients experienced after diagnosed HIV positive. This chapter ends with providing a literature gap.

2.2 HIV/AIDS in Nigeria

HIV/AIDS has been a challenging historical disease in the entire universe. Over 36.9 million people living with HIV/AIDS in 2017 (Girum et al., 2020). Sub-Saharan Africa and Nigeria are also affected by the disease (Awofala & Ogundele, 2018; Kwenti, 2018). HIV/AIDS has significantly reduced the socio-economic and educational status of the country (Ogunmola, Oladosu, & Olamoyegun, 2014), and PLWHA (Turan et al., 2017). However, the Anti-Discrimination Act 2014 came into practice on 27th November 2014 by the former President of Nigeria to provide social justice for PLWHA (NACA, 2014).

Nigeria is a mixed society with different socio-cultural and religious beliefs featuring over five hundred different ethnic groups and many different languages. Hausa-Muslim, with about 29% dominates the north, and 21% of Yoruba-Christian

Protestants in the south and 18% Igbo-Roman Catholics in the east (Okolie et al., 2018). Traditionally, women inherited the position of becoming housewives, daughters, mothers, and sisters with the sole responsibility for procreation and home affairs with little or no incomes generated from house to house commercial exchange or contribution and small business crafts, which adversely contribute to HIV (Asad et al., 2017).

The socio-cultural and religious differences influence the role of women in Nigeria (Abubakar, 2017). Odimegwu et al. (2018) revealed that ethnic differences are the primary determinant of HIV stigma and discrimination in Nigeria. Studies reveal an association between inadequate HIV testing among women confinement to the household and the HIV prevalence in Northern Nigeria (Anthony, Adetayo, & Folajinmi, 2016; AVERT, 2018b). Also, the socio-cultural and prescribed social law of inheritance is an impediment to women's human rights by subordinating women within the patriarchal systems and structures (Allanana, 2013). It encourages early and forced marriage (or denied the right to marry), denied freedom of education, prevent income-earning and inheritance of properties, restrict freedom of association, movement, and expression (UNESCO, 2014).

A study conducted by Ivanova and colleagues indicated that the adolescent girls exposed to early and forced marriage, sexual violence, unwanted pregnancies, as well as increase the risk of contracting sexually transmitted diseases like HIV/AIDS (Ivanova, Rai, & Kemigisha, 2018). It is often associated with physical, psychological trauma, and social phobia (Akin-Odanye, 2018; Badejoko et al., 2014; Hassan et al., 2016). The restricted policy encouraged by the culture and religion affected women's access to the knowledge of Family Life and HIV Education [FLHE]. The program educates students HIV testing, antiretroviral therapy, use of a condom, attitude towards

PLWHA, HIV/AIDS transmission and prevention, and stigma and gender-related violence. It leads women to risk behavior of transacting sex for food, income, clothes, shelter, and protection (Erinosho, Isiugo-Abanihe, Joseph, & Dike, 2012; Ssewanyana et al., 2018).

Further, Nigeria's low socio-economic status has necessitated that the country capitalizes on the grants and donor-driven approach to HIV prevention programs, as the available financial resources allocated for the procurement of ARV and HAART. According to Faust et al. (2017), Nigeria's socio-economic status is based on the unequal distribution of resources for the maintenance of different agencies and institutions responsible for national development. As shown in Figure 2.1, wealth inequality also influences how other variables like gender, education, socio-cultural, and legislative policies affect the prevalence of HIV/AIDS. Jackson-Best and Edwards (2018) observed that there is a lack of financially independent to access healthcare service as a result of dismissal from the workplace, which has terrible consequences to the physical, social, and general well-being of the HIV patients.

As shown in Figure 2.1, the evil ideology of gender inequality, social differentiation, and wealth inequality among gender contribute to high-risk behavior of transacting sex for money, food, shelter, and security, thereby increasing the vulnerability of HIV infection (Kilburn et al., 2018). According to the World Education News and Review (WENR) in 2017, the socio-economic and religious instability in Nigeria has deteriorated the educational system. Lack of proper education has affected the development of government policies that will enhance the health sector and improve access to excellent healthcare services (Uzochukwu et al., 2015).

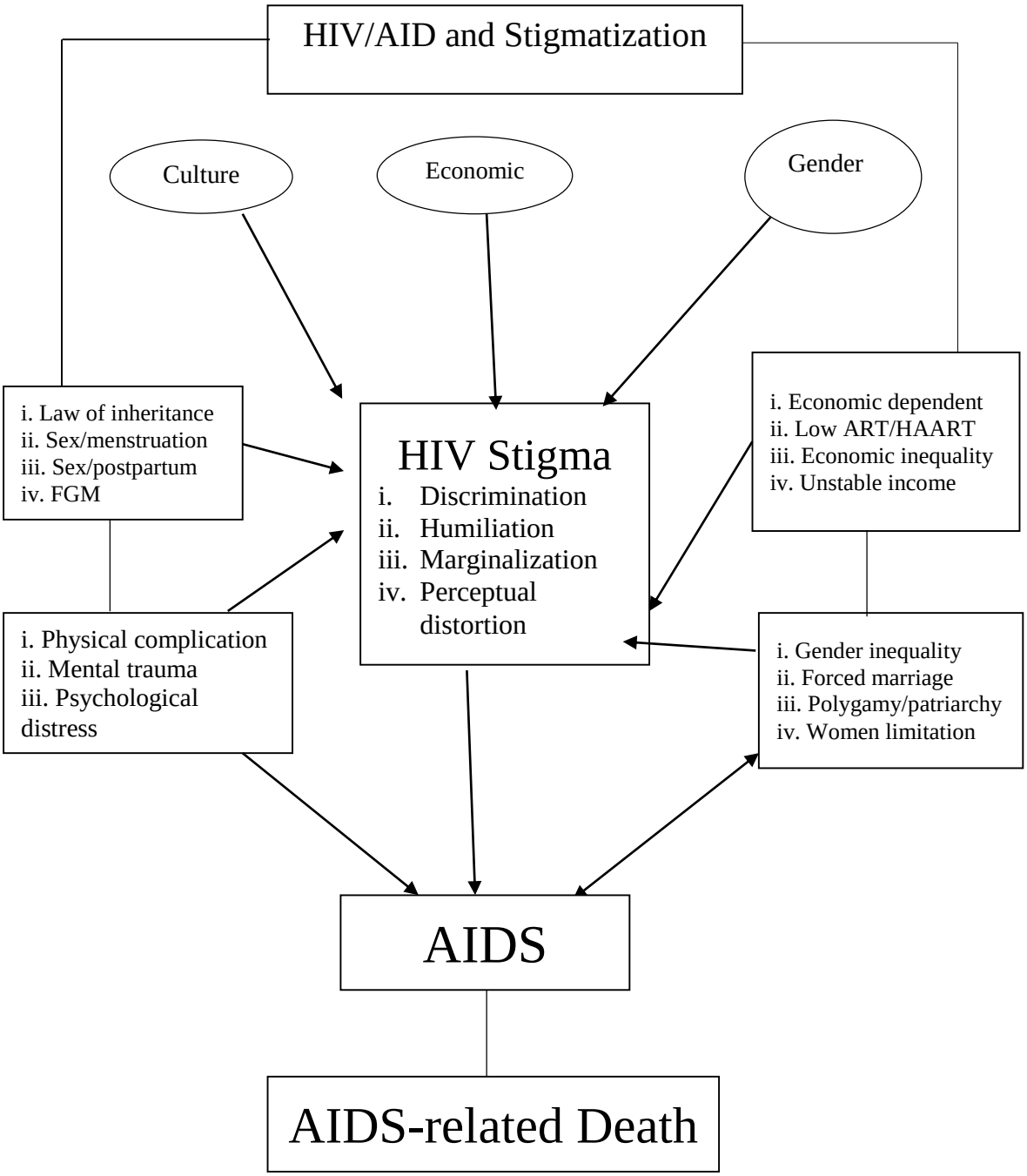


Figure 2.1 Determinant Factors to HIV Stigma and AIDS-related Death

2.3 Empirical Review of Related Literature

The empirical literature reviewed focused on understanding how meaningful the influence of socio-demographic variables like gender inequality, socio-cultural, socio-economic, and education status can contribute to HIV stigma and the prevalence of HIV/AIDS in Nigeria (Awofala & Ogundele, 2018).

2.3.1 Stigmatization and HIV/AIDS

Stigmatization among HIV patients has been a universal phenomenon fighting against the treatment and prevention of HIV/AIDS (Davtyan, Olshansky, & Lakon, 2018). PLWHA develop the fear, guilt, shame, despair, and anxiety disorder due to the ascribed negative perception of the health condition by the society (AVERT, 2019; Odimegwu et al., 2017; UNAIDS, 2019b). It hinders consistent antiretroviral therapy (ART) and frustrates the social relation, educational process, and economic status (Fido, Aman, & Brihnu, 2016; Odimegwu et al., 2018). It increases the widespread of sexually transmitted diseases (STDs) like HIV/AIDS (Dong et al., 2018).

In Nigeria, HIV stigma is a social issue that influences the infected person, and other members of the society (AVERT, 2019) propel by socio-cultural belief and socio-economic status. Nigerian culture associated HIV to spiritual sickness attacking evil people who inherited or committed an abomination against the gods of the land or the ancestors (Olaore & Olaore, 2014; Pantelic et al., 2018). Society evaluated the infected persons with prejudice and stereotype of discrimination and stigmatization (Odimegwu et al., 2018). The infected person also develops internalized or self-stigmatized. HIV stigma is related to stigmatize names like '*gawa mai rai*' meaning '*living corpse,*' '*katangan mutuwa*' meaning '*dead wall*,' '*gama shika*' meaning

'*bloodsucking snake*,' '*vampires*,' and '*zombies*' among others (Doka, Danjin, & Dongs, 2017). Other studies revealed that educating the spiritual leaders (religious leaders/traditional leaders) on HIV/AIDS prevention can have a meaningful role in the reduction of HIV stigma (Kruger, Greeff, & Letšosa, 2018a; Leclerc-Madlala, Green, & Hallin, 2016; Norder et al., 2015).

Stigmatization in Nasarawa State, North Central Nigeria, is associated with the patriarchal social structure with gender inequality and social differentiation against women (Allanana, 2013; Attoh, 2017). The husband determines women's economic, educational, and healthcare. The social structure restricts women from attaining an advanced educational level and financial stability, contributing to risk behavior among women (Ssewanyana et al., 2018). The close family members (CFMs), community cultural associations (CCA), colleagues, and healthcare workers (HCWs) dissociates and discriminates against HIV positive (Nyblade et al., 2018; Utuk, Osungbade, Obembe, Adewole, & Oladoyin, 2017), which hinders attendance to antiretroviral therapy (Onadeko, Balogun, Onigbogi, & Omokhodion, 2017).

2.3.2 Determinants of HIV Stigma

HIV positive individuals experienced stigmatization and discrimination. The CFMs and HCWs caring for HIV patients are stigmatized by the general public, which negatively affected their relationship and attitude towards PLWHA (Utuk et al., 2017). The socio-demographic variables like socio-cultural belief, socio-economic status, gender inequality, educational level, and religious tenants contributed to HIV stigma and well-being (Doka et al., 2017).

2.3.2(a) Socio-Cultural Belief and HIV Stigma

The Northern part of Nigeria recorded the prevalence of HIV/AIDS in the past years with North Central Nigeria having 27.5% HIV prevalence, North-East 24.1%, and North-West 20.9% Despite HIV/AIDS is contracted biologically and medically, the socio-cultural belief is a major leading factor influencing HIV stigma, treatment, and prevention among women in Nigeria (Fagbamigbe et al., 2016; Udeh et al., 2016). The socio-cultural value emphasizes gender role and social inequality against women especially in rural areas (Onokerhoraye, Maticka-Tyndale, & HP4RY Team, 2012).

Men are trained with leadership skills to control, acquire, grow, and provide for the family and community, while women are taught vocational and domestic skills to be humble, obedient, and dependent on men for health and survival primarily at home (Ejukonemu, 2018). HIV is said only to affect wicked people whom they or their parents committed an act of abominable character to man and gods of the land (Pantelic et al., 2018). Society restricted PLWHA from attending societal meetings and participating in festivities related to purification and cleansing (Faust et al., 2018). Additionally, people with HIV positive tend to develop self-stigma, living in shame, guilt, and fear of discrimination and humiliation to death by a member of the society (Odimegwu et al., 2018).

The socio-cultural or traditional practice of postpartum sexual abstinence during breastfeeding (Rossier & Hellen, 2014a), is another severe but unnoticed contributing factor to the contraction of HIV/AIDS among men in Nigeria (Kinuthia et al., 2018; UNICEF, 2018). It encourages men's extramarital affairs during postpartum with increase vulnerability after postpartum (Davey et al., 2018). Some

women get a divorce due to HIV positive status they contracted after postpartum syndrome (Best & Alubo, 2017).

2.3.2(b) Gender and HIV Stigma

The contraction of HIV/AIDS infection has been heterosexual in Nasarawa State, North Central Nigeria. The prevalence of HIV/AIDS necessitated by the polygamous nature of marriage and the trading of sexual activities by single ladies. Men of the older age of 60 to 65 with multiple sexual experiences get married to a young girl of 18 to 22 years, placing the wives at risk of contracting HIV/AIDS (UNAIDS, 2004). It encourages gender inequality against women (UNAIDS, 2014). Gender understanding of masculinity and femininity contributes to the widespread HIV/AIDS. Masculinity characterized leadership charisma in initiating and establishing control of the interpersonal relationship with a sex partner, either wife, female friend, or sex workers. Femininity is synonymous to a woman being polite and hospitable in accommodating men's sexual approaches (Nankinga, Misinde, & Kwagala, 2016). It increases women's risk of contracting HIV/AIDS since they are not expected to resist or insist on using a condom as protection against sexually transmitted diseases (STD) like HIV/AIDS.

HIV/AIDS eventually became prevalent among women than men in *North-Central, Nigeria* (Anthony et al., 2016; AVERT, 2018b). HIV/AIDS is, therefore, viewed as a deadly disease spread by women through extramarital affairs and exchanging sex for money (Kilburn et al., 2018). Society treats HIV infected men with consideration, while infected women handle hatred, disgrace, disappointment, discrimination, and rejection. Gender inequality and social differentiation encourage

women stigmatization from friends, loved ones, community members, and healthcare providers (AVERT, 2018a; UNESCO, 2014).

Additionally, Nigerian is a patriarchal society where every man is born with leadership potential to be a prospective head of a family from one generation to another. The birth of a male child comes with the celebration and joy of having a leader that will maintain a lineage of his father. Men taught leadership qualities that will make them go out of the house to work and bring food to the family. Women are trained in vocational and domestic skills that will keep them permanently at home (Valashany & Janghorbani, 2018). That is why the virtue of a woman in most African societies, including Nigeria, is her local potentials in how best she can cook and manage the kitchen. Also, patriarchal nature restricts women's access to acquire formal education. Lack of formal education affected the opportunity to learn about Family Life and HIV Education (FLHE) taught in the primary, secondary and tertiary institutions of learning. It increases risky behavior of transacting sex without the use of a condom, sharing needles, no HIV testing, antenatal clinic, antiretroviral therapy, antiretroviral drugs, and no knowledge of mother to child transmission of HIV/AIDS. Gender norms regulate sexual activities with men deciding how it should be done; women cannot suggest safe sex using a condom (Shabnam, 2017). Men suspect women for infidelity when the demand for a condom can lead to sexual violence or divorce (Blondeel et al., 2018; T. A. George, 2015).

2.3.2(c) Socio-Economic Issues and HIV Stigma

Financial security influences the health of every person. Poverty has eaten so deep the health status of people of North Central Nigeria. The most affected victims of women have a historical economic analysis that supported economic gender

inequality and social differentiation against women (International Monetary Fund, 2018; World Economic Forum, 2017). The law of inheritance positioned women as commodities to be bought and handled by men at all times. Women are denied privileges to be educated and to inherit any material property bearing their name. As the law of survival for the fittest entails, women use what they have to transact sex for cash or kind (i.e., trading sex for money, food, security, and accommodation). The low economic state makes women more vulnerable to the increasing prevalence of HIV transmission in Nigeria (Faust et al., 2017; UNAIDS, 2016). HIV infection is presumably higher among uneducated poor rural women. HIV stigma increases the risk of contracting HIV/AIDS. Also, infected individuals demonstrate HIV stigma through fear, guilt, shame, despair, and feeling of anxiety (Owolabi et al., 2012). The community expresses it through isolative and discriminative behavior towards infected persons. It negatively increases physical and psychological problems (Olley, Ogunde, Oso, & Ishola, 2016).

Nigeria characterized society of low socio-economic status with inadequate health infrastructures, poor education, low gender equality, and a high level of poverty. The socio-economic status of every community determines the general welfare and directly or indirectly influences the individual member (Amassoma, Sunday, & Onyedikachi, 2018). The prevalence of HIV/AIDS in Northern Central Nigeria affected the poor socio-economic state of the predominantly rural people Also, the American Psychological Association documented an association between socio-economic status and HIV/AIDS (American Psychological Association, 2018). The people live in abject poverty struggling to manage two-square-meal with no hope of being able to access healthcare even at the public healthcare units.