

Perception about HIV and People Living with HIV/AIDS (PLHIV) in Three Local Government Areas of Bauchi State

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ABSTRACT

HIV prevalence rate is 3.34 percent in Nigeria with 3.2 million persons living with HIV (PLHIV). The North-East has a prevalence rate of 3.5% with Bauchi State having decreased to 0.6% in 2014 from 2.0% in 2010. Despite the high response to HIV epidemic in Nigeria and in Bauchi State, there still remain challenges. Stigma is prevalent in both communities and healthcare settings and is a major barrier to HIV prevention and treatment adherence. The overall objective of this study is to investigate the burden of stigma and discrimination among PLHIV that impede access and utilization of HIV Services in three Local Government Areas (LGAs) in Bauchi State (Bauchi LGA, Katagum LGA and Tafawa-Balewa LGA) with a view to suggest innovative strategies for improvement. The study investigates 436 respondents consisting of 200 males and 236 females within the ages of 15 to over 50 years. Eligibility criteria for selection were based on age, residency within the LGAs, and membership of Support Group (s) within the LGAs. Purposive and Convenience Sampling were the methodology employed for selecting respondents. Data was analysed using SPSS Version 21. The analysis employed descriptive statistics involving the use of frequencies and percentage distribution which provides general information about the respondents and variables used for the study, Statistical tables were cross-tabulated to show relationships between outcome variables. Some of the findings suggest that 34.1% percent of respondents are ashamed of their HIV status because they are excluded from social gathering, while 41.7% feel guilty because they are excluded from family activities. Over 70% of respondents who earn less than N20,0000 (about \$57) per annum do not have access to HIV services due to cost of transport and 49.6% of respondents are divorced within the first 5 years of marriage. The conclusion drawn is that there is evidence to suggest that HIV stigma & discrimination is prevalent among PLHIV in the three LGAs studied

Keywords: Stigma and Discrimination, People Living with HIV (PLHIV), Local Government Areas (LGAs), Support Groups of PLHIV, Health Care facilities.

INTRODUCTION

HIV/AIDS is a pandemic that continues to threaten human livelihood and existence, especially in Sub-Saharan Africa where many lives are lost. It was noted that about 25 million people live with HIV/AIDS, globally [1]. The World Health Organization provided a global estimate of the “Top 10” countries with the highest burden of HIV in absolute figures as at January 5th, 2011, including: Democratic Republic of Congo (1,100,000), United States (1,148,200), Uganda (1,200,000), Zimbabwe (1,200,000), Tanzania (1,400,000), Mozambique (1,400,000), Kenya (1,500,000), India (2,400,000), Nigeria (3,300,000), and South Africa (5,600,000) [2]. Another global estimate show that 24.7 million (71%) lived with HIV in 2013 across countries and 1.5 million were newly infected with the disease, out of which 4.7% were adult prevalence and 39% of adults had access to antiretroviral treatment and deaths due to HIV related causes were 1.1 million [3]. However, decreasing evidence suggest that the HIV/AIDS epidemic is slowing down for countries such as Afghanistan, Cape Verde, which are reported to have the lowest prevalence of the disease estimated at less than 0.1% of their populations and West African countries of Senegal, Gambia, Niger, which have low range estimated at 0.5%. Despite this positive development, other countries including Nigeria still indicate high prevalence exceeding 20%. The WHO and UNAIDS above, indicate that Nigeria, according to estimates is next to south Africa, having a HIV prevalence rate of 3.34 percent with 3.2 million persons that are HIV positive. Nigeria has over two hundred thousand (220,394) new HIV infections in 2013 and about 1.5 million positive patients that need ARV (anti-retroviral) drugs [4, 5]. Regional variation indicates that the North-East of Nigeria has 3.5 percent prevalence, unveiling Bauchi State’s decreasing rate of 2.0 percent in 2010 to 0.6% [4]. Other states in the North-East include; Gombe (3.4%), Borno (2.4%), Adamawa (1.9%), Taraba (10.5%), and Yobe (5.3%) [6]. NACA provides a chronological order of prevalence that indicates the “Top 10” in Nigeria which revealed that in 2014, Benue was the state with the highest HIV/AIDS prevalence in the country. However, this leading position was taken over by Rivers State in 2015 with the highest prevalence rate of 15.2% followed by Taraba State with a 10.5 % prevalence rate and Kaduna State with a 9.2 %. Nasarawa State (8.1%), Federal Capital Territory, Abuja (7.5% 6) Akwalbom (6.4% 7), Oyo and Sokota(5.6%), Yobe State (5.3% 9), Cross River (4.4%) and Ondo state (4.3%) showing relatively lower rates [6],

HIV/AIDS-related stigma and discrimination is implicated to be the most driving force that spearhead the disease and impede access to HIV/AIDS services in Sub-Saharan Africa [7, 8]. HIV-related stigma refers to the negative beliefs, feelings and attitudes of HIV infected people and those affected (families, close relatives, friends, etc.) who become withdrawn from other people due to the shame associated with the condition. Stigma is internalized and perceived by the individual involved. HIV-related discrimination on the other hand, refers to the unfair and

unjust discriminatory treatment of an individual based on his/her real or perceived HIV status (by immediate family, friends, close relations, neighbors, or other community members). Unlike stigma, discrimination is inflicted on the individual involved.

Stigma and discrimination are among the foremost barriers to HIV prevention, treatment, care and support services. HIV stigma and discrimination discourage people living with HIV from disclosing their status even to family members and sexual partners and undermines their ability and willingness to access and adhere to treatment. This undermines HIV prevention efforts since PLHIV distance themselves from seeking HIV information and services. This paragraph relates closely with the focus of this study.

Goffman, maintains that stigma is labelled when individuals are stigmatized as possessing a 'spoiled' identity and makes them deviate from normal behavior or acceptable behavior. Stigma is a labelled stereotyping, experienced by loss of status for the stigmatized [9, 10]. In his theory of *Social Role Valorization* (SRV), Wolfersberger holds the belief that only people with valued social roles in society are respected and have the best things in life [11]. Those devalued in society are far more likely to be treated badly such as HIV patient, and to be subjected to negative experiences such as the following: (1) being rejected by community, society, and even family and services; (2) being cast into negative social roles, such as "subhuman," "menace," and "burden on society;" (3) being put and kept at a social or physical distance, the latter most commonly by segregation; and (4) having negative images (including language) attached to them. Two ways Wolfersberger suggested that can enhance their Social Role Valorization are: (a) enhancement of their social image in the eyes of others, and (b) enhancement of their competencies [11]. This theory thus, depicts the psychological and social consequences associated with HIV disease and the people infected as labelled against them in their communities, among families, friends, and immediate neighborhood. This study investigates the prevalence of stigma and discrimination labelled against people living with HIV/AIDS (PLHIV) among 436 respondents within Support Groups of PLHIV in three Local Government Areas (LGAs) of Bauchi State.

2.0 Study Objective:

The overall objective of this study is to investigate the impact of stigma and discrimination among PLHIV that impede access and utilization in three Local Government Areas (LGAs) of Bauchi State (Bauchi, Katagum and Tafawa-Balewa LGAs) with a view to suggest innovative strategies for improved access and utilization. The long-term goal aims at drawing the attention of government and other stakeholders within and outside the communities in providing policy direction that would improve access and service uptake among PLHIV that can contribute to

meeting the unique personal, social, and familial needs of this segment of population for better health and improved quality of lives.

3.0 Methodology of the Study.

3.1 The Study Population

The study population consists of People Living with HIV/AIDS (PLHIV) both males and females in selected Support Groups of PLHIV in three Local Government Areas (LGAs) of Bauchi State. The total sample drawn was 436 respondents (200 males and 236 females) from a population of Support Groups across the three LGAs: Bauchi, Tafawa-Balewa, and Katagum LGA in Bauchi State. The study population is homogenous in terms of language and culture. Hausa language is the common language spoken in all three LGAs. Only persons that are members of a Support Group who are confirmed HIV positive or living with AIDS were purposively selected for this study.

2.2 Sampling Design

A non-probability purposive sampling (based on intent because the study is for a specific group of people) and convenience sampling (based on availability of respondents) were the methodology employed for selecting cases as only respondents whose HIV status were known and who belonged to a PLHIV Support Group were involved in this study. A total sample of 436 respondents (200 males and 236 females) was drawn from selected Support Groups of PLHIV in the three LGAs. The eligibility criteria for selecting all types of respondents across the LGAs was based on availability; membership of a Support Group of PLHIV; residency within the LGA; and willingness to participate regardless of gender, duration with the disease and marital status. The study considered only participants from the age of 15 years for interview, as this study focuses on PLHIV support groups members who are adults and who have the competency to give informed consent. Those below the age of 15 years and those documented medically as having severe mental health disabilities were excluded from the interview. Each respondent interviewed completed a consent form by agreeing to freely participate in the interview and which serves as a legal backing as an assured informed consent. Proxies for consent were not considered due to the nature of the study which involved a special group (HIV/AIDS patients) for the study. Convenience sampling was adopted (based on access and availability of respondents) due to the sensitivity of the subject matter which requires confidentiality and willingness to participate. Participation in the interview was voluntary, ensuring that no respondent was excluded based on gender, ethnicity or socio-economic status across the three LGAs.

This study considers stigma and discrimination against PLHIV as the dependent variables and were determined by: (i) perceived (internalized) stigma experience among PLHIV that prevent access to HIV services; (ii) discrimination experience among PLHIV that prevent access to HIV services; and (iii) HIV-related stigma and discrimination noticed as perceived by PLHIV exhibited by health care workers. The independent variables were determined by socio-demographic characteristics of respondents, knowledge about HIV, perceived institutional support, availability of HIV services, etc.

3.3 Data Collection Procedure

The study employed a method of “triangulation” (mixed method) for data collection where relevant information for the conduct of the study was collected. The mixed method involved both quantitative data collection method (using structured interviewer administered questionnaire which looks at numerical data about outcome variables) and qualitative method (using an in-depth interview guide that gathered information regarding people’s general perception, perceived intentions or actions about an issue). The two methodological approaches provide measurable (quantitative) evidence of the impact of HIV related stigma on PLHIV, and qualitative evidence that provide clear undersatandi8ng on the reasons for the occurrence (the why and how) of the manifestation of HIV among those affected in the study areas. A total of 436 respondents were sampled using purposive and convenience sampling methods. A question schedule designed contained both closed and open ended questions which allow flexibility for further probing. The question schedule was pretested to determine the validity of the questions, permit clarity of terminology, observes time schedule, and the ordering or sequence of the questions. Field enumerators were recruited and trained who worked as research assistants. The minimum qualification for any interviewer was a qualified secondary school holder or polytechnic/college of education certificate holder. Familiarity with the prevailing socio-cultural environment was a requirement and the ability to speak Hausa language fluently. Three interviewers were recruited for each site to enumerate a total of 145 respondents (both males & females) that were available for the study drawn from Support Groups of PLHIV in each of the three LGAs. The questionnaire was translated into the local language (Hausa) as well, for ease of understanding and interpretation to avoid ambiguity. Data collection lasted for a period of 15 days in each site for accuracy, reliability and completeness of each question schedule. During the interview, respondents were fully informed about the nature of the study and what the interview entailed and were assured of their confidentiality during the entire process. The interview process was individual and involved asking respondents every question with respect to each category of expected responses. Prior to conducting each individual interview, respondents were asked by individual interviewers to complete and sign an interview consent form or thumb print a consent form completed in his/her presence (for non-literate respondents). The right to participate and/or

to withdraw from the study at any point in time, was based on the discretion of respondents due to the sensitive nature of the HIV/AIDS disease. At the end of each interview, each respondent was acknowledged by a word of thanks for his/her participation in the interview. Confidentiality of participants was assured. The respondents were homogenous as they speak the same language as the interviewers. Hausa was the common language spoken in all three LGAs as stated earlier, and was used throughout the interviews along with English (for literate respondents). The Principal Investigator cross-checked the completeness and correctness of each completed questionnaire for quality assurance.

A second method employed for the study is in-depth interview (IDI). Forty-Five (45) respondents (20 males and 25 females) making a total of 135 respondents were selected in each LGA from the Support Groups and administered a set of questions in an in-depth interview using interview guide. The interview was conducted with respect to their perceived stigma and discrimination; their feelings and knowledge about HIV/AIDS as a disease; their attitude towards family and community members; the relationship with friends, social networks, and other people; their relationship with health care workers or how they are seen by health care workers; their level of access or reasons for lack of access to HIV services in health facilities; their response to treatment; sources of livelihood; etc. The interviews, using interview guide, were audio-recorded, transcribed, and translated from English to Hausa language. The IDIs were conducted in a face-to-face contact in a private and quiet place to maximize privacy and lasted for 20 to 25 minutes. Each respondent was asked the same set of questions using the guide. The consent of the interviewee was sought before the start of each interview. This was meant to compliment the quantitative method described above which used a structured questionnaire. Three University Post Graduate Diploma Students of Public Health, Abubakar Tafawa Balewa University (ATBU), Bauchi, were recruited and trained by the Principal Investigator and conducted the interview. Each interviewer was assigned to an LGA and interviewed a maximum of 45 respondents under the supervision of the Principal Investigator

4.0 Data analysis techniques.

Data analysis involved the use of simple frequencies and percentages for the major variables in the questionnaire which helped to describe the general patterns, the distributions and the representativeness of the questionnaire in the study. The interviews, using interview guide, were audio-recorded, transcribed, and translated from English to Hausa language. A process of thematic analysis was employed to analyze the data. Thus; the information obtained were analyzed through the examination and categorization of respondents' comments. The analysis went through three stages: (i) using line-by-line coding of field notes and transcripts; (ii) by in-depth examination and interpretation of the resultant codes and their categorization into

descriptive and analytical themes; and, (iii) by development of an overarching theme or concept. The coding involved concepts development by piercing the data into discrete elements to expose underlying thoughts and meanings. The thematic network analysis process has reflections with global codes[12, 13] which have direct focus with this study (though adjusted). The major themes used include: (i) stigma experience among PLHIV that prevent access to HIV services; (ii) discrimination experience among PLHIV that prevent access to HIV services; and (iii) HIV-related stigma and discrimination noticed as perceived by PLHIV exhibited by health care workers. The investigator devoted time to spot-check all returned interview materials for consistency and accuracy of recording in the field.

Data collected was analyzed using SPSS Version 21 computer software package. The analysis of data was restricted to descriptive statistics using simple frequencies and percentage distributions presented in statistical tables which provide general information about respondents and variables used for the study. Statistical tables were cross-tabulated to show relationships between outcome variables. Additional information that are part of the findings which are not presented in the tables are explained during discussion or as examples for clarity of purpose.

5.0 Results.

A total of 436 respondents were interviewed out of which 200 respondents (45.87%) are males and 236 respondents (54.13%) are females and about 96% fall within the ages of 15-49 years. The concept of stigma and discrimination analyzed and presented in tables, in subsequent pages, below include personalized stigma such as feeling of shame, feeling of guilt, feeling of low esteem, etc. Access and utilization of HIV services include; ability to access and use HIV drugs and related drugs for opportunistic infections. Occupation, income, geographical distance, and provider's attitude were also assessed as determinants of access to HIV services. As demonstrated in the tables, respondents experienced degrees of stigma and discrimination with 34.1% percent of respondents showing feeling of shame of the HIV status because they are excluded from social gathering, while 41.7% feel guilty because they are excluded from family activities (Table 6). Over 70% of respondents who earn less than N20,000 (about \$57) per annum do not have access to HIV services due to cost of transport (Table 4) and 49.6% of respondents are divorced within the first 5 years of marriage (Table 2). Furthermore, 46.9% of respondents "Know where to access ALL HIV Related Drugs but are Not Currently Taking" due to geographical distance to facilities. On the other hand, 45.3% of respondents who are "Currently on HIV Medication (ART)" indicated that despite geographical distance and cost of transport to health facilities, they still access and use HIV services (Table 5). Majority of respondents (52.56%) have only Qur'anic education (Table 1). Petty trading and farming, indicating 192 and

105 respondents respectively, are the major occupations of respondents across the LGAs (Table 3). The study findings are presented in the following tables

Table 1: Distribution of Respondents by Demographic Characteristics		
Age of Respondents		
Age Groups	Frequency	Percent
15-19	196	44.95
20-24	91	20.88
25-29	62	14.22
30-39	41	9.4
40-49	28	6.42
50+	18	4.13
Total	436	100
Sex of Respondents		
Sex	Frequency	Percent
Males	200	45.87
Females	236	54.13
Total	436	100
Education of Respondents		
Education	Frequency	Percent
Quranic Education	215	52.56
Primary School	102	23.08
Secondary School	60	13.59

Vocational Training	55	10.26
University/Colleges	04	0.51
TOTAL	436	100

Across age groups, as shown in table 1 above, no respondent was interviewed below the age of 15 years and 96% of respondents are between the ages of 15-19 years, while about 4% of respondents are above 50 years of age. The table also shows that of all respondents interviewed 45.87% are males and 54.13% are females. This indicates that predominantly more females were available for interview. Across educational categories, less than 1% of respondents have more than a vocational training skill, 13.59% have secondary education, about 23% acquired primary certificates, and more than half have qur'anic education.

Table 2: Distribution of Respondents by Marital Status and Duration of Marriage

Marital Status	Duration of Marriage					Total
	1-5 years	5-10 years	10-15 years	10-20 years	20 years and above	
Married and lives with husband	(25) 62.5%	(9) 22.5%	(4) 10.0%	(0) 0.0%	(2) 5.0%	(40) 100.0%
Never married but lives with a sexual partner	(48) 51.6%	(13) 14.0%	(16) 17.2%	(9) 9.7%	(7) 7.5%	(93) 100.0%
Separated	(16) 36.4%	(16) 36.4%	(1) 2.3%	(10) 22.7%	(1) 2.3%	(44) 100.0%
Divorce	(114) 49.6%	(44) 19.1%	(34) 14.8%	(20) 8.7%	(18) 7.8%	(230) 100.0%

Widowed	(14) 48.3%	(13) 44.8%	(0) 0.0%	(2) 6.9%	(0) 0.0%	(29) 100.0%
Total	(217) 49.8%	(95) 21.8%	(55) 12.6%	(41) 9.4%	(28) 6.4%	(436) 100.0%

Table 2 above shows marital status of respondent’s cross-tabulated with duration of marriage. Over 60 % of respondents were in marital union within their first years of marriage at the time of interview. The length of stay in marriage decreases as duration increases and by 20 years, only 5% of respondents were still being married. About half (51.6%) of respondents had never been married but lives with a partner. This pattern also decreases as duration increases. The decreasing pattern may be attributed to hidden or undisclosed HIV status among couples during early years of marriage or co-habitation which are likely to have been exposed in later years. Most couples would not want to remain in union on discovery of partner’s status. This may, also, be true among the proportion of those couples divorced with almost half (49.6%) of respondents are divorced before they reach 5 years of marriage. A female respondent (25 years old) narrated that *“there is no sincerity among most of our men who hardly disclose their status to their wives. No woman would like to continue such marriage knowing that she lives with such a wicked husband. [And]when their status is disclosed, they usually place the blame on their wives saying ...my wife gave me the disease due to her infidelity because in this community, the wife or wives of a HIV positive man or a widower due to HIV, is regarded as a prostitute.”*

More testimonies among female respondents during the in-depth-interviews revealed that most respondents developed resilience in adapting to live with their husbands due to their faith and devotion to their religion. “I believe that every disease comes from God (a 37-year-old female respondent).”Other respondents expressed that they remain in union either married or co-habiting because they marry among themselves “marriage of convenience.”

Table 3: Respondents by Type of Occupation and Access to HIV/AIDS Services

Type of Occupation	Access to HIV/AIDS Services in Health Facilities			Total
	Geographical Distance	Means/Cost of Transport	Attitude of Health Provider	
No Occupation	(8) 4.2%	(148) 77.1%	(36) 18.8%	(192) 100.0%
Farming	(3) 2.9%	(73) 69.5%	(29) 27.6%	(105) 100.0%
House Help	(7) 6.3%	(86) 77.5%	(18) 16.2%	(111) 100.0%
Government Employment	(2) 9.1%	11) 50.0%	(9) 40.9%	(22) 100.0%
Petty Trading	(1) 16.7%	(4) 66.7%	(1) 16.7%	(6) 100.0%
Total	(21) 4.8%	(322) 73.9%	(93) 21.3%	(436) 100.0%

In table 3 above, most respondents affected by inaccessibility to HIV/AIDS services due to means or cost of transport are those with “No occupation” (77.1%) and those who are “House Helps” (77.5%). Geographical distance did not show much impact as only “Petty Traders” (16.7%) indicated that it poses a challenge to accessing HIV services. About 41% of “Government Employees” expressed that health care provider’s attitude constituted a constraint in having access to HIV services and this is followed by the proportion of respondents who are involved in farming (27.6%) as their primary occupation. This occurrence may be due to delay in accessing services as both occupational category of respondents may not want to stay longer than necessary at the point of service due to the nature of their work. A 48-year-old respondent narrated his encounter with a health worker during the in-depth interview as follows:

“One morning, I needed to go to the office early but passed through the hospital to collect my HIV drugs and to see a doctor because I was feeling weak and I had severe headache. Having followed through all necessary protocol and collected my HIV drugs at the pharmacy, I

complained to a nurse that I wanted to see a doctor but she neglected me and was attending to other patients. I sat down for over 30 minutes waiting for her to turn to me as I was being cautious of my status to avoid any embarrassment. More than 70% of the patients had left. So, I spoke with her to gain her attention. She shouted at me and said... 'let me attend to live humans and not those already dying...' I was completely blinded for over 5 minutes and realized that I was in tears. I looked at the little girl who was as old as any of my daughters. Everyone steered at me and no one could sympathies with me. I didn't say nor do anything. That was the last of my visit to that hospital without having the strength to fight for my right."

Table 4: Distribution of Respondents by Income and Access to HIV/AIDS Services

Income Per Annum	Access to HIV/AIDS Services			Total
	Geographical Distance	Means/Cost of Transport	Attitude of Provider	
Less than N20,000.00	(241) 72.8%	(74) 22.4%	(16) 4.8%	(331) 100.0%
N20,000.00 – N30,000.00	(67) 76.1%	(16) 18.2%	(5) 5.7%	(88) 100.0%
N30,000.00 – N40,000.00	(12) 85.7%	(2) 14.3%	(0) 0.0%	(14) 100.0%
N40,000.00 – N50,000.00 & above	(2) 66.7%	(1) 33.3%	(0) 0.0%	(3) 100.0%
Total	(322) 73.9%	(93) 21.3%	(21) 4.8%	(436) 100.0%

Similarly, as demonstrated in table3 above, table 4 shows respondents by their level of income and accessibility to HIV/AIDS services. Those who earn less than \$100 (N20000) per annum, 22.4% among them indicated that means or cost of transport stands as a constraint to their accessing HIV services and 72% of respondents said that geographical distance is equally a challenge; while about 5% hold that health provider’s attitude did not permit access to HIV services in those health facilities they visited for treatment. Provider’s attitude in the higher income category (N30,000-N50,000+) show no effect as no respondent (0.0%) say that a health provider constituted a constraint to his/her access to HIV services.

Table 5: Distribution of Respondents by Access and Utilization of HIV/AIDS Services

Access to HIV/AIDS Services in Health Facilities	Utilization of HIV Services					Total
	Geographic Distance	Means/Cost of Transport	Attitude of Health Provider	Don't Like the Services	Choice of Drug is Not Always Available	
Know where to access ALL HIV Related Drugs and Currently Taking HIV Medication (ART)	(24) 45.3%	(14) 26.4%	(6) 11.3%	(3) 5.7%	(6) 11.3%	(53) 100.0%
Know where to access ALL HIV Related Drugs but Not Currently Taking	(98) 46.9%	(57) 27.3%	(21) 10.0%	(11) 5.3%	(22) 10.5%	(209) 100.0%
Do Not Have Access to All HIV and Related Drugs	(53) 40.8%	(37) 28.5%	(17) 13.1%	(11) 8.5%	(12) 9.2%	(130) 100.0%
Have Access to HIV & Related Drugs but Don't Use Regularly	(13) 29.5%	(16) 36.4%	(3) 6.8%	(4) 9.1%	(8) 18.2%	(44) 100.0%
Total	(188) 43.1%	(124) 28.4%	(47) 10.8%	(29) 6.7%	(48) 11.0%	(436) 100.0%

The distribution in table 5 above shows accessibility to HIV services and service utilization. Despite geographical distance, cost of transport, attitude of health care providers to their patients, 45.3%, 26.4% and 11.3% of respondents, respectively, indicated that they know where to access services and are currently on HIV medication. Over 70% of respondent have full knowledge of point of HIV services but are not currently on medication due to geographical distance to health facility (46.9 %) and cost of transport (27.3%), Those who know where to access but do not currently use HIV drugs may be due to any or all the range of variables listed: geographical distance, cost of transport, attitude of health worker, dislike of services offered and/or non-availability of choice of drug. Other possible explanation may include use of alternative therapy, unwillingness to disclose usage to interviewers, socio-cultural taboos, and other personal reasons, etc. Those who don't use HIV medication regularly, apart from 29.5%, 36.4% 6.8%, etc. who indicated geographical distance, cost of transport, provider's attitude as their reasons, other factors may be associated with type of occupation e.g. farmers during farming season may not have time for refill of drugs, forgetfulness by which hidden drugs kept in secrecy may easily be forgotten by user, defaulting due to absence from home e.g. petty traders. A 42-year-old male respondent narrated that,

“Due to the shame associated with this disease, I always hide my drugs from friends and relations to avoid any suspicion. Apart from my members of support group, no one knows my status in this neighborhood. I don't even visit the hospital in this community for fear of being noticed. So, I easily forget to take my drug, regularly.”

A 35-year-old female respondent also stated that;

“None of my friends know my HIV status. I keep my drugs in a special container hidden in the cupboard of my room. I use my drugs mostly at night when there is no movement in the house. Sometimes, I sleep off early due to the day's hustle...”

Table 6: Distribution of Respondents by Burden of Stigma & Discrimination

Perceived Stigma (Personalized)	Perceived Discrimination					Total
	Excluded from Social Gathering	Excluded from Social Network	Excluded from Family Activities	Verbally Insulted	Being Gossiped About	
Feeling Guilty	(40) 38.8%	(8) 7.8%	(43) 41.7%	(7) 6.8%	(5) 4.9%	(103) 100.0%
Blaming Self	(34) 45.3%	(13) 17.3%	(19) 25.3%	(1) 1.3%	(8) 10.7%	(75) 100.0%
Feeling Shame	(15) 34.1%	(4) 9.1%	(11) 25.0%	(5) 11.4%	(9) 20.5%	(44) 100.0%
Feeling Suicidal	(8) 22.2%	(3) 8.3%	(19) 52.8%	(3) 8.3%	(3) 8.3%	(36) 100.0%
Total	(124) 28.4%	(47) 10.8%	(188) 43.1%	(29) 6.7%	(48) 11.0%	(436) 100.0%

The result of the analysis in table 6 shows that perceived personalized stigma and discrimination are prevalent among respondents. Nearly 40% of respondents feel guilty about their HIV status because they are excluded from taking part in social gathering, 41% from family activities, while 4% feel guilty because they are being gossiped about in the neighborhood or within the community. Slightly over 45% of respondents blame themselves for being excluded from social gathering, 25% feel ashamed by being excluded from family activities, while more than half (52.8%) of respondents feel like committing suicide because their own family discriminate against them by not allowing them participate in the family activities. During the in-depth interview process (IDI), a 54-year-old male respondent narrated that the level of stigma and discrimination within family, among friends & social groups and the community, sometimes makes it difficult for their members to freely walk around in their immediate neighborhood and no one wishes to provide any financial or in-kind assistance. He stated thus;

“we live in a community of our own within the wider community, marry among ourselves, and with the little earnings we make, we support those among us who can’t support themselves. We

engage with Community Based Organizations (CBOs) who support us to undertake joint activities such as home visits, community mobilization by encourage people to go for HIV test especially women, hold meetings within our support groups, refer women to access health services and similar initiatives. This keep us together.”

Another respondent narrated that;

“Bad words kill. Remarks from people are more dehumanizing than the AIDS disease itself. Remarks like “more dead than alive”, “human skeleton”, “good for nothing”, “sending the cow to the abattoir”, “Karuwan Namiji (meaning Male Prostitute in Hausa language),” and the like. It makes you feel like committing suicide or burying yourself deep down into the ground because it comes from your immediate friends, families, health workers and neighbors. This is the situation faced by a HIV/AIDS patient in this community”.

All the above testimonies were outcropped during the in-depth interviews across support groups in the three LGAs chosen for this study and provide qualitative explanation to compliment the quantitative data presented in the tables above.

6.0 Discussion

The findings of this study support other findings from similar studies in Nigeria, Africa and the world at large. survey using quantitative method with an aim to determine the prevalence of internalized stigma among a sample of 238 PLHIV in Bangladesh, found significant difference between groups with the low- and the high-internalized HIV/AIDS stigma for age & gender. Internalized stigma prevalence was found to vary in accordance with poverty status of PLHIV. The results further indicated that 68% of the PLHIV felt ashamed of their status, while 54% felt guilty of their HIV status. Over 80 % (87.5% male and 19.8% female) of PLHIV blamed themselves for their status, and about 40% of both sexes felt that punishment was the best thing to be inflicted on them [14]. This has similarity with the findings of this study which show that for both sexes, 34.1% percent of respondents show feeling of shame of their HIV status because they are excluded from social gathering, while 41.7% feel guilty because they are excluded from family activities. This study also show that 38.8% of respondents blamed themselves for their HIV status because they are excluded from social gathering and 41.7% because they are excluded from participating in family activities (Table 6). Another study was done that assessed the perceived experience of patients with HIV on stigma and discrimination and patients seeking behavior in Iran. The study findings revealed that stigmatic labelling was insulting and humiliating, mostly felt by female positive HIV patients. Participants in the study reported having the feelings of shame and embarrassment. For instance, a 32-year-old female participant

reported having to wear big sunglasses, “since I felt shameful of being cured in an AIDS center.”[15].A convenience sampling method was used in a study to elicit information from 486 PLHIV in 10 clinics of 4 provinces in South Africa. Eligibility criteria was based on participant’s voluntary consent and were current HIV positive patients in selected clinics for ethical reasons and due to their familiarity with health workers. The results showed significant levels of stigma and discrimination that negatively impact on the lives and health of PLHIV and their access to health care services. Participants blamed themselves due to internalized stigma [16].

Mburu et al.; [17] explored the impact of network groups of PLHIV in Jinja and Mbale districts of Uganda. The research participants consisted of a total of 65 respondents: PLHIV (40), their households (10) and health care workers (15). The findings revealed a decline of HIV stigma due to the collective activities of the support group network. Some of the activities undertaken by the network included peer mobilization; education; home visits to PLHIV and members of their communities. This has similarity with this study as respondents were selected from PLHIV Support Groups. This further buttresses a respondent’s view in this study who narrated that “we live in a community of our own within the wider community, marry among ourselves, and with the little earnings we make, we support those among us who can’t support themselves...we engage with CBOs and undertake joint activities such as home visits, community mobilization.....”

The relationship between utilization of Voluntary Counselling & testing (VCT) and HIV stigma was conducted in 2013 in 2 states of Nigeria. The findings revealed that attitude to HIV and those with the disease by the community people in both states was negative. Also, increasing negative feelings towards the disease and those infected negatively impacted on utilization of VCT [18].Another study was conducted in Nigeria among HIV patients accessing care at the Virology Department, Federal Medical Centre, Abeokuta from 1st September to 30th November, 2012. The occupational category showed that about 50% were self-employed, nearly 30% earned salaries, and about 18% were unemployed. The average monthly income indicated that N10,000 was the highest paid and accounted for 24.1% of respondents [19]. This shows the level of poverty of respondents. This has similar findings with the result of this study where more than half (52.96%) of respondents are found unemployed. The highest form of self-employment is farming with 67.19% of respondents and as many as 11.5% are in government employment. This also goes with poverty level which indicate that over 60% of respondents earn less than \$100 (N20,000.00) per annum, thus a monthly income of less than \$10 (N 2,000). About 10% of respondents serve as house helps in people’s homes for livelihood, and only about 3% earn above \$250 (N50,000) per annum. **Note** that these results are used here only for showing similarity with Ojieabu, et al (2014) findings. They are contained in the simple frequency and percentage tables constructed for this study but are not shown in the results section of this study.

As stated earlier, cross tabulations are presented to show some level of relationships rather than simple frequency tables which provide only general information about respondents and variables used for this study.

7.0 Conclusion

The conclusion that can be drawn from this study is that stigma and discrimination are prevalent among PLHIV in communities in the three selected LGAs in Bauchi State of Nigeria. Therefore, if the findings of this study are utilized, it can inform policy decision for an enhanced uptake and utilization of services and possible pathways to reduce the burden of stigma and discrimination experienced by PLHIV in the three LGAs studied or extend to other parts of Bauchi State or Nigeria at large.

8.0 Recommendations

Recommendations are focused on strategies to reduce stigma and discrimination hence improve uptake of HIV services among PLHIV which would include: (a) promoting community interaction that involves focus group or guided group discussions or a town hall meeting that would bring together both PLHIV and members of community together especially who are vulnerable to HIV infection. This would be intended to addressing fears and misconceptions about HIV transmission and to promote understanding, compassion and increased resilience; (b) use of electronic and print media to promote campaigns, enter-educate or edutainment (education & entertainment) relating to the negative impact of discrimination against PLHIV;(c) integrating non-stigmatizing messages into television and radio shows or ijngles; (d) awareness creation campaigns that provide information about rights and laws related to HIV through social media (electronic &Internet); (e) engagement with religious leaders, community leaders, youth leaders, women leaders and celebrities; (f) enforcement of non-discrimination as part of institutional and workplace policies in employment, health care settings and community settings; (g) peer mobilization and support to promote health and human rights of PLHIV; (h) promote the enactment and implementation of policies and laws by the legislative house both national and states assemblies to prohibit discrimination and promote support for access to HIV prevention, care and support services.

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Competing interests

The author declares that there are no competing interests, financial or of any kind.

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