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RESEARCH ARTICLE

Effects of Expected Community Stigmatisation on HIV/AIDS Counselling and Testing in Nigeria.

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Abstract

Objective: The objective of this study was to explore the effects of expected community HIV/AIDS Stigmatisation on HIV Counselling and Testing (HCT) by looking at the impact of stigma on HIV Counselling and Testing.

Design: The research entailed a qualitative study involving the use of 11 Focus Group Discussions (FGDs) with 89 participants and 11 persons who took part in In-depth Interviews (Interviews) in three communities comprising an urban location and two rural settings in Delta State, Nigeria.

Result: The result from the study indicate that though most persons are knowledgeable about HIV/AIDS, their knowledge is still distorted and full of misconceptions which give rise to community stigmatisation which in turn impact on the desire of people to go for HIV testing. Furthermore, the desire to test is equally hampered by the fear of lack of confidentiality which the people tied to medical personnel attitude that might expose their test results and lead to stigma.

Conclusion: The fear of stigmatisation is a big obstacle to HIV/AIDS treatment since many persons refuse to go for HCT as a result of stigma. There is need to put programmes in place to correct the myths which produce fear and stigma and open up opportunities for greater community participation in HCT.

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Introduction:-

One of the most serious health challenges all over the world in the last two decades has been HIV/AIDS (1). Nigeria like many other countries in the world has been in the fore front of the fight against HIV/AIDS through international alliances and her government individual efforts to see that the menace of the pandemic is put to check by treating those who has been infected by the disease or prevent new infections.

Despite all efforts, Nigeria still has the second highest HIV/AIDS burden in the world. However, estimates show that new infections have declined from an estimated 316,733 in 2003 to 239,155 a decade later in 2013 (2). In spite of the relative achievement of the reduction of HIV/AIDS infections within the decade, HIV is still a huge health challenge in Nigeria. For example, based on projected HIV estimates for 2014, about 3,391,546 are living with HIV in Nigeria while it is estimated that 227,518 new HIV infections occurred in 2014 (male 103,917 and female 123,601). A total of 174,253 died from AIDS related cases in 2014 which is lower than 210,031 people in 2013. It is also estimated that a total of 1,665,403 (1,454,565 adults and 210,838 children) required anti-retroviral drugs (ARV) in 2014. The result from the 2010 sentinel survey shows that national HIV prevalence was 4.1% (2) and this rose to 5.7% in 2011. This figure might be considered low when compared to other African Countries but the population of Nigeria makes the figure very significant (3).

Nigeria has adopted various strategies in order to prevent and reduce HIV/AIDs among which is setting up the HIV/AIDS Emergency Action Plan, which is a mixture of emergency policies with the objective of increasing awareness and sensitisation of Nigerians. A focal point of the policies is HIV Counselling and Testing (HCT)(4). It has been documented that HCT can reduce high-risk sexual practices and can decrease rates of sexually transmitted infections (5, 6). In addition, HCT is necessary for directing HIV infected people to highly active antiretroviral therapy (HAART), (7), hence the National Agency for Control of AIDS (NACA) had focused on HCT to drive the process of HIV/AIDS prevention (2). The number of facilities providing HCT has increased eight fold and multiple strategies are used to increase access to HCT including community outreaches that were adopted. As a result, a total of 6,716,482 persons age 15 years and above were counselled, tested and received their results in 2014 compared to 4,077,668 in 2013 (2). Despite these efforts and focus on HCT, the number persons that have been involved in HCT are still very low since only 26% of the general population has ever been tested for HIV/AIDS. This figure is tilted highly in favour of urban locations compared to their rural counterparts – an indication that a greater number of persons are yet to test and know their HIV/AIDS status especially in hard-to-reach locations spread across the country in hilly and coastal communities (2, 8).

Plethora of reasons such as shame, fear of marital disruption, denial by family members as a result of stigma among others have been given as to why the rate of testing is low in Nigeria (2, 9, 10) and in other places (1, 7, 12,). A factor which is common to most of the studies whether national or international is HIV/AIDS stigma (1, 2, 7, 10,12). What is Stigma? Stigma is “an attribute that is deeply discrediting within a particular social interaction (13). Put in other words, stigma focuses on the public’s attitude towards a person who possesses an attribute that falls short of societal expectations. Persons in the society with HIV/AIDS are stigmatised and ostracised socially with negative public attitude attached to them. HIV/AIDS is stigmatised epidemic since person living with HIV/AIDS are discredited and are seen as lesser human in locations where they are found (14). There are two types of HIV/AIDS stigma - felt and enacted stigma (15). Felt stigma includes self-isolation, blaming oneself, shame, guilt and denial of HIV/AIDS positive status by people who are infected and affected by the disease. Enacted stigma on the other hand includes: ostracism, ridicule, neglect of health care and violence against PLWHA perpetuated by family, peers, health personnel and other community members (16). Stigma, whatever form it takes, devalued the person that is stigmatised and called to question the humanity of the person (17, 18). Evidence from studies indicate that stigma is a serious barrier to accessing HIV Counselling and Testing since it lead to denial of the epidemic and persons refusal to go for HCT(20, 21, 21, 22,23,24), thereby disrupting the entire programme designed to curtail HIV/AIDS . For example, Lepine et al (23) in their study concluded that people will not be willing to take to HIV/AIDS testing if they expect they will be discriminated against in their communities. Equally, the study by Odimegwu et al (9) found that it will be much more difficult for person living with HIV/AIDS to access services in rural communities since relationship are more primary due to stigmatisation. In another study by Okoro et al (24), people tend to stigmatised themselves due to their weak appearance before receiving ART. From the study by Johnson (25), disclosure of HIV status was only done to close family members due to fear of stigmatisation. The works by Owolabi et al (26), Mbonu et al (27) and Olagbuji et al (28) point to the association between stigma and HCT. Hence it is imperative to ascertain the relationship between HIV/AIDS stigma and HCT uptake. Thus, the objective of this study is to explore the effects of expected community HIV/AIDS Stigmatisation on HCT by looking at the impact of stigma on HIV Counselling and Testing.

Methods:-

The Study Area:-

The study was conducted in one urban community and two rural communities in Delta State, Nigeria. The State is one of the oil rich states of Nigeria with an active population of young adults who are attracted to the Central and South Senatorial regions by the presence of oil resources which provide a level of employment to the teeming population of young people with attendance social vices including commercial sex activities. Delta State is located in the Southern part of Nigeria and lies roughly between latitudes 5°00' and 6°30' north of the equator and longitudes 5°00' and 6°45' east of Greenwich Meridian. It has a total land area of 16,842 sq. km with a total population of 4,098,391 spread across 25 Local Government Areas. The study was conducted in Ughelli North Local Government Area – one of the largest Local Government Areas in the state with a population of 321,028. Three communities were selected for this study including Ughelli main town with all attributes of urbanisation where several community based organisations and civil societies are active in HIV/AIDS awareness and sensitisation including HCT. The other two communities for the research were rural in nature. All communities are from Urhobo ethnic nationality of the state.

Data Collection and measurement:-

The study took place from June – September, 2015. Before the commencement of the study, reconnaissance visits were made to the study area to set contact with relevant persons such as leaders of community groups and to get their consent to participate in the research with an assurance of confidentiality. It was at the end of the contact setting that the main activities of data collection started. The study population was purposefully and strategically picked from community based organisations which serve as the units for data collection. In order to select the participants, 40 community based organisations were identified in the study area with the assistance of community leaders. These comprised 20 groups from Ughelli main town and 10 each from each of the rural communities. From the 20 groups in Ughelli, 5 groups were purposively selected from different community categories (gender) such as youth (separated into male and female), men, women and a group where all of the categories of persons were mixed. In the rural communities, three groups were equally selected purposively from each community divided into adult female and adult male and a third group that was mixed. The use of balloting was done to select 7 to 10 persons from the selected groups that took part in the focus group discussions.

A qualitative study design was used in data collection using focus group discussions and in-depth interviews with guides. From all the groups, eleven focus group discussions were held with 7-10 persons (made of 4 all male, 4 all-female and 3 mixed groups with male and female). These were made up of five focus group discussions in the urban locations and three each in the rural communities. Four Research Assistants served as interviewers (comprising two male and two female). For ease of the discussions, one male was made to moderate in the discussions involving male participants while the other take the notes and record the discussions while still observing non-verbal communication within the groups. The same situations also applied to female participants with female facilitating the group and another one taking the notes, record the discussions and equally observe non-verbal communication. The discussions were recorded with tape recorders. After the focus group sessions, the leaders (eleven of them comprising 6 male and 5 female) of each of the groups who did not take part in the focus group discussions were engaged in in-depth interviews to explore the association between HIV/AIDS stigma and uptake of HCT with male interviewing male and vice versa. The eleven focus group discussions were done with 89 persons comprising 47 males (24 rural and 23 urban) and 42 females (21 rural and 21 urban). All the participants were from Urhobo ethnic group with 74 of them who were married and 15 unmarried; Only 12 of them did not complete basic education (Primary or Secondary Schools), 61 completed basic education and 16 of them completed one form of tertiary education or the others. The average age of participants was 36 with only 12% of the participants who were already HCT compliant in that they have tested and know their HIV/AIDS status.

Question asked ranged from knowledge about HIV/AIDS, mode of transmission, how to know if one is having HIV/AIDS, knowledge of HIV/AIDS counselling and testing, reason for HCT, consequences of being negative or positive, reaction to person living HIV/AIDS, knowledge of stigma and, , stigmatisation and consequences of stigma in the communities

The discussions were preceded with the filling of a short demographic form and a verbal consent seeking with a promise of anonymity and confidentiality. The discussions were done using Pidgin English. At interval during discussions, the participants were allowed to switch to the traditional language (Urhobo) depending on how fluent they were. Each discussion lasted for approximately one hour.

Data Analysis:-

The analysis of the data from the field entailed the transcription of the audio-taped focus group discussions and in-depth interviews. The transcripts from focus group discussions and interviews were analysed using N6 software. The discussions and interviews were later arranged into themes and sub-themes after coding. The identified themes were: (1) knowledge about HIV/AIDS (2) knowledge of HIV/AIDS counselling and testing and the reason why people go for HCT (3) Reaction to persons living HIV/AIDS (PLWHA) (4) Causes of and Consequences of HIV/AIDS stigma (5) Effects of Stigmatisation.

Results:-

Knowledge of HIV/AIDS

Iliyasu et al.(8) observed in their study that misconceptions, fear, gaps in knowledge and limited access to HCT and HIV/AIDS still remain prevalent – a testimony to the fact that knowledge about HIV/AIDS is still not complete all over Nigeria. In this study, it was evidence from the results from the FGDs and In-depth-interviews that a good

number of the section of the population in Nigeria are still holding distorted information about the epidemic which has fueled stigmatisation. No doubt a vast portion of the studied population have heard about HIV/AIDS and have knowledge about the epidemic, the level of information in term of correctness weighed heavily in favour of groups in urban centres compared to those in rural locations. However, incorrect information exist in urban environments as well as in the rural areas. Among most of the discussants, the fearful nature the population attached to the diseases is manifested through the incomplete knowledge as a participant in one rural community depicts:

“If we say we should be careful about HIV, what happen to all these mosquitoes? We are told that blood from one person to the other will cause HIV. What of if mosquitoes suck the blood of one man and take it to the other person?”

The extreme views which are not also correct that the persons hold about HIV/AIDS was equally put forward in most FGDs and Indepth interviews was based on the names most participants give to HIV/AIDS. According to some discussants in the FGDs and the persons interviewed, some called it “ogwu” the Urhobo people term for death. To others, HIV/AIDS was understood to mean “orivwin” translated to mean corpse in Urhobo. Still to some of the persons in the interviews and FGDs, HIV/AIDS is death sentence. In one of the interviews, an interviewee described HIV/AIDS as “untimely call- to-meet-the maker”. A statement from an interview captured this more explicitly thus:

“Konoyivwovwara? Onoyimrugwuodayara? Agha oyatakomotete”;

The literary interpretation of the above is that: “Who is not afraid of danger? Who sees death and still run to embrace it? We forbid it. That is what one says to a little child”. This supposed that the people still equate HIV/AIDS to death and must be avoided. This is a position which still promote stigma in most communities where HIV/AIDS is equated to death.

A dimension in term of knowledge of mode of transmission as portrayed by one of the FGDs apart from the observation that mosquitoes can transmit HIV/AIDS from one person to the other has to do with the belief that the use of item such as bed sheets and eating together and shaking the hands of PLWHAs can make others contract the epidemic as evidence from these excerpts from some of the FGDs and echoed by four of the interviews:

“Why bother to bring a dying person close to the dwelling of living people if the association may lead me to be like him”----an FGD

“Shake chit. e no go happen at all. Sleep with coffin? I know say God say make we loveoo but the love no go kill me na. I go fit give money to am but I no go go near am at all”--an interview excerpt
(Shake hand with chit? It will not happen at all. Sleep with coffin? I know that God says we should love but that should not lead to my death. I could give money to him/her but I will not go near to the person at all)

“I beg no be say I wicked. I no fit eat or sleep or even shake hand with the person wen get HIV/AID. Na tru be datoo. Nobidem talk say the diseases no get cure?. I no go play that kind rough play. That one na eating with the devil himself and one go dey think say e go better with am”-----FGD

(It is not that I am wicked. I cannot eat or sleep or even shake somebody with PLWHAs. That is the truth. Is it not true that that the disease has no cure? I cannot be playing with fire. That is eating with the devil himself and still thinks that you will survive it)

A common trend equally evident in most FGDs and interviews irrespective of the location is the linking of HIV/AIDS to heterosexual activities which puts the blame of the epidemic on the carriers as earlier on observed by Odimegwu et al(9). According to the study, carriers of HIV/AIDS are to be blame for their fate. The statement below summarised it better:

“The people wey carry this yamayama disease no deserve our sipati atall. E even good make we look for ways to punish them wellwell. People go dey wakawaka any how like say na only them de this world dey fuck all about. Wetin demdey think before. Everything get wetin follow am. Ebevwerhohwoyighwe”

(The persons who are HIV positive do not deserve pity from all of us. It is even good for us to look for a way to punish them very well. Persons will be walking all over the places as if they are the only ones existing in the world. They go about having sex all over everywhere. What were they thinking? Every action has a consequent. It is that thing that one treasured that will lead to his/her death)

Another aspect of distorted knowledge that the interviews and FGDs brought out is on the identification of persons with HIV/AIDS. On a question of how they recognise persons with HIV/AIDS, though a good number of the participants were right to point out that taking a test is the best option, most discussants and interviewees associated slimness with HIV/AIDS as the statement below revealed:

“Na how we go know the person who get HIV/AIDS order than say e don lin like dry bogafish. The person go come thin wellwell. If anybody be like that, naim be say he don get HIV/AIDS”

(How do we identify somebody with HIV/AIDS order than he/she will be looking like dry fish? He/she will be looking so thin. If there is anybody with that kind of body, it is an indication that he/she is HIV positive)

Factors militating against the uptake of HCT:-

The Global AIDS Country Progress Report by the National Agency for the Control of Nigeria AIDS (2) and Iliyasu (8) point to the limited knowledge of people regarding HCT. The FGDs and interviews result indicated that a very large proportion of the participants know about HCT but only 12% them have tested and obtained their results, hence the groups provided a good cohort of a study of reasons why persons have refuse to go for HCT. Various studies have documented the lack of motivation by people to go for HCT (2, 7, 29, 30, 31-34). These range from fear of being positive, stigma, lack of testing facilities, medical personnel attitude, fear of lack of confidentiality of results, ignorance among others. In this study, the fear of being HIV/AIDS positive was mentioned repeatedly in all the FGDs and interviews as the major obstacle to having HCT. Most of the participants revealed that, it really difficult having a test if you reflect on what has transpired in the past as stated below:

Wich kind test be dat. I no go try am at all. One thing go kill man. E good say I no know am at all than to come know say one dey carry am. Only the knowledge of say this thing dey body go fit kill man. I no won die before my time. -----Interview

(Which kind of test are you talking about? I am not going to have a test. One thing must kill man. It is good that I have no idea whether I have HIV than to know that I have it. Only knowing that one is positive can kill the person. I don't want to die before my time)

It was indeed a widely heard view that most the participants preferred a situation of not knowing about their status to support their fear of not going for an HIV test. To them, knowing is creating and inventing unnecessary worries as this extract from an FGD puts it:

“E good say I no know say I get am. This one naim good for me. I no fit die of worry”

(It is good that I do not even know I have it. This is good for me. I don't want to die of worry)

Another person from an interview reacted this way:

“What is the need of knowing the thing that can psychological ruin your life in seconds. It is better not to know about it.

Though persons are knowledgeable about HIV/AIDS and HCT, they provided a defense line which shield them from getting involved in HCT in line with stress and coping theory by Wenzel et al (35)

Apart from being scared of result of a test which stands as a barrier to engagement in HIV/AIDS testing, two other reasons that were evident from the interviews and FGDs were the issue of confidentiality which most participants attributed to medical personnel attitude. Put in other words, the expectation of lack of confidentiality from previous study perspective is a barrier to the use of a particular service include HCT (36, 37, 38 -41). In this study, it was clear from most FGDs and interviews that the expectation of lack of confidentiality was a major reason for not partaking in HCT as a participant put it:

“Some time person won go do this so-called test but wetin person dey fear na all those nurses with their mouth like mosquitoes. Dem go fit go dey tell people about the result. If that kind thing happen, naim be say all the world don hear you be HIV/AIDS”

(One is willing to go for the so-called test but my fear is that of the nurses with their long mouth like that of mosquitoes. They may tell other people about the result of the test. If that happens, it means that the whole world will hear that you are HIV/AIDS positive)

Giving a voice to the position of confidentiality promoted by medical personnel attitude as a barrier to HCT, was one of the women participants. Hear her:

“No bi say I no wan testoo. My concern be say all those small small nurse person no go fit trust them to close their month make another ear no hear the result because if people hear, you go be automatic outcast for your village and family”

(It is not that I do not want to test. My concern is that those little nurses cannot be trusted to keep their month close so that other persons will not get to know about one's HIV/AIDS result. If people should hear that one is positive, you become an outcast automatically in your family and community)

The issue of confidentiality occasioned by medical personnel attitude as this work showed is in line with the findings of Lindberg et al (42) that the attitude of medical personnel may affect health services usage.

Though participants in the study recognised the place of brotherhood in a typical Urhobo community, they nevertheless were emphatic that, getting to live with an HIV/AIDS carrier will not be a fun and since one may not be willing to accommodate HIV/AIDS positive people, it is better to forget the test that will lead to the discovery of the status. According to the discussants in some FGDs why should one use his/her own hand to “pour excreta on his/her body?” From their perspectives, not knowing is better since knowing might bring a situation where one will be ostracised by family or community as this participants statement revealed:

“if people hear, you go be automatic outcast for your village and family”

(If people should hear that one is positive, you become an outcast automatically in your family and community)

Equally prominent among the reasons given for having a test was routine exercise. These are mostly situations where most of the persons involved were “compelled” to have the tests. This normally happens during antenatal care, blood screening, marriages, job placements and involvement in an unsafe sexual activity. These reasons for testing have been documented in other previous studies (32, 34, 43). It is important to say here that the only beneficial time people voluntarily go for a test is after an awareness programme so that they can know their status and start antiretroviral treatment in the event of testing positive as the statement below revealed:

“Some of us at a time decided to listen to the voice of reason. We took it upon ourselves to take advantage of the test that was available during an HIV/AIDS project. The few of us that have tested only achieved the feat during projects like this one. I am sure if not for antenatal care and job, many Nigerians will not agree to test.”

Reactions to Person Living with HIV/AIDS (PLWHA):-

The study was concerned about the reaction of persons to people living positive HIV/AIDS. The way people react to persons who are HIV positive to a great extent determine whether they will be stigmatised or not (3). From the result in the FGDs and the interviews it was obvious that the reaction of persons to PLWHAs was negative and unwelcoming – most of the participants indicated that people still negatively react to PLWHAs. One thing was obvious from the reactions. There was the general belief that PLWHAs were the cause of their calamities. Reacting to a question “if it is possible for one to sleep, eat or bath together with an HIV/AIDS patient?” An excerpt from one of the FGDs has this to say:

“Na wetin light and darkness get together. If one de come, the other one dey run. Wensombodi don destroy imself finish, e want say make I be like am. That kind thing no good at all - I go give am chance wellwell”

From the view of a lady that was interviewed, people should bear their own cross. What has happened to most PLWHAs is a consequent of not listening to their parents. From her position, PLWHAs are people who have been engrossed in prostitution or men who are chronic womanisers who are reaping the fruits of their promiscuity. Here is a portion of her position.

Ihworurhobotane, wodatotakomo ominyo. No be only dem get body wen demdey take waka. Leave them make dem carry their cross. Na the result of say dem no listen to their parents naim we dey see so. Girl go waka anyhow and man go carry prick everywhere. Na the result we dey see so.

(According to an Urhobo adage, if you talk to a child, his/her duty is to listen. They are not the only ones having legs to walk everywhere. They should be allowed to bear their cross. What we are witnessing is a product of not listening to their parents. Girls do whatever they desire and men carry their penis all about to everywhere. What we are witnessing is the result)

The FGDs and interviews clearly revealed that, HIV/AIDS and indeed PLWHAs will still have to develop coping strategies to living with stigmatisation since the general reaction of the community is still very negative. Though there are voices that try to be tolerant and understanding, it is explicit that when personally confronted with the challenge of having a relative with HIV/AIDS that understanding cannot stand the test of time. To them, they do not see their family members engaging in casual sex which will bring such humiliation to their families. This section of the FGDs summarised this situation.

“The PLWHA are persons from irresponsible family background. Their parents were not concerned about the affairs of their families. I don’t see my children going into that kind of life style. Well if that happens, it will be very sad then, that child will for once know my other side”

Causes of and Consequences of HIV/AIDS stigma:-

This study was interested in the community awareness of stigma and if the community know the causes of such stigma. When there is stigmatisation, it is seen from the community point of view that shared attitudes, beliefs, and values have been violated. The consequences usually could be judgmental thoughts, behaviours, or actions on the part of governments, communities, employers, health care providers, coworkers, friends, and families (44, 45, 46). Evident from the FGDs and interviews indicated that fear of sickness and death are the driving force behind community stigmatisation which agreed with work of Meiberg et al (3) and Brown et al (12) that the fear of illness and death are among the reasons person are stigmatised. This fear stemmed from the perception of the

community concerning the contagious nature of HIV/AIDS by community stakeholders. This is fueled by the incomplete knowledge of the mode of transmission. For example, in most FGDs and interviews, some of the discussants were emphatic that they will not sleep with PLWHAs, embrace PLWHAs, share the same toilets, they will not eat or take bath from the same source. To these class of participants, HIV/AIDS is a sentence to untimely death once contracted and there is nothing one can do about it – a testimony to the life threatening nature of the epidemic when it first started without the drugs we know today (47, 48, 49). The above situation is captured in the statement from an interview below:

“Even Pastors wen dey tell us say heaven good never die. No be mi won start am. HIV na quick death be dat. Since wi no get cure na careful we go dey careful. Battle wen dem don hear no dey hard to fight”

(Even Pastors that talk to us about the goodness of Heaven are still alive. I will not be the one to die first. HIV is quick death. Since there is no cure, what we need to do is to be careful. It easier fighting a battle we are informed about)

The level of HIV/AIDS stigma in the community is reinforced by the perception of community members on how PLWHAs came about their disease. To some of the participants, PLWHAs are promiscuous people who go about having sex with multiple partners. From this perspective, they do not see reasons why people should sympathised with such morally ruined persons. Put in other words, the PLWHAs in the eyes of these group of community members are “guilty – as – charged” – having a reward for their immoral activities. This position equally agreed with the work of Meiberg (3) where those with HIV/AIDS were seen as people sleeping around and having so much intercourse. An excerpt from an FGD will expose this position very well.

“I beg make we talk beta things. People wen go fuck about and don carry HIV wetin be my own for inside. E sweet dem naim make dem dey am

(Please let us talk about better things. People who went about having sex and in the process contracted HIV – What is my concern in that. It was something they love and so continued to indulge in their sexual activities)

From the FGDs and interviews, one common thing was the presentation of myths as facts. The presence of myths is as a result of incomplete knowledge at the community level. For example, people still believed that as soon one contract HIV/AIDS, death is imminent and it is important that such a person prepare for death. Also, myths such as: sleeping, shaking hands, embracing, eating and bathing with PLWHAs will lead to contracting the virus are still prevalent. If these are added to the perceptions that HIV/AIDS has no cure, and that one dies as soon as the virus is contacted, will obviously lead to stigma as the statement below revealed.

“We just dey careful. I no say as soon as you get this thing e don finish for you and nobodi go talk to you again”

(We are just being careful. I am aware that as soon one contract HIV/AIDS, that is the end. Nobody will be willing to talk to you after that)

Another results from the FGDs and interviews was the importance which participants place on their culture and family value system and prestige. This was in line with the submission of Mechanic (50) that culture and belief system place a role in the way people disclose their HIV/AIDS status. According to him in locations with serious cultural implications where PLWHAs will be derided, they chose to keep their status to themselves. Put in other words, whether people are stigmatised or not is function of how the community see the disclosure. The FGDs and interviews showed that some participants were more concerned about their family prestige and culture than to attend to ailing family members especially when they interpret most PLWHAs condition as self-inflicted as the statement below revealed:

“Wetin we dey talk for here. Somebodi wen don go drag our family for mud by fucking and sleeping with every dick tom and jerry? The de grace to the famili reach. Make e jus pak e bag. I no won see am for our house. Na e hand e take go carry and so na e head e go take carry am, tory don end”

(What are we talking in this place? Somebody who has gone to drag our family into the mud by fucking and sleeping around with every Dick, Tom and Jerry? The disgrace for the family is enough. He/She should just pack his/her bag. I do not want to see him/her in our house. He/She use his/her hand to carry HIV/AIDS. Therefore, it is only right he/she shoulders it all alone)

A new dimension in the study was that stigma was not restricted to only PLWHAs, but the health personnel as well as family members involved in the care for PLWHAs. Brown et al (3) observed that the PLWHAs are not the only persons stigmatised but people who are also close to them. The excerpt below captured this tersely:

“The mata don big wellwell. Even the brothers and nurses wen dey treat HIV people no free. Dem sef people no dey go near becos people dey think say dem go don take style get this diseases”.

(HIV/AIDS matter has taken a new dimension. Even relatives and those health workers taking care of PLWHAs are not free. People don't even come close to them since they believed somehow they too have contacted the diseases)

What happens if one is stigmatised:-

The study found from the participants the likely consequences of the regime of stigmatisation of PLWHAs. The FGDs and interviews were clear on the likely outcomes of the situation. From their views, stigma was promoted because people know that those people were HIV/AIDS positive. According to them, the likely result from the fact that people are stigmatised is that more cases of HIV/AIDS will be recorded. From some of the enlightened members of the groups, greater incidents of sickness and eventual death will be recorded. This they attributed to the fact that people will be hiding their status and will not be willing to even go for test which is usually the first step in the HIV/AIDS treatment programme. The result from this study agreed with Odimegwu et al (9) that stigmatisation of PLWHAs in communities had succeeded in achieving one thing- deprived more people from having an HIV test and the consequent has been more infections that will be recorded in the days ahead. Reacting to question of what happens if persons living with HIV/AIDS are stigmatised, it was clear that it was going to affect the testing by persons who want to test as this FGDs discussant put it:

“With what I know, it is the foolishness of PLWHAs to volunteer to go for the test. Now nobody wants to talk to them. In few places I know of PLWHAs, even their families are not left out in disowning their own blood. With this experience, one thing is sure yesterday, today and in the future, I will equally be foolish to go for HCT. The way I am is just okay. I know I am going to die one day why hasten that process by going for a test and being stigmatised if the result turn out to be positive?”

From the point of view of one of the group leaders interviewed, stigmatisation is a killer and sermonised the reason for his position thus;

“Ignorance they say is a disease. I am lucky that my parents sent me to school. Many of my peers are not so. They claimed to know so much in the society but the truth is that they are ignorance. Testing is the entry point to any HIV/AIDS treatment but I know that many of my friends – even at gun point will not be willing to take a test. They know themselves and their lifestyles. Not agreeing to test has so many consequences –new infections will not be detected and treatment cannot

begin for such persons. The reason for all these is from the way people look at PLWHAs. The society sees them as outcast. Hence my peers preferred to stay the way they are inspite of my encouragements most times. The issue of stigma leads to people not going for test and if they go, they conceal their status for fear of being stigmatised”

Discussion:-

Nigeria as well as her major world partners have continued to wage a sustained war on HIV/AIDS from all sides. While much gains has been made through the use of HIV/AIDS Counselling and Testing (HCT), a huge gap still exist between the number of persons who know their HIV/AIDS status and those who do not. According to the Global AIDS Response Country Progress Report Nigeria (2), only 26% of Nigeria have tested and obtained their test results. Unfortunately, the attempt to get more people to test had been enmeshed by general community apathy brought about by expectations of stigma. Inspite of the willingness of people to take to HCT, this drive is being slowed by expectations of stigma – promoted by myths which are in turn caused by incomplete knowledge; contagious nature of the epidemic, culture and stigma tied to friends and relatives of PLWHAs including health workers who are in charge of their care.

The question which this study tried to answer was if there was a relationship between the number of persons getting tested and expected community stigma? The results from the study demonstrated that while a very good number of the community members are aware and knowledgeable about HIV/AIDS, the knowledge is still distorted and incomplete which fuel stigma and fear of the epidemic. The level of misconceptions the community holds about HIV/AIDS which equally promote stigma is in the area of the kind of names the participants used in the describing the epidemic. To some, it is “ugwu” (death), to others, it is “orivwin” (corpse), equally, a group named it as death sentence and yet others call it “a call-to-meet-the-maker. All these names are used to describe the dreadful perception of the community of what HIV/AIDS is all about fueling fear and stigma in the community and discouragement from testing. A promoter of stigma as stemmed from misconceptions is the belief by most community participants in the interviews and FGDs is that HIV/AIDS is only caused by heterosexual engagement and that PLWHAs are promiscuous – giving a false identity and thereby typecasting PLWHAs as prostitutes and womanisers – hence nobody wants to be identify as PLWHA due to this kind of labeling.

Relating to knowledge and why people go for HCT or not, the study indicate that a vast proportion of the studied population are yet to test for HCT inspite of their relative knowledge of HCT. The factors which inhibit testing in this study are: fear of testing positive to HIV, since most participants preferred remaining untested due to stigma that might follow if the result is positive. Their refusal to test as result of expected stigma serve as a defense line which shield them from getting involved in HCT in line with stress and coping theory by Wenzel et al (35). Equally, evident from the study was the fear of stigma which comes from the exposition of the status of person who would like to test by medical personnel. It was explicit that the participants fear was also hinged on their fear of lack of confidentiality which comes from medical personnel exposing their results which might trigger their stigmatisation and that of their love ones - thus agreeing with Lindberg et al (42) that the attitude of medical personnel might affect health services usage. Related to the issue of confidentiality, participants in this study were concerned about the social relation with their families and friends which they expect that testing positive to HIV/AIDS might affect. From their view, HIV/AIDS is a life threatening and contagious diseases which everybody must try to avoid hence, inspite of the social links and ties to families in Africa, once a member test positive to HIV/AIDS, this relationship is automatically strained since stigmatisation of the persons involved is done. From this understanding, not testing is an option which many of the community participants cherished as a way of keeping the harmony with their love ones and thereby keep the family name intact from community disgrace. One major premise that participants espoused as a favourable reason why people get involved in HCT is what could be described as “mandatory test”. These tests are done even against the wish of the people involved. For example, some of them are done during marriages, antenatal care, job placements, and blood screening before blood transfusion. During some of these activities, the persons involved may not be willing but because it is mandatory, they have no choice but go ahead with the test as documented in previous studies (32, 34, 43). The only perceived benefit for testing where people are motivated to test has to do with a situation where a few rational people summed up the courage to go for a test after a programme so that they can be beneficiaries of early detection and receive antiretroviral treatment.

An aspect of having an HIV/AIDS testing and getting the result and making a disclosure about this from the study is the fact that PLWHAs are seen as responsible for their situation since they are seen as promiscuous. This

misconception promotes a culture of negativity against PLWHAs and a fertile ground for stigma in the community which is one of the causes of stigma in the community. Others range from fear of the diseases as a contagious epidemic, promotion community culture and value system above blood ties and general incomplete knowledge about the diseases.

Result from the question of “what happens if people are stigmatised” revealed that the programme of HCT will be disrupted since more and more persons will abandon their attempt to take a shot at HIV test. The consequences of this is that, the refusal to go for a test will lead to greater infections and greater number of death from the epidemic since getting people into antiretroviral drugs will become increasingly difficult. This lead to a hidden fight by some of the persons living with the virus might use the opportunity to spread the virus to a larger group of people.

The implication of the result of this study is that stigma is a big barrier to HCT. Participants in this study are still having serious misconceptions and myths which are fertile grounds for stigmatisation – and stigmatisation is standing as barrier to HCT which is the entry point to anti-retroviral treatment. It is in realisation of this position that some participants in the study concluded that stigmatisation of PLWHAs will lead to more death since prevention and treatment efforts will be hampered. It is therefore imperative to promote projects to bridge the information gap so that a vast proportion of people can have access to correct knowledge, which get more people to understand the fundamentals of HCT and greater motivation to test - thereby reducing stigma. Another implication from this study which is equally tied to stigmatisation is the issue of confidentiality and medical personnel attitude. It has been documented that people will not use health services when they are not located and operated in confidential locations (36). Project to promote confidentiality must be put in place to avoid situation where PLWHAs and their love ones are stigmatised because people know about their status due to medical persons disclosing what they know in the secret, thereby lead to situation where more persons refuse to go for test and reversing attempt to reduce HIV/AIDS infections.

Limitation of this study:-

The limited study area compared to the vast land area of Nigeria. However, the studied populations represent the ethnic nationalities in Nigeria in term of culture and family togetherness

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