

Stigma and Discrimination towards HIV Positive People among In-School Adolescents, in Babile Town, Eastern Ethiopia: a Cross Sectional Study

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Abstract

Background: Stigma and discrimination against HIV cases is a process of prejudice, devaluation, and unfair treatment based on real or perceived HIV status. Stigma and discrimination towards HIV/AIDS is prevalent all over the world and its challenge is more severe in developing countries. It leads people to leave their home, and to change their daily activities such as shopping or schooling. Our objective was to assess perceived stigma and discrimination towards HIV positive people among in-school adolescents in Babile town, Eastern Ethiopia.

Method: The study was conducted at Babile town in 2015. School based cross-sectional study was carried out among 328 in-school adolescents. All in-school adolescents in Babile town were the source population, whereas the study populations were adolescent students enrolled in randomly selected schools. Systemic random sampling was applied to identify participants and direct interview was used to collect data. The data was cleaned and entered using EPI info version 3 statistical packages and exported to SPSS version 16 for analysis.

Result: Overall 328 (99.7%) participants were interviewed, and 57 (17.3%) of the participants showed unwillingness to test for their HIV status. The prevalence of stigma and discrimination against hypothetical HIV positive case were recorded in 44.1%. About 19.3% of the participants showed misperception on HIV transmission & prevention mechanism. More than one third (36.5%) of the respondents declined to disclose HIV status, if he/she became positive.

Conclusion and Recommendation: The prevalence of stigma and discrimination remains high. Significant number of respondents showed failure to HIV disclosure, low motivation for HIV testing and less knowledge on HIV transmission and prevention. Information, communication and education is important strategy to tackle HIV stigma and discrimination problems among in-school adolescents.

Keywords: HIV positive; HIV testing; Transmission and prevention

Introduction

The term “stigma” originates from Greek language which refers to a tattoo mark branded on the skin of an individual as a result of some incriminating action, identifying the person as someone to be avoided [1]. As Goffman described stigma can happen as a result of three general causes. These are physical deformities, moral transgression, and membership of a despised social group [2]. People living with HIV/AIDS are associated with these causes; physical manifestations of AIDS, deviant/immoral behaviors of sexual promiscuity and despised social group. Stigmatization and discriminatory attitudes are a challenge globally that makes management of diseases ineffective. Report showed that people from Africa and Caribbean often fail to seek HIV/AIDS services that they need for fear of being stigmatized. This makes preventive activities very difficult to achieve the intended goals [3].

Stigma and discrimination may also cause to lose the opportunity to change victim's behavior to prevent infecting others, and accessing HIV related services. Stigma remains poorly understood, particularly in developing countries. When stigma exists people often prefer to ignore their real or possible HIV status. This can lead the risk of faster disease progression for them and increases the risk of HIV spreading to others [4]. Negative attitudes about HIV also create a climate in which people

become more afraid of the stigma and discrimination associated with the disease than of the disease itself [5].

Despite of the existing laws that protect people against discrimination, the problem persists across the country. People have been denied services, residence and employment just because they are living with HIV/AIDS. Empirical evidences revealed that despite of increment in awareness about HIV/AIDS, stigma and discrimination towards HIV cases also increase paradoxically [3,6].

Stigma and discrimination is experienced in different places such as in homes, workplaces, schools, and health facilities. A recent study found that 8% of PLHIV respondents had experienced human rights violations such as denial of employment (3%), eviction from home (3%), and loss of job (2%) as a result of their HIV status. In addition, 18% had verbal insults directed at them because of their HIV status [7].

In spite of the effort made by the government and other NGO'S to protect individuals from stigma and stigmatization against HIV/AIDS, the impact of these efforts are still unfortunately very low. Children living with HIV/AIDS who attend school also experience stigma and discrimination from their teachers, partners and fellow children in several ways [8]. To the best of our knowledge, only few studies have been conducted to address the

issue of HIV/AIDS related stigma and discrimination among in-School adolescents in Ethiopia. Hence, this study was intended to explore stigma and discrimination against HIV cases in Babile town, Eastern Ethiopia.

Methodology

This study was conducted in Babile town which is 551 km east of the capital city of Ethiopia, Addis Ababa. The total population of the town was 41,000 with 20,844 males and 20,156 females [9]. There is one health center and eleven private clinics during the study period in the town. In total, 4,673(3,827 governmental & 846 private) primary school students have been enrolled in Babile town. The study was carried out in March 2015.

A cross-sectional study design was employed. Sample size was determined by single population proportion formula. Since there is no previous similar study we use 50% proportion at marginal error of 5% and 95% confidence interval. Taking this variable, the sample was calculated at 384 and since our study participants were below 10,000 we use reduction formula to get representative sample. Therefore, final sample size of the study was 329.

First, two out of three schools (one governmental and one private primary school) were selected using lottery method. Then, all students who actively followed their education, and their age laid in the adolescent age category (10-19 years) were identified and listed in alphabetical order. Systematic sampling was applied after determining the K^{th} value by dividing eligible participants to total sample size and random start number was drawn by lottery method. We use structured questionnaire to collect the data. The questionnaire was first prepared in English from different literatures then translated in to local languages which are Afan Oromo and Amharic. Translation validation was made by other person to check consistency of questionnaire. Data was collected by two 4th year public health students by direct face to face interview.

Training was given for data collectors to have common understanding on the study methodology and how to administer the questionnaire. Interview was also carried out by local language that the participants can easy understand it. The questionnaire was also pre tested in 5% of the total sample on similar population but not part of the actual respondents. Filled questionnaire was checked by supervisor on daily basis and inconsistency was corrected on spot. Data were checked daily for its completeness and consistency. Data were cleaned, coded, and entered using statistical software (EPI info) and then analyzed using SPSS version 16.

Both binary and multivariate logistic regression was applied. First independent variables like religion, willingness to test HIV & others were tested using binary regression model individually. In the multivariate regression model all independent variables showing association in the binary regression model was tested together. P-value less than 0.05 was considered statistically significant. Descriptive statistics such as frequencies, percentage, median, and proportions was calculated. Finding was presented in statements, graph, figures, and tables.

Ethical approval has been obtained from Institutional Health Research Ethical Review Committee of Haramaya University. Letter of permission was obtained from Babile district Health Office and Educational Bureau. Written consent was also obtained from respective school heads. The study participants were informed about the purpose of the study, and the right not to participate or terminate any time he/she would like to. Verbal assent was obtained from each participant before interview started. Participant's right, dignity, language and cultural taboos were respected throughout the study. We consider Perceived stigma and discrimination if respondent is unwilling to have any social interaction (like play, eating,) when his intimate friend is assumed to be HIV positive.

Results

A total of three hundred twenty eight participants (99.7% response rate) with 184(56.5%) male and 143(43.5%) female were interviewed. Majority 211(64.4%) of the participants were aged between 13-15 years and the remaining 117(35.6%) were greater than 15 but less than 18 years. About 243(74.08%) were from government school whereas 85(25.9%) from private school. Regarding religion, two hundred forty three (73.9%) of participants were Muslims, 57(17.6%) were Orthodox Christian, 26(7.9%) were protestant and 2(0.6%) were Catholic (Table 1).

With regards to occupation of the care takers, 94(28.6%) reported their care takers were private employee, 49(14.9%) governmental employee, 39(11.9%) farmers, 36(10.9%) daily laborers, 43(13.1%) merchants, and 16(4.9%) were house wives. Participants were asked whether they have health worker relatives or not and about 93(28.3%) reported they have health professional relative/s and the rest 236(71.7%) reported they have not professional relative.

Getting information about HIV/AIDS is important to minimize stigma and discrimination and 89(27.13%) of respondents confirm as they have obtained education on HIV/AIDS in the last three months from health professionals by different means (individual or media). However, significant number (72.6%) were not getting any information about HIV/AIDS in the reference time (Table 1).

Of the total respondents 326 (99.4%) of them heard about HIV/AIDS. Media, learning/school, friends/family, and health professions were the

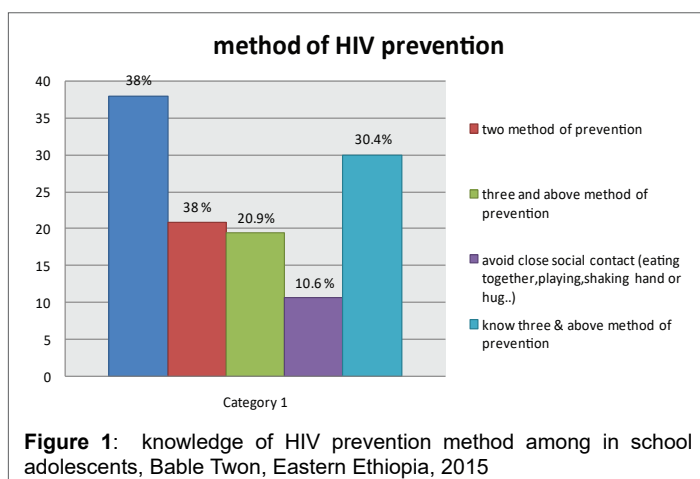
Table 1: Summary of socio-demographic variables on stigma and discrimination, among in school adolescents, Bable town, eastern Ethiopia, 2015

Socio demographic characteristics		Frequency	Percent (%)
Age	13-14	211	64.4
	15-18	117	35.6
	Total	328	
Sex	Male	185	56.4
	Female	143	43.59
	Total	328	
Religion	Orthodox	57	17.4
	Muslim	243	74.1
	Protestant	26	7.9
	Catholic	2	0.6
	Total	328	
Care taker education	Primary+unable to read	178	54.26
	High school	75	22.9
	Certificate & above	75	22.9
	Total	328	
With whom you live	With father & mother	230	70.12
	With mother or father	68	20.7
	With relatives	30	9.14
	Total	328	
School	government	243	74.08
	Private	85	25.9
	Total	328	
Willingness for HIV testing	Willing	271	82.7
	Not willing	57	17.4
	Total	328	
Disclosure if tested and become positive for HIV	Yes	208	63.41
	No	120	36.58
	Total	328	
Ever heard about HIV	Yes	326	99.4
	No	2	0.61
	Total	328	

main source of information for 141(42.8%), 255(77.5%), 78(23.7%), and 88(26.7) respectively. 321(97.8%) of the respondents reported as they know the mode of transmission. Nevertheless, 7(2.1%) did not know how HIV transmitted. From those who know the mode of transmission, 83 (25.2%) of them mentioned one mode of transmission, and 218 (66.3%) mention two and more mode of transmission means. Meanwhile, 128(39%) respondents believe that HIV can be transmitted by mosquito bite. Participants were asked whether they perceive that condom can prevent HIV transmission or not and nearly one fifth (17%) perceived that condom cannot prevent HIV transmission. Only 3% reported that they do not know whether condom prevent HIV/AIDS or not. Nearly one third of the respondents replied as they can worry more if drop of saliva placed in their skin from HIV positive person.

We also asked them the ideal HIV disclosure if they test and become positive. More than two third, 209(63.5%) expressed as they wish to disclose their HIV status to their friends or family but about one third (36.5%) declined to disclose their HIV status if they test and were assumed to be positive (Table 1). From total respondents 244(74.4%) knew someone living with HIV/AIDS from these 60(24.5%) said that community has no good attitude towards HIV cases. Significant number of the respondents 96(29.2%) perceived that HIV positive people should be isolated from any social relation. However, 233(70.8%) thinks that people with HIV should not be isolated. Knowledge on HIV prevention mechanism is an important prerequisite for HIV prevention. Only 30.4% knew three and above method of prevention, 20.9% knew only two methods, and 38% knew only one method. Surprisingly, 10.6% of participants believe that one can acquire HIV through social relations like playing or eating together, hand shaking, and other similar events (Figure 1). About 271 (82.7%) of the respondents were willing to take HIV test while the rest 57(17.3%) have no willingness (Table 1). Of those who have no willing to test for HIV fear of positive result and fear of stigma and discrimination were mentioned as reason for 28%, & 21% respectively.

We asked participants if they ideally support to appoint HIV positive house worker or not. The finding shows that, more than half 191(58.1%) of the respondents perceived as they were not willing to appoint HIV positive house worker but 137(41.9%) were interested to appoint. Similarly, more than two third 230 (70%) of the respondents reported as they disagreed to share food from the same container with HIV positive friend. They were also asked if they are ready to provide HIV care at community providing that proper protection is in place. Significant proportion of the respondents (57.8%) disagreed to provide the services. We asked the participants if they have interest to shopping from known HIV positive shopper and 30.6 % of them replied as they would not be shopping from HIV positive cases.



Presence of stigma and discrimination was assessed using five closed ended questions like “would you shop from known HIV positive person?” and if the respondent replied ‘NO’ for three or more of the questions, then he/she was taken as practicing stigma and discrimination. Based on these 145(44.1%) respondents were with perceived stigma and discrimination against HIV positive cases. Misperception in regard to HIV mode of transmission and prevention mechanism were assessed using four questions and those who answered ‘YES’ for two or more negative questions were considered misperceived cases. By using this measurement, 63(19.33%) of the respondents had shown misperception about HIV. The main reason for stigmatization was fear of transmission (47%), due to family orientation (24.8%), for psychological reason (12.4%) and to respect colleague’s idea or to have similar stand with colleagues (11.7%).

Binary and multiple logistic regression analysis were done (Table 2). In the binary logistic regression, the odds of having perceived stigma and discrimination was 4.08 (CI,1.8, 8.9) times higher among Muslim followers than being Orthodox Christian follower. Similarly, living with single parent shows a relieve factor that is those with single parent was 0.37(CI, 0.17, 0.80) less likely to have perceived stigma and discrimination than those with both parents. The odds of perceived stigma and discrimination was 3.67 (CI, 2.04, 6.63) times higher among in-school adolescents who were unwilling for HIV test than their counterpart. In the multiple logistic regression analysis, religion was identified as predictors of stigma and discrimination (Table 2).

Discussion

In this study stigma and discrimination was prevalent at 44.1%. About 19.3% of the respondents has misperception towards HIV transmission and prevention aspects. Correspondingly, not willingness to HIV testing and disclosure if become positive was reported at 57(17.3%) and 36.5% respectively. Religion was significantly associated with stigma and discrimination towards HIV positive peoples (Table 2).

This study revealed a higher prevalence rate (44.1%) of stigma and discrimination among adolescent students. Participants were confirmed that their reason for stigma and discrimination was fear of transmission (47%), due to family orientation (24.8%), for psychological reason (12.4%) and to respect colleague’s idea (11.7%). In this study, stigma and discrimination was expressed in terms of not willing to playing, to sharing food and drink, to appoint house worker and to shopping from HIV cases. Lack of in-depth knowledge of participants may be associated with this high stigma and discrimination. This may also indicate the effect of social stigma at the community level.

The issue of HIV/AIDS problem is also deeply linked with social, cultural and religious aspects of the community. Religiously, people who are living with the virus were considered as deviant and it was decided from God to have HIV/AIDS. This makes individuals to fear disclosure. As the study conducted in Ethiopia indicated [10], HIV was assumed as a fatal disease and these make individuals to avoid any social interaction with HIV cases because any contact with HIV cases may put them at high risk of getting the disease.

The communities also believe that HIV/AIDS has no medical treatment that cure the disease as a result many people need to care by avoiding any interaction with persons who are confirmed or suspected of having the virus. According to the EDHS 2011 of Ethiopia [11] the prevalence of stigma and discrimination towards people living with HIV was reported at 17% for women and 28% for men. This difference may be attributed to difference in measurement, type of study participants, and nature of study area.

Table 2: Association between socio-demographic and perceived stigma and discrimination, among in school adolescents, Bable Town, Eastern Ethiopia, 2015

Variables	Category	Perceived stigma & discrimination		OR(95%CI)	
		Yes	No	COR(CI)	AOR(CI)
Religion	Orthodox	50	5	1	1
	Muslim	147	95	4.08(1.8, 8.9)	4.487 (1.287, 15.673)
	Protestant	20	3	0.81 (0.19, 3.359)	1.128 (1.128, 1.128)
With whom you live	With both (father+mother)	161(49.08%)	69(21%)	1	1
	With either	46(14.02%)	22(6.7%)	0.37(0.17, 0.80)	0.59(0.25, 1.4)
	With relatives	14(4.2%)	16(4.8%)	0.41(0.174, 1.08)	0.56(0.21, 1.5)
Willing to test HIV	Yes	197(60.0%)	74(22.56%)	1	1
	No	24(7.3%)	33(10%)	3.67(2.04, 6.63)	2.2(0.23, 21.39)

NB: Perceived stigma and discrimination as defined in page six, last paragraph.

Participants were asked four questions on HIV mode of transmission and prevention mechanism and about 19.3% of the respondents had shown misperceived information; that is they answered two or more out of four incorrectly. In community like Babile, adolescent are usually taken as children and hence they are less exposed for health education. They are also assumed as less risky for HIV so that they may not be packaged under different HIV interventions. This finding may also associate with low access to radio or others. In this survey HIV misperception was high compared to a study done in eastern Ethiopia [12] and this may be due to difference in measurement of the study research questions.

Similarly, 42% of male and 35% of female believe that HIV can transmitted by anopheles mosquito and this is in line with study conducted by EDHS 2011 [11], in that 37% male 48% female think that HIV can be transmitted by mosquito. Seventeen percent of the surveyed participants believe that HIV cannot prevent by using condom, however, a research from Kenya [13] indicates that 67% said condom cannot effectively prevent HIV infection. This variation may occur due to chronological difference.

Respondents were asked their hypothetical acceptance for HIV testing and the finding showed that 57(17.3%) of the total participants failed to accept HIV testing. Meanwhile, 36.5% of participants replied that they would not disclose their HIV status to anyone if they become HIV positive. This may associated with fear of psychological and social outcomes as confirmed by study done in Zambia [14] where adolescents who disclose their HIV status were experienced anxious, depressed and self-blaming.

The odds of stigma and discrimination were 4.47 (CI, 1.287, 15.67) times higher among Muslim followers than orthodox (Table 2). Even if, our study is conducted in Babile town majority of the students are coming from the rural part and the rural area is highly dominated by Muslim followers where access to health information is very less, and less educated parents are commonly live there as compare to urban.

Conclusion and Recommendation

The prevalence of stigma and discrimination was high (44.1%). The higher magnitude of stigma and discrimination was related to lack of knowledge, fear of transmission, and community attitude on HIV positive cases. Significant number of respondents (19.3%) showed misperception on HIV transmission and prevention mechanism. High proportion of participants (36.5%) was not interested to disclose their HIV status to anyone in case their test is positive for HIV. Religion showed statistically significant association with in-school adolescents' stigma and discrimination towards HIV positive peoples. Adolescent are a basis for generation so to bring great changes at community level, adolescents should get a priority in information, communication and education. All

programs currently implemented in the nation should consider HIV problem of adolescents. Different sectors particularly the education and health office of the district should design an approach that addresses adolescent HIV problems. Different NGOs (local and international) should give emphasis for adolescent HIV problems.

Competing Interests

We all authors declare that we have no competing interest.

Authors' Contributions

MG, GT, GG and TG have brought the title of the study, has critically revised the study design, data collection techniques and helped the statistical analysis. LK and KJ write the proposal, collected the data, and performed statistical analysis. MG and GT thoroughly done the manuscript and contribute to publish the article. All authors finally approved this manuscript for submission.

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