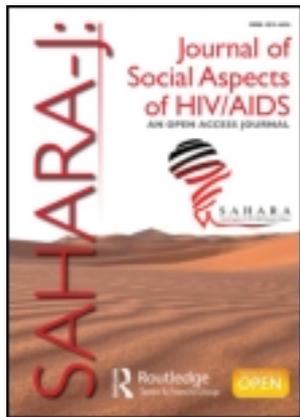


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## Social impact of HIV/AIDS on clients attending a teaching hospital in Southern Nigeria

Ofonime E. Johnson

### Abstract

People living with human immunodeficiency virus and acquired immune deficiency syndrome (PLWHA) face numerous social challenges. The objectives of this study were to assess the level of self-disclosure of status by PLWHA, to describe the level and patterns of stigma and discrimination, if any, experienced by the PLWHA and to assess the effect of sero-positivity on the attitude of friends, family members, health workers, colleagues and community. This was a cross-sectional descriptive study carried out among PLWHA attending the University of Uyo Teaching Hospital, Uyo, Southern Nigeria. Information was obtained using an interviewer-administered semi-structured questionnaire, which was analysed using the Epi 6 software. A total of 331 respondents were interviewed. A majority, 256 (77.3%), of the respondents were within the age range of 25–44 years. A total of 121 (36.6%) PLWHA were single and 151 (46.6%) were married, while the rest were widowed, divorced or separated. A majority, 129 (85.4%), of the married respondents disclosed their status to their spouses and 65 (50.4%) were supportive. Apart from spouses, disclosure to mothers (39.9%) was highest. Most clients (57.7%) did not disclose their status to people outside their immediate families for fear of stigmatization. Up to 111 (80.4%) of the respondents working for others did not disclose their status to their employers. Among those whose status was known, discrimination was reported to be highest among friends (23.2%) and at the workplace (20.2%). Attitudes such as hostility (14.5%), withdrawal (11.7%) and neglect (6.8%) were reported from the private hospitals. Apart from disclosure to spouses, the level of disclosure to others was very low. Those whose status was known mainly received acceptance from their families but faced discriminatory attitudes such as hostility, neglect and withdrawal from friends, colleagues and hospital workers. There is a need for more enlightenment campaigns on HIV/AIDS by stakeholders to reduce stigma and discrimination and ensure adequate integration of PLWHA into the society.

**Keywords:** disclosure, discrimination, enlightenment campaigns, stigma, sero-positivity, workplaces

### Résumé

Les personnes vivant avec le virus de l'immunodéficience humaine et le syndrome d'immunodéficience acquise font face à de nombreux défis sociaux. Les Objectifs de cette étude étaient d'évaluer le niveau d'auto-divulgence de la PVVIH afin de décrire le niveau et les tendances de la stigmatisation et de la discrimination, le cas échéant, vécue par les malades du SIDA et d'évaluer l'effet de la séropositivité sur l'attitude des amis, des membres de la famille, des travailleurs de la santé, des collègues et de la communauté toute entière. Il s'agissait d'une étude descriptive transversale réalisée auprès des PVVIH au centre hospitalier universitaire de l'université d'Uyo, dans le sud du Nigeria. L'information a été obtenue en utilisant une enquête administrée par questionnaire semi-structuré, qui a été analysé à l'aide du logiciel Epi 6. Un total de 331 répondants a été interviewé. Une majorité de 256 (77.3%) des répondants étaient de la tranche d'âge 25–44 ans. Un total de 121 (36.6%) PVVIH étaient célibataires et 151 (46.6%) étaient mariés, tandis que le reste étaient veufs, divorcés ou séparés. Une majorité, 129 (85.4%) des répondants mariés ont révélé leur maladie à leurs épouses et 65 (50%) étaient solidaires. Mis à part les conjoints, la divulgation des mères (39.9%) étaient le plus élevé. La plupart des clients ne divulguent pas leur maladie à des personnes extérieures à leur famille proche, de peur de la stigmatisation. Jusqu'à 111 (80.4%) des remplissants qui travaillent pour d'autres n'ont pas révélé leur séropositivité à leurs employeurs. Parmi ceux dont la souffrance a été connue, la discrimination a été signalée à être plus élevé chez leurs amis (23.2%) et le lieu de travail (20.2%). Les attitudes telles que l'hostilité (14.5%), l'éloignement et la négligence (6.8%) ont été signalés dans les hôpitaux privés. En dehors de la révélation aux conjoints, le niveau de divulgation aux autres est très faible. Ceux dont leur mal a été connu, ont largement été acceptés par leur famille, mais faisaient face à des attitudes discriminatoires telles que l'hostilité, la négligence et l'éloignement des amis, des collègues et du personnel hospitalier. Il ya une nécessité pour plus de campagne de sensibilisation sur le VIH/SIDA par les parties prenantes pour réduire la stigmatisation et la discrimination et assurer l'intégration adéquate des PVVIH dans la société.

**Mots clés:** révélation, discrimination, campagnes de sensibilisation, séropositivité, lieux de travail

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## Introduction

Stigmatization has been described as a quality that significantly discredits an individual in the eyes of others, while discrimination is said to occur when a distinction is made against a person that results in his or her being treated unfairly and unjustly on the basis of being perceived to belong to a particular group (UNAIDS 2002a, 2002b). While in some cases HIV/AIDS provokes compassion, solidarity and support, in other cases, it has caused stigma, repression and discrimination to be slammed on the people living with human immunodeficiency virus and acquired immune deficiency syndrome (PLWHA), causing social and psychological trauma, which have proved nearly worse than the HIV pain itself (UNAIDS 2000). Stigma and discrimination are so significant that they became the themes for the World AIDS Day for 2 consecutive years, 2002 and 2003, respectively (Avert 2004a, 2004b).

HIV is a highly stigmatized disease. This is due largely to the fact that it is commonly sexually transmitted, leading to moral and cultural judgements (Dickinson 2003). A study carried out in Benue State, Nigeria, reported a high level of stigmatization and low acceptance of PLWHA. Some of those interviewed suggested that the PLWHA be eliminated before they infect others (Alubo, Zwandor, Jolayemi, & Omudu 2002).

Studies have shown that disclosure of status affects friendships and other interpersonal relationships. A study carried out in Ile Ife, Nigeria, among university students showed that 64.5% indicated that it was not safe to have a close relationship with PLWHA; 96% indicated that it was not safe for a student who was HIV positive to be living in the hostel and that any HIV-infected student should be isolated, while 98% indicated that one must not eat in the same place with any HIV person (Omoteso 2003).

Disclosure of status to spouses and family members has been reported to have some negative effects on PLWHA. In India, for example, some men who infected their wives with HIV may turn around to abandon them. Rejection by wider family members is also common. This can be a terrible experience especially when one considers the family as the primary source of comfort to the patient (UNAIDS 2001). In a study done in Sagamu, Nigeria, among 53 PLWHA, 86.8% had disclosed their status to at least one person. Spouses/main sexual partners were most frequently informed. Up to 10% reported domestic violence (Olusoji 2004). A study carried out among symptomatic HIV-positive children whose mothers were also HIV positive but fathers were negative reported lack of care and support from the fathers. Their reasons included fear of being infected, reluctance to waste funds on a dying child and doubt of the child's paternity (Adejuyigbe & Odebiyi 2006). Another study carried out in China reported that after disclosure of status, 17% of the PLWHA's family members decided to have them use separate utensils and eat from separate food dishes (Li, Sun, Wu, Lin, Wu & Yan 2007).

Workplace discrimination of PLWHA has been reported by several studies. Even when a workplace puts in place medical

care for HIV-positive employees, the discriminatory atmosphere denies them access to the services. An example is Deco, a South African company with about 2000 HIV-positive employees, with only 200 registered for the medical aid HIV/AIDS programme and with just one employee openly disclosing his status (Dickinson 2003). In Nigeria, cases of discrimination and stigmatization at the workplace also abound. An example is the case of Mr John Ibekwe who reported that he lost his job in 1997 after testing positive the previous year (NACA 2004).

PLWHA also face discrimination from health workers at health facilities. UNAIDS reported that many were stigmatized and discriminated against by healthcare systems in forms of withheld treatment, non-attendance of hospital staff to patient, HIV testing without consent, lack of confidentiality and denial of hospital facilities and medicines. A survey conducted in 2002 among 1000 physicians, nurses and midwives in four Nigerian states reported 1 in 10 doctors and nurses to having admitted to have refused to care for an HIV/AIDS patient or denying such a patient admission into the hospital. Up to 20% felt that PLWHA had behaved immorally and deserved their fate. (Avert 2004a, 2004b) In another study done at Obafemi Awolowo University Teaching Hospital, Ile-Ife, Nigeria, of the 10 health workers who had contact with a full-blown AIDS patient, only 3 were willing to care for the patient, 8 felt that HIV patients should be labelled and isolated when hospitalized and 6 were very concerned about HIV acquisition despite present infection control precautions (Adegboye 1992).

Goal 6, target 7 of the millennium development goal, which is to have halted by 2015 and begun to reverse the spread of HIV/AIDS (WHO 2003), is more likely to be achieved when there is a reduction in the social impact of HIV/AIDS on the PLWHA. Akwa Ibom State in southern Nigeria had the second highest HIV sero-prevalence of 8% in a nation with a national prevalence of 4.4% in 2005 (FMOH 2006). There is no known study which has assessed the social implications of living with HIV/AIDS in this part of Nigeria. The objectives of this study were to assess the level of self-disclosure of status by PLWHA, to describe the level and patterns of stigma and discrimination, if any, experienced by the PLWHA and to assess the effect of sero-positivity on the attitude of friends, family members, health workers, colleagues and community in order to suggest ways of improving the situation.

## Methodology

A descriptive study was carried out on PLWHA attending a clinic at the University of Uyo Teaching Hospital, Uyo, Akwa Ibom State, Nigeria, in 2005. The state is one of the 36 states in Nigeria and is located in the southern part of the country with Uyo as the capital. The estimated population of Uyo metropolis as of 2006 was 304,000 (National Population Census 2007). A majority of the inhabitants are civil servants, artisans and petty traders. At the time of the study, the teaching hospital was the only centre for national antiretroviral treatment in Akwa Ibom and Cross River States. A few patients were also attending the clinic from the neighbouring States of Imo and Abia. The study population consisted of all clients who were registered and had commenced treatment on the antiretroviral therapy.

The sample size was calculated using the following formula:

$$n = \frac{z^2 pq}{d^2},$$

where  $n$  is the desired sample size when the population is more than 10,000,  $z$  is the standard normal deviate at the 95% confidence level = 1.96 and  $p$  is the proportion in the target population estimated to have a particular characteristic = 0.5.

$$q = 1 - p$$

$$d = \text{acceptable margin of error} = 0.05.$$

This gave a sample size of 384. However, since the population was less than 10,000, the following formula was subsequently used:

$$nf = \frac{n}{1 + n/N},$$

where  $nf$  is the desired sample size when the population is less than 10,000,  $n$  is the desired sample size when the population is more than 10,000 (384) and  $N$  is the estimate of the population size (1000).

The calculated minimum sample size became 278. However, to compensate for possible non-response, the minimum sample size was divided by the anticipated response rate of 84% (0.84), giving a sample size of 331.

A total of 1430 names of clients were in the register including those who had defaulted or died. Of these, 1000 were on treatment at the time of the study. All PLWHA attending the clinic were enrolled into the study on each clinic day until the desired sample size was obtained. About 20–25 PLWHA were enrolled into the study on each clinic day. The clinic operated twice a week at the centre. Data was collected on 14 clinic days over a period of 7 weeks. A semi-structured interviewer-administered questionnaire was developed and used to obtain information from the PLWHA. Such information included socio-demographic characteristics, employment status and disclosure of status to the employer, spouse, family and others. Information was also obtained on the different ways they were subsequently treated after disclosure and the attitude of health workers towards them. Four trained personnel among the health workers assisted in administering and collecting the questionnaires. They underwent a 2-day training session during which the content of the questionnaire was fully explained to them so that they could effectively guide the respondents while administering the research instrument. This helped to minimize bias during the administration of the research instrument. The questionnaire was pre-tested on 30 PLWHA in another health facility in another State about 3 weeks prior to the study. From the result of the pre-test, ambiguous questions were rephrased or totally removed. Data collection lasted for 7 weeks. All the 331 questionnaires that were administered were retrieved. Before the study was commenced, permission to carry out the study was obtained from the ethical committee of the teaching hospital. In addition, prior to the administration of the research instrument on each clinic day, the purpose, content and significance of the study were explained to the subjects and written informed consent was obtained from them. The investigator and the trained research assistants administered the questionnaires to the participants in

a location of the health facility where the respondents' privacy was maintained. The respondents were assured that their responses would be kept confidential and that the questionnaires would be kept in a safe place and would only be accessible to members of the research team. They were informed that they were free to decide not to participate and could choose to discontinue at any point during the process of the interview and that they would not suffer any consequences if they chose not to participate. Data analysis was carried out using the Epi info 6 software. Frequencies were generated and the Chi-square test was used to compare different proportions and test associations.

## Result

This study was carried out among 331 PLWHA attending a clinic at the University of Uyo Teaching Hospital, Uyo, Nigeria. The respondents comprised 167 males and 164 females. The age of the respondents ranged from 15 to >50 years. About 256 (77.3%) of the respondents were aged 25–44 years. Up to 46.6% were married (Table 1), with a male-to-female ratio of 3:2. Twenty seven (16.3%) females were widowed compared with 6 (3.6%) males ( $p < 0.05$ ). A total of 121 (36.6%) were single with a male-to-female ratio of 1:1.

More than two-thirds of the PLWHA in this study were employed. Up to 109 (46.4%) were employed in government establishments, while 29 (12.3%) worked in private establishments. Of the 138 respondents who had employers, a majority, 111 (80.4%), did not disclose their status. A total of 23 (85.2%) of 27 PLWHA who had disclosed their status to their employers

**Table 1. Socio-demographic characteristics of PLWHA.**

Socio-demographic characteristics	Frequency (N = 331), n (%)
Age group (years)	
15–24	31 (9.4)
25–34	150 (45.3)
35–44	106 (32.0)
>44	44 (13.3)
Sex	
Male	67 (50.5)
Female	64 (49.5)
Highest level of education	
Nil formal education	8 (2.4)
Primary	80 (24.2)
Secondary	108 (32.6)
Tertiary	133 (40.2)
No response	2 (0.6)
Marital status	
Single	121 (36.6)
Married	151 (46.6)
Separated/divorced	26 (2.8)
Widowed	33 (10)

were accepted and supported. Only 1 person (3.7%) experienced rejection and discrimination. The most common reason given by the respondents for non-disclosure of status to their employers was fear of stigmatization, 71 (60.2%) (Table 2).

Most of the married PLWHA, 129 (85.4%), had disclosed their status to their spouses. About half, 65 (50.4%), of the respondents reported receiving support from their spouses. Only 2.3% experienced hostility, while 1 person (0.8%) experienced violence (Table 3).

Up to 72 (47.7%) of the couples were reported to be sero-concordant and 24 (15.9%) did not know the sero-status of their spouses, while 55 (36.4%) were sero-discordant. No divorce was reported as a result of sero-positivity.

Apart from spouses, the PLWHA disclosed their status mostly to their mothers, 132 (39.9%), and siblings, 128 (39.7). Disclosure to colleagues, 31 (9.4), and community, 24 (7.3%), was low (Table 4).

The level of support after disclosure was highest among the children (89.6%), mothers (83.9%) and siblings (81.1%). It was least among colleagues (45.7%) and community (47.8%). Hostility was highest in the community (26.1%) and among colleagues (17.2%) and friends (13.9%). It was least among mothers (3.8%) and siblings (4.7%).

Health workers comprising doctors, nurses, laboratory scientists, cleaners and others were reported to be generally supportive in the hospital where the study was carried out (public hospital). The level of hostility, neglect and withdrawal reported among the different groups was very low ranging from 0.6 to

**Table 2. Reasons for non-disclosure of status to employers.**

Reasons	Frequency (N = 118), n (%)
Fear of stigmatization	71 (60.2)
Fear of termination	32 (27.1)
Guilt	7 (5.9)
Others	8 (6.8)

**Table 3. Reaction of spouse to self-disclosure by PLWHA.**

Reaction	Frequency (N = 129), n (%)
Supportive	65 (50.4)
Indifference	6 (4.7)
Hostility	3 (2.3)
Violence	1 (0.8)
Accusation	12 (9.8)
Apprehension	20 (15.5)
Depression	22 (17.1)

**Table 4. Disclosure of status to other persons.**

Persons	Frequency <sup>a</sup> , n (%)
Friends	92 (27.8)
Father	76 (23.0)
Mother	132 (39.9)
Siblings	128 (39.7)
Church leader	73 (22.1)
Children	41 (12.1)
Colleagues	31 (9.4)
In-laws	44 (13.3)
Community	24 (7.3)

<sup>a</sup>Multiple responses.

**Table 5. Attitude of health workers in private hospitals towards PLWHA.**

Attitude	Frequency (N = 103), n (%)
Supportive	57 (55.3)
Hostility	15 (14.5)
Withdrawal	12 (11.7)
Neglect	7 (6.8)
No response	12 (11.7)

1.5%. Only 103 PLWHA reported attending private hospitals. About one-third of them, 34 (33%), experienced some negative attitudes from the health workers such as hostility, 15 (14.5%), withdrawal, 12 (11.7%), and neglect, 7 (6.8%) (Table 5).

Of the 191 PLWHA who did not disclose their status to many people, 105 (55%) said that they were afraid of stigmatization. Only 69 (20.8%) PLWHA actually reported experiencing any form of discrimination. The incidence was highest among friends, 16 (23.2%), and at the workplace, 14 (20.3%). Other sources of discrimination included immediate family (15.9%), community (11.6%), church (10.1%) and extended family (8.7%).

The PLWHA reported receiving different forms of treatment from family members. A majority (62.5%) of them felt that their family members were supportive. Other forms of treatment received included indifference (21.3%), being ignored (6.5%), rejection (4.1%), being scolded (3.1%) and being driven away (2.6%). There was a difference in the way the male and female PLWHA were treated by their family members as 10.6% of the females were ignored compared with 5.4% of the males. Also, 4.5% of the females were driven from home compared with 2.7% of the males and 6.1% of the females were scolded compared with 2.7% of the males.

Among those whose status was known to the community, 50.8% were accepted. Others experienced different types of stigma and

discrimination including denied privileges (27.1%), being despised (18.6%) and being barred from community gatherings (3.4%). This was higher among females as 17.1% of the females were discriminated against compared with 5.9% of the males. Also, 13.6% of the females were denied privileges compared with 6.8% of the males.

## Discussion

The PLWHA involved in this study were those attending the University of Uyo Teaching Hospital, Uyo, Nigeria. The male-to-female ratio of 1:1 differed from that reported by the studies conducted by UNAIDS in sub-Saharan Africa where the women living with HIV were said to outnumber the men with a ratio of 13:10 (UNAIDS 2004). This difference may be due to the fact that only those PLWHA who could afford treatment came to the clinic. Women are often economically disadvantaged and many of them may have remained at home. The sex distribution of PLWHA in the general population may, therefore, have differed from that obtained in this study. However, there were more female PLWHA in this study who were widowed compared with males. This would lead to an increase in the female-headed households. A survey done in South Africa reported that almost three-quarters of the AIDS-affected households were female headed with a significant proportion of them battling with AIDS-related illnesses (Steinberg, Johnson, Schierhout & Ndegwa 2002).

A little above one-third of the respondents were single, of which up to half were females. Being single, they were not enjoying extra support from spouses and, apart from their own income, would depend solely on their relatives for support. This may lead to having multiple sexual partners in an attempt to increase sources of income, which may in turn lead to further spread of HIV.

More than two-thirds of the PLWHA in this study were employed. This is to be expected as over 80% of them were aged less than 45 years. They were, therefore, in their most productive ages. Moreover, being HIV positive did not prevent them from working as serious symptoms are only likely to occur when the disease progresses to AIDS. It is common to find HIV-positive people at the workplace. Anglo Platinum in South Africa reported in its 2000 annual report an estimated HIV prevalence of 22% among its employees (ANGLO-PLATINUM 2001). The most common form of employment among the PLWHA in this study was government employment as there were few industries in the State. More than 80% of the respondents did not disclose their status to their employers for fear of stigmatization or termination of employment. Other studies have also reported such fear among PLWHA at the workplace. The fear of being sidelined in terms of training and promotion acted as disincentives for employees in Deco, a South African company, to find out, respond to or disclose their status. The effects of these discriminatory and stigmatizing attitudes made many to not disclose their status (Dickinson 2003). A study carried out in Trinidad and Tobago reported that 50% of HIV-positive persons did not apply for jobs because they feared discrimination and felt that they would not be hired because of their status (CARE 2000). This attitude is likely to

make many of them to not utilize their potentials maximally, leading to a lot of wasted manpower.

More than 80% of those who had disclosed their status in this study were accepted and supported by their employers. Disclosure of status can, therefore, be beneficial to PLWHA and can be utilized as a means of encouraging support for them. None of them lost their job as a result of disclosure of status. This is contrary to the experience of Ahamefule (2002) who had her appointment as an auxiliary nurse terminated when she was confirmed HIV positive.

Though cases of discrimination reported by the PLWHA was negligible in the hospital where the study was carried out, up to one-third of those who attended private clinics reported discrimination in forms of hostility, withdrawal and neglect. A study conducted in Nigeria on the attitude of physicians in private hospitals towards the care of PLWHA in two states reported similar findings as 35% of them felt that the best they could offer their patient was referral to a government hospital, 30% felt that it was appropriate for a physician to decline to manage a PLWHA and 28% felt that revealing a patient's status to relatives was acceptable (Ihekweazu 2002). Health workers in the private hospitals seemed to lack adequate knowledge and training on HIV and the concept of universal precaution, and this may explain the level of discrimination reported in such facilities. The better attitude exhibited by the health workers in the public hospital where the study was carried out may have been due to the opportunities for training on HIV that the health workers had as the hospital was one of the centres for anti-retroviral treatment in the country. A study carried out among health workers dealing directly with PLWHA in four states in Nigeria showed that some healthcare professionals discriminated against and stigmatized PLWHA as 9% reported of having refused to care for PLWHA, while 9% reported of having refused them admission and 20% felt that many of these patients had behaved immorally and deserved the disease. Two-thirds reported of having observed other health professionals refusing to care for a patient with HIV/AIDS and 43% reported of having observed others refusing them admission into the hospital (Reis *et al.* 2005).

A majority of the PLWHA disclosed their status to their spouses and up to half of them received support. Only one-tenth of them were, however, accused by their spouses, while one person reported actual violence. There was no incidence of separation or divorce as a result of disclosure of status. This may have been due to the fact that the spouses of almost half of the respondents were also HIV positive. A similar study done in Sagamu, Nigeria, among 53 PLWHA on antiretroviral treatment showed that 70.3% had informed their spouses/main sexual partners. The commonest reason for non-disclosure was fear of separation or divorce (57.1%). Of all those who had disclosed their status to their spouses, 65% took it in good faith and 15% had their marriages dissolved, while 20% reported other experiences (Olusoji 2004).

Apart from spouses, disclosure to mothers and siblings was highest and to colleagues and community members was least.

Similar findings were reported in Sagamu where self-disclosure was highest among main sexual partners/spouses, followed by immediate family members (60.4%), other relatives (11.3%), friends (9.4%), co-workers (7.5%) and casual partners (1.9%) (Olusoji 2004). The PLWHA naturally expected more solidarity from their family members than from their distant acquaintances. This was not surprising as the care of PLWHA seems to be heavy on the family, especially on the mothers. UNAIDS report states that in many countries, women are the carers, producers and guardians of family life. This means that they bear the largest AIDS burden and older women are reported to shoulder the burden of care when their adult children fall ill (UNAIDS 2004).

The level of support received by the PLWHA varied among the different people that disclosure was made to. Support was highest from family members and least from colleagues and communities. Similar findings were reported in a study conducted on the prevalence of and factors associated with HIV/AIDS-related stigma and discriminatory attitudes in Botswana. While most people exhibited discriminatory attitude towards a teacher or a shopkeeper with HIV/AIDS, only 11% of the 4147 respondents reported unwillingness to care for a family member with HIV/AIDS. Women portrayed a more tolerant attitude towards caring for their sick relatives (Letamo 2003).

The most common reason for secrecy about HIV status among a majority of the PLWHA in this study was fear of stigmatization. They desired to be treated equally with everyone else. In a study carried out at Eskom, a South African company, more than 90% agreed that their colleagues and family would ridicule and gossip, whereas only 23% feared that they would lose their jobs if they tested positive (Eskom 2002).

In all, about one-fifth of the respondents reported experiencing discrimination. The sources of discrimination cut across the entire social network, comprising health workers, colleagues, church members, community, friends and families, but were most common among friends and colleagues at workplaces. Hostility was highest in the communities. This was expressed in different ways. Some were denied privileges, despised and barred from community gatherings. A similar study conducted in South Africa found that only one-third of the respondents who had revealed their status received support from their communities. One in ten reported being met with outright rejection (Steinberg *et al.* 2002). These negative attitudes are mostly the result of the common perception of HIV as a consequence of promiscuity and, as such, the people affected deserved to have the disease and should not be pitied. In this study, females were more discriminated against compared with males. In many African countries and other developing countries, men are likely to be excused for their behaviour that led to infection, whereas women are not (Averts 2004a, 2004b).

## Conclusion

Disclosure of status was generally low among the PLWHA in this study. The main reason they gave was fear of stigmatization. Disclosure to spouses and family members, who were mostly supportive, was highest. The PLWHA face many discriminatory attitudes

in the communities, at the workplace and among friends, health workers and even family members. These included hostility, being barred from gatherings, rejection, neglect and denial of privileges. A lot of awareness campaigns have to be carried out by all stakeholders to reduce stigma and discrimination and ensure adequate integration of PLWHA into the society. This is likely to increase their level of disclosure of status, which will enable them to enjoy more support and improved quality of life.

## Limitation

This study was limited to PLWHA attending a clinic in the teaching hospital in Uyo, Nigeria. It did not include others who may have been seeking care elsewhere as well as those who could not afford treatment at all. Future studies may benefit from the use of in-depth interviews, which may capture some information that the questionnaire may not have covered adequately.

## References

- Adeboye, A.A. (1992). Health Workers Attitude to Hospitalised Patient: Urgent Need for Intervention. VII International Conference on AIDS in Africa, Cameroon, 1992. Abstract No. 35-5-CA 92-3.
- Adejuyigbe, E.A. & Odebiyi, A.I. (2006). Parental HIV serodiscordance: implication for the care of HIV positive child in a resource poor setting. *AIDS Care: Psychological and Socio-medical Aspect of HIV/AIDS*, 18(6), 537–543.
- Ahameful G. (2002). Human Right Violation: My Experience as a Person Living with HIV. XIV International Conference, Barcelona, Spain, 2002. Abstract No. 277-38-BA02-5.
- Alubo, O., Zwandor, A., Jolayemi, T., & Omudu, E. (2002). Acceptance and stigmatization of PLWA in Nigeria. *AIDS Care: Psychological and Socio-medical Aspect of HIV/AIDS*, 14(1), 117–126.
- ANGLO-PLATINUM (2001). Annual Report. <http://www.angloplatinum.com>
- Avert (2004a). World AIDS Day. <http://www.avert.org/worldaid.htm> (Accessed 1 December 2004).
- Avert (2004b). HIV&AIDS Stigma and Discrimination: Attitudes Towards HIV&AIDS. <http://www.avert.org/aidsstigma.htm> (Accessed October 2004).
- Caribbean Epidemiology Center and Community Action Resource (CARE) (2000). Quality of HIV/AIDS Care in Trinidad and Tobago: The Care Receiver and Care Provider Perspective.
- Dickinson, D. (2003). Managing HIV/AIDS in the South African workplace: just another duty? *South African Journal of Economic and Management Sciences*, 6(1), 25–49.
- Eskom (2002). Addressing HIV/AIDS Stigma and Discrimination in a Workplace Programme: Emerging Findings. Eskom in Partnership with the Horizons Program and Development Research, Africa. June, Interim Report.
- Federal Ministry of Health (2006). National HIV Sero-prevalence Sentinel Survey. Technical Report, Abuja.
- Ihekweazu, C. (2002). Ethical Considerations in the Management of Patients with HIV/AIDS among Physicians in Private Hospitals in 2 Nigerian States. XIV International Conference, Barcelona, Spain. Abstract no. 277-38-BA02-5.
- Letamo, G. (2003). Prevalence of and factors associated with HIV/AIDS-related stigma and discriminatory attitudes in Botswana. *Journal of Health, Population and Nutrition*, 21(4), 347–357.
- Li, L., Sun, S., Wu, S., Lin, C., Wu, Z., & Yan, Z. (2007). Disclosure of HIV is a family matter: field notes from China. *Journal of Family Psychology*, 21(2), 307–314.
- National Action Committee on AIDS (NACA) (2004). Tested positive in 1996 but I still live a normal life. *The National Response Newsletter*, 1(1), 7–19.
- National Population Census, Nigeria (2007). Report of Nigeria's National Population Commission on the 2006 Census. *Population and Development Review*, 33(1), 206–210.
- Olusoji, D. (2004). Self-Disclosure of HIV Sero-status to Perceived Significant Others among PLWHA on HAART in Sagamu, Nigeria. 4th National Conference on HIV/AIDS in Nigeria, May 2004. Abstract No. A176.
- Omotoso, B. A. (2003). Perception of AIDS as Correlate of Sexual Behaviour among University Undergraduates in South Western Nigeria. An unpublished Ph.D Thesis of Obafemi Awolowo University, Ile-Ife, Nigeria.
- Reis, C., Amowitz, L.L., Heisler, M., Moreland, R.S., Mafeni, J.O., Anyamele, C., et al. (2005). Discriminatory attitudes and practice by health workers towards patients with HIV/AIDS in Nigeria. *PLoS Med*, 2, e246.

Steinberg, M., Johnson, S., Schierhout, S., & Ndegwa, D. (2002). *Hitting Home: How Households Cope with the Impact of the HIV/AIDS Epidemic*. Cape Town, Henry J. Kaiser Foundation and Health Systems Trust, October 2002.

UNAIDS (2000). *HIV and AIDS-related Stigmatization, Discrimination and Denial: Forms, Context and Determinants*, June.

UNAIDS (2002a). *A Conceptual Framework and Basis for Action. HIV/AIDS and Discrimination*, November.

UNAIDS (2002b). *The Sector Response to the Epidemic-A Global Benchmark, UNAIDS Best Practices Collection*, December.

UNAIDS (2004). *Report on the Global AIDS Epidemic, 4th Global Report*, July, 41–59.

UNAIDS, India (2001). *HIV and AIDS-related Stigmatization, Discrimination and Denial*, August.

WHO (2003). *Shaping the Future. The World Health Report*, 17–45.