GENDER INFLUENCE ON THE LEVEL OF DISCRIMINATION AND STIGMATIZATION OF PEOPLE LIVING WITH HIV/AIDS IN GARISSA COUNTY

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Abstract

Purpose: The purpose of the study was to establish whether gender influences the level of discrimination and stigmatization of people living with HIV/ AIDS in Garissa County.

Methodology: The target population of the study was all the patients with HIV and AIDS attending The Comprehensive care Centre at Garissa Provincial General Hospital in Garissa County. There are approximately 2000 people actively on ARVs attending the facility. A sample of 200 respondents was selected using random sampling from the listed list of all patients in the hospitals. The study used primary data. Data collection methods included: questionnaires and interview guide. Data was analyzed quantitatively and qualitatively. Information was sorted, coded and input into the statistical package for social sciences (SPSS) for production of graphs, tables, descriptive statistics and inferential statistics. Results were presented by use of tables and charts.

Results: Based on the findings, the study concluded that gender does not influence stigmatization and discrimination levels. Stigmatization and discrimination occurred to anyone irrespective of their gender. The study concluded that gender is not statistically significant in explaining stigmatization and discrimination of people living with HIV in Garissa County.

Unique contribution to theory, practice and policy: Based on the findings, the study recommends that health drives and campaigns should be conducted in order to raise the knowledge levels on how HIV can be spread.

Keywords: gender, discrimination, stigmatization, HIV/AIDS, Garissa County
1.0 INTRODUCTION

1.1 Background of the Study

Stigma is the identification that a social group creates of a person (or group of people) based on some physical, behavioral or social trait perceived as being divergent from group norm (Castro and Farmer, 2005). Also, as Deacon (2006) states, negative effects of stigma include status loss and discrimination. Discrimination often includes harassment, violence, and the social tendency to blame the victim (Appleby et al., 2001). Also, according to Carr-Ruffino (1998) discrimination refers to actions, whereas prejudice refers to viewpoint. Although the UNAIDS Vision is zero new HIV infections, zero discrimination and zero AIDS–related deaths as per its global report of 2010, the epidemic of stigmatization against people living with HIV/AIDS remain a big challenge. According to Michel Sidibe, UNAIDS Executive Director, growth in investment for the AIDS response has flattened for the first time in 2009, Demand is outstripping supply. Stigma, discrimination, and bad laws continue to place roadblocks for people living with HIV and people on the margins.

The epidemic of HIV/AIDS has been accompanied by the epidemic of stigmatization against people living with HIV/AIDS (PLWHA) (Varas-Dríaz et al., 2005). Even though two decades have passed since the first five AIDS cases were reported in 1981 in the USA and HIV/AIDS cases have become more widespread, stigmatization against individuals with HIV/AIDS continues to persist in both overt and covert forms (Herek, 2002). HIV/AIDS stigma is a worldwide social phenomenon. PLWHA are often stigmatized partly because HIV/AIDS is a disease transmitted by modes and behaviors that are disapproved by society (e.g. homosexual behavior, drug use and commercial sex), and partly because people are afraid of contracting HIV/AIDS due to the fact that it is a degenerative and incurable disease with a high mortality rate.

Given that HIV/AIDS is a fatal contagion and prevalent in some social groups (e.g. gay and bisexual men and intravenous drug users among others), stigmatized reactions to PLWHA are thought to be a result of at least two types of attitudes: instrumental attitudes which derives mainly from fear of AIDS contagion, and symbolic attitudes which derives from the expression of hostility towards deviant behaviors of the risk groups (Herek and Capitanio, 1998). PLWHA are subjected to greater blame if they have been known to have contracted the infection through sexual behaviors (either heterosexually or homosexually) (Herek and Capitanio, 1999).

HIV-related stigma and discrimination have been acknowledged as an impediment to mitigating the HIV epidemic since its early days, yet programming and activities to reduce stigma and discrimination have been given much less attention than other aspects of the epidemic. Fortunately, in recent years there has been an increase in the literature on HIV stigma as the issue has gained visibility and greater conceptual clarity and as means to measure stigma have been refined (Nyblade and MacQuarrie, 2006; Genberg et al., 2008; Stein and Li, 2008; Visser et al., 2008). However, key gaps remain in the literature. Definitive studies demonstrating a causal link between the availability of treatment and lower stigma and discrimination, as well as the effect of stigma-reduction interventions on uptake of HIV prevention, care and treatment are lacking. Evaluation data on the potential range of
stigma-reduction programmes is still limited, and documentation and evaluation of country programmes are non-existent.

It can range from almost imperceptible attitudinal hostility through to physical violence. It can manifest itself in forms which appear reasonable and justifiable, or in extremes of pathological behavior. It is sometimes blatantly explicit, but more often subtle, sophisticated and difficult to define (New South Wales Anti-Discrimination Board, 1992). The Board identified eight forms of discrimination: direct discrimination, discrimination that is explicitly based on characteristics of or attributed to the individual against whom the discrimination is directed, including characteristics attributed on the basis of stereotyping.

Indirect discrimination is discrimination that is based on the establishment of rules, policies or conditions that do not in discriminatory, but that have the effect of discriminating against particular groups of people who are unable, or less able, to comply with the conditions. Reactive discrimination occurs when a person is confronted with someone who is, or who is assumed to be, a member of a group against which the person holds strong prejudices; such discrimination is not intentional or planned. Proactive discrimination is intentional and planned; it is often found in the development of policies, procedures, and rules that have as their purpose to preclude certain groups, or to exclude them if they are found to be present. Passive discrimination occurs by failure to act, when the particular needs of particular groups are not met, often with the justification of providing equal treatment for all, but, in fact, failing to meet the special needs of some. Scapegoating is discrimination that seeks to subject people to punishment, usually on the basis that they are to blame for some social evil, and that involves actively seeking out and victimizing the objects of prejudice. Harassment is discrimination that involves subjecting a person to psychological, emotional, and sometimes physical discomfort, because of characteristics s/he has or are attributed to him/her; it may range from refusal to acknowledge or deal with a person, through indirect and direct verbal ridicule or abuse, to interference with property, and to the extreme of physical assault. Vilification is discrimination that involves making statements about a group of people on the basis of their characteristics or of stereotypical assumptions about them that bring members of the group into hatred, ridicule or contempt (Visser et al., 2008).

Intervention measures aim at reducing stigmatization and discrimination. While it may be unrealistic to think that we can eliminate stigma altogether, the studies reviewed here show that we can do something about stigma and that it can be reduced through a variety of intervention strategies including information, counseling, coping skills acquisition, and contact (Brown, Trujillo and Macintyre, 2001).

Previous studies have suggested that stigmatizing attitudes towards PLWHA impacts on the quality and timing of testing, treatment and care of infected individuals (Chesney and Smith, 1999) and the social support infected individuals received (Lee et al., 2002). It also negatively impacts on the participation of infected individuals in seeking treatment, and enrolling in prevention programs (Bond et al., 2002). In addition, stigmatization effects and damages the social interactions of PLWHA with others (Varas-Díaz et al., 2005). Such fears and stigmatizing attitudes towards PLWHA displayed by the general population could potentially lead to discrimination against PLWHA (Brown et al., 2003).

A number of studies have examined the correlates of stigmatizing attitudes towards PLWHA (Herek and Capitanio, 1998; Pryor et al., 1999). Research in the USA and Africa has
suggested that stigmatizing attitudes towards PLWHA might be associated with an inaccurate understanding of the modes of HIV transmission (Herek et al., 2002; Letamo, 2003). While people in general were able to identify the correct transmission routes of HIV, they were less certain about activities that do not in fact transmit HIV (Herek et al., 2002).

A study in Botswana showed that young people who had the misconception of people getting HIV infection through sharing a meal with PLWHA were more likely to possess stigmatizing attitudes towards PLWHA (Letamo, 2003). Some studies have suggested an association between the individual’s socio-demographic characteristics and his/her attitudes towards PLWHA, although the findings have been mixed. Lau et al (2005) found that among general Chinese population in Hong Kong, respondents who were younger, single, and more educated had less stigmatizing attitudes towards PLWHA. In contrast, a study in Kenya found that younger and single respondents had a higher level of stigmatizing attitudes towards PLWHA (Hamra et al., 2006).

1.2 Problem Statement

Since the beginning of the AIDS epidemic, more than 60 million people have been infected with the HIV virus and approximately 30 million people have died of AIDS. In 2010, there were an estimated 34 million people living with HIV, 2.7 million new infections, and 1.8 million AIDS-related deaths (WHO). The WHO African Region is the most affected, where 1.9 million people acquired the virus in 2010. The estimated 1.2 million Africans who died of HIV-related illnesses in 2010 comprised 69% of the global total of 1.8 million deaths attributable to the epidemic. It is therefore, crystal clear that the HIV/AIDS epidemic poses the biggest challenge to Africa.

In its 26th Meeting, the UNAIDS Programme Coordinating Board Geneva, Switzerland defined HIV-related stigma as follows: HIV-related stigma refers to the negative beliefs, feelings and attitudes towards people living with HIV and/or associated with HIV. Thus, HIV-related stigma may affect those suspected of being infected by HIV; those who are related to someone living with HIV; or those most at risk of HIV infection, such as people who inject drugs, sex workers, men who have sex with men and transgender people. HIV-related stigma exists worldwide and manifests itself in countries, communities, religious groups and individuals, though its basic elements are surprisingly common across cultures. It is expressed in stigmatizing language and behavior, such as ostracization and abandonment; shunning and avoiding everyday contact; verbal harassment; physical violence; verbal discrediting, blaming and gossip. Stigma often lies at the root of discriminatory actions. Stigma may also be internalized by stigmatized individuals in the form of feelings of shame, self-blame and worthlessness (UNAIDS, 2000).

HIV-related discrimination refers to the unfair and unjust treatment (act or omission) of an individual based on his or her real or perceived HIV status. Though HIV-related stigma often leads to discrimination, it is important to note that even if a person feels stigma towards another, s/he can decide to not to act in a way that is unfair or discriminatory. Conversely, a person may discriminate against another without personally holding stigmatizing beliefs, for example, where discrimination is mandated by law (UNAIDS, 2000).

Stigma not only makes it more difficult for people trying to come to terms with HIV/AIDS and manage their illness on a personal level, but also interferes with attempts to fight the
AIDS epidemic as a whole. On a national level, the stigma associated with HIV can deter governments from taking fast, effective action against the epidemic, whilst on a personal level it can make individuals reluctant to access HIV testing, treatment and care.

UN Secretary-General Ban Ki Moon says: "Stigma remains the single most important barrier to public action. It is a main reason why too many people are afraid to see a doctor to determine whether they have the disease, or to seek treatment if so. It helps make AIDS the silent killer, because people fear the social disgrace of speaking about it, or taking easily available precautions. Stigma is a chief reason why the AIDS epidemic continues to devastate societies around the world."

HIV/AIDS-related stigma has persisted world-wide for decades however, studies on the linkage between stigmatizing attitudes towards people living with HIV/AIDS (PLWHA) and misconceptions about HIV transmission routes in the general population, especially among the people of this region, are sparse; a research gap this study is intends to fill. The primary goal of this study was to establish whether gender influences the level of discrimination and stigmatization of people living with HIV/AIDS in Garissa County.

1.3 Research Objectives
To establish whether gender influences the level of discrimination and stigmatization of people living with HIV/AIDS in Garissa County.

2.0 LITERATURE REVIEW
2.1 Empirical Review
HIV/AIDS-related S&D are also linked to gender-related stigma. The impact of HIV/AIDS-related S&D on women reinforces pre-existing economic, educational, cultural, and social disadvantages and unequal access to information and services (Aggleton and Warwick, 1999). In settings where heterosexual transmission is significant, the spread of HIV infection has been associated with female sexual behavior that is not consistent with gender norms. For example, pro widely perceived as non-normative female behavior, and female sex workers are often identified as “vectors” of infection who put at risk their clients and their clients’ sexual partners. Equally, in many settings, men are blamed for heterosexual transmission, because of assumptions about male sexual behavior, such as men’s preference or need for multiple sexual partners (Population Council, 2002).

As per UNAIDS Global Report 2010, a sample of results from the People Living with Stigma show that stigma and discrimination are reportedly experienced by people living with HIV in diverse settings in all regions: In Myanmar, 11 per cent of respondents reported that they were often excluded from social events, and 15 percent reported that they were often excluded from family events in the last 12 months. Although 90 percent of respondents had not been denied health care in general due to their HIV-positive status in the last 12 months, 35 percent reported that they had been denied family planning services, and 20 percent had been denied other sexual and reproductive health services.

In the People’s Republic of China, a major concern for respondents was that they might become the subjects of gossip if their status was known with 87.3 percent of female respondents and 79.4 percent of respondents overall expressing this concern. More than half of respondents worried about being insulted or threatened, and almost one quarter worried
about being physically attacked. In addition, 41.7 percent of respondents reported having faced some type of HIV related discrimination, and 12.1 percent of respondents had been refused medical care at least once since they were tested positive. Of those respondents with children, almost one tenth (9.1 percent) said that their children, who were not necessarily HIV positive themselves, had been forced to leave school because of the HIV status of their parents.

Although 87 percent of the respondents in Rwanda reported that they had never been denied health services, a large percentage (88 percent) of respondents reported being denied family planning services because of their HIV positive status in the last 12 months. HIV-positive status was also a major reason reported for denial or refusal of access to accommodation, work, and educational services. In the United Kingdom, 46 percent of respondents reported that their rights may have been violated in the last 12 months. Twenty-two percent of participants reported being physically harassed, and 40 percent reported being verbally harassed, with 54 percent of respondents saying that the harassment was at least partly due to their HIV status. Seventeen percent reported that they had been denied health services in the last 12 months. Human rights are no longer considered peripheral to the AIDS response.

Today, the vast majority of countries (89%) explicitly acknowledge or address human rights in their national AIDS strategies, with 92% of countries reporting that they have programmes in place to reduce HIV-related stigma and discrimination (UNAIDS, 2010).

At the same time, however, criminalization of people living with HIV still presents significant challenges to the AIDS response. More than 80 countries across the world have laws against same-sex behavior, and the free travel of people living with HIV is restricted in 51 countries, territories and areas. Such laws are not only discriminatory and unjust—they also drive HIV underground and inhibit efforts to expand access to life-saving HIV prevention, treatment, care and support (UNAIDS, 2010).

3.0 RESEARCH METHODOLOGY

This research utilized the survey design. The study focused on the population of Garissa County of people living with AIDS. Those living with HIV/AIDS are approximately 2,000. In this regard, the men and women attending the HIV/AIDS Comprehensive Care Center (CCC) in Garissa County Hospital formed the sample frame of those living with HIV/AIDS since they are more accessible considering the nature of the study area and the topic in question. About 2,000 HIV/AIDS positive patients attend the clinic for collection of weekly ARV, testing, nutritional, pharmacy and laboratory, family planning, prevention of mother to child transmission and counseling services. The target sample was 10% of the population/patients. Therefore, the sample size of this study was 200 patients living with HIV and 12 key informants. Random sampling technique was used to select 200 individuals from the list provided by Garissa County Hospital. In order to collect primary data in appropriate form, detail and accuracy, questionnaires and in depth interview guide were used at the hospital and VCT center. Primary data was derived from questionnaires distributed to the patients. The questionnaire had closed-ended questions. Both quantitative and qualitative data was collected. Quantitative data analysis was done using descriptive statistics and inferential statistics. Specifically, descriptive statistics involved frequencies and means. Inferential statistics involved chi square and odd ratio regressions. The statistical package for social
sciences (SPSS) was used to conduct the descriptive as well as the inferential statistics. Chi square and odd ratio regressions were used to achieve the objective. Content analysis was also used to address the qualitative information obtained from key informants and from open ended questions in the questionnaire. The study preferred qualitative content analysis since it addressed some of the weaknesses of the quantitative approach.

4.0 RESULTS AND DISCUSSIONS

4.1 Response Rate

The number of questionnaires that were administered was 200. A total of 200 questionnaires were properly filled and returned. This represented an overall successful response rate of 100% as shown on Table 1. According to Mugenda and Mugenda (2003) and also Kothari (2004) a response rate of 50% is adequate for a descriptive study. Babbie (2004) also asserted that return rates of 50% are acceptable to analyze and publish, 60% is good and 70% is very good. Based on these assertions from renowned scholars 80 % response rate is adequate for the study.

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Returned</td>
<td>200</td>
<td>100%</td>
</tr>
<tr>
<td>Unreturned</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>200</td>
<td>100%</td>
</tr>
</tbody>
</table>

4.2 Demographic Characteristics

This section presents the descriptions of the respondents in terms of their gender, age, marital status, religion, level of education, employment type and level of income.

4.2.1 Gender

The respondents were asked to indicate their gender. Majority of the respondents were female who represented 81% of the sample while 19% were male. These results imply the population of Garissa County is female dominated.
4.2.2 Level of Education

The respondents were asked to indicate their level of education. Majority of the respondents had acquired up to primary level education as represented by 59%, 19% had post-secondary level education, 18% had no education, while only 4% had secondary school education. This implies that people in Garissa County are not very educated.

Figure 1: Gender of Respondents

4.2.3 Age

The respondents were asked to indicate their age. Majority of the respondents were between 21-30 years as represented by 32.5%, 25.5% were between 31-40 years 19% were between 41-50 years, 10.5% were less than 20 years while 12.5% were above 51 years. This implies that the majority of people in Garissa County are in their middle age.

Figure 2: Level of Education

4.2.4 Marital Status

The respondents were asked to indicate their marital status. Majority of the respondents were single as represented by 41.0%, 23.5% were married, 22.5% were widowed while 13.0% were divorced.

Figure 3: Age
4.2.5 Religion

The respondents were asked to indicate their religious affiliations. Majority of the respondents were Muslim as represented by 55.5%, while 44.5 were Christian.

4.2.6 Employment Type

The respondents were asked to indicate their employment type. Majority of the respondents are not employed as represented by 61.0%, 23.5% were self employed while only 15.5% were formally employed. This implies that a majority of the people in Garissa county are unemployed.
4.2.7 Level of Income

The respondents were asked to indicate the income range that best described their level of income. Majority of the respondents earn between Kes 0-Kes 20,000 as represented by 75%, 16% earn between Kes 21,000-Kes 40,000, 6.5% Kes 41,000-Kes 60,000 while only 2.5% earn above Kes 60,000. This implies that majority of the people in Garissa County earned low income.

Figure 7: Level of Income

4.3 Inferential Statistics

4.3.1 Chi-Square Test for Gender

Table 2 presents results of the gender and stigmatization and discrimination chi-square test. Results show that the relationship between gender and stigmatization and discrimination was significant ($\chi^2=6.988$, p=0.008). This implies that gender significantly influenced stigmatization and discrimination.

Table 2: Gender

<table>
<thead>
<tr>
<th>Stigmatization and Discrimination</th>
<th>Total</th>
<th>Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Stigmatization and Discrimination</td>
<td>High Stigmatization and Discrimination</td>
<td>6.988 p=(0.008)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender of respondent</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>Chi square</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>24</td>
<td>64</td>
<td>88</td>
<td></td>
</tr>
<tr>
<td></td>
<td>14</td>
<td>98</td>
<td>112</td>
<td></td>
</tr>
<tr>
<td></td>
<td>38</td>
<td>162</td>
<td>200</td>
<td></td>
</tr>
</tbody>
</table>

4.3.2 Bivariate Multiple Odd Ratio Regression for Gender

Binary logistic regression was used to model relationship between gender and accounts stigmatization and discrimination levels. Table 3 shows that gender was statistically associated with stigmatization and discrimination (p<0.005). The probability of stigmatization and discrimination increases by 2.625 when one is female.
Table 3: Logistic Regression for Gender

<table>
<thead>
<tr>
<th>Construct</th>
<th>B</th>
<th>S.E.</th>
<th>Wald</th>
<th>df</th>
<th>Sig.</th>
<th>Exp(B)</th>
<th>95% C.I. for EXP(B)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower</td>
</tr>
<tr>
<td>Gender(1)</td>
<td>0.965</td>
<td>0.373</td>
<td>6.704</td>
<td>1</td>
<td>0.01</td>
<td>2.625</td>
<td>1.264</td>
</tr>
<tr>
<td>Constant</td>
<td>-0.539</td>
<td>0.336</td>
<td>2.569</td>
<td>1</td>
<td>0.109</td>
<td>0.583</td>
<td></td>
</tr>
</tbody>
</table>

4.4 Content Analysis

From the interview guide responses all the respondents indicated yes to the question, “In your opinion, do people living with HI/AIDS experience stigmatization and discrimination.” They cited verbal abuse, people living with HIV being perceived to die soon, people living with HIV being shunned by their families and friends, people avoiding physical contact with the infected persons and general fear from the public as some of the ways in which stigma and discrimination is expressed. When asked about factors that promote stigmatization and discrimination they mentioned illiteracy, ignorance and poverty. They recommended health drives and campaigns, civic education, guidance and counseling, group therapy, encouraging members of the public to be tested and holding regular village barazas to increase public awareness and openness about HIV/AIDS.

5.0 DISCUSSION CONCLUSIONS AND RECOMMENDATIONS

5.1 Discussion

The objective of the study was to establish whether gender influences the level of discrimination and stigmatization of people living with HIV/AIDS in Garissa County. Binary logistic regression results showed that gender was statistically associated with stigmatization and discrimination. The probability of stigmatization and discrimination increased.

5.2 Conclusions

Gender does not influence stigmatization and discrimination levels. Stigmatization and discrimination occurred to anyone irrespective of their gender. The study concluded that gender is not statistically significant in explaining stigmatization and discrimination of people living with HIV in Garissa County.

5.3 Recommendations

Health drives and campaigns should be conducted in order to raise the knowledge levels on how HIV can be spread.

5.4 Areas for Further Research

A replica of this study can be carried out with a further scope to include more Counties in Kenya other than Garissa County. A similar study can be done on other types of diseases such as people living with physical or mental disability for comparison purposes.
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