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HIV/AIDS-related stigma in Kumasi, Ghana

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ABSTRACT

Objective: To assess HIV/AIDS-related stigma and discrimination of people living with HIV/AIDS (PLWHA) in Kumasi, Ghana.
Methods: A cross-sectional survey of 104 adults from the four sub-districts in Kumasi was conducted.
Results: Four stigma constructs, employment-based discrimination, screening and identification of HIV positive people, revelation of HIV status and social contact stigma were determined based on reliability measures from responses to the questionnaire. Regression analysis showed that participants with higher educational attainment were more likely to favor policies denying employment to PLWHA ($p<0.05$), but disapproved of revealing HIV sero-status ($p<0.05$). Muslims were more likely than Christians to agree with identifying PLWHA ($p<0.05$) and more likely to advocate revealing HIV sero-status ($p<0.05$). Males were more likely to favor revealing HIV status ($p<0.05$). Employed persons were more likely to have social contact with PLWHA ($p<0.05$).
Conclusions: These findings are useful in guiding the design of interventions against HIV/AIDS-related stigma in Kumasi.

Introduction

In 2005, an estimated 24.5 million people were living with HIV/AIDS in sub-Saharan Africa (UNAIDS, 2006), and 75% of all deaths since the beginning of the HIV/AIDS pandemic has occurred in this region. Currently, 320,000 Ghanaians are estimated to be living with HIV/AIDS (UNAIDS, 2007) and 30,000 Ghanaians have died from AIDS (CIA, 2005). The HIV prevalence rate in Ghana is 2.3% and HIV prevention and treatment programs have been established to combat the AIDS epidemic. However, reports from the United Nations Integrated Regional Information Networks (IRIN) on Africa indicate that the Ghanaian government's AIDS program is in danger of failure due primarily to stigma and a failing health system (IRIN, 2005). Identifying the predictors of stigma and designing effective interventions may be key to ensuring successful HIV/AIDS prevention and treatment programs, and thus, successful reversal of the AIDS epidemic. The purpose of our research was to determine the predictors of HIV/AIDS-related stigma and discrimination, and to identify the perceptions of community members towards HIV/AIDS and persons living with HIV/AIDS (PLWHA) in Ghana. The paper provides insight on the factors influencing the perceptions of community members towards PLWHA.

Goffman (1963) defines stigma as a "mark" that links a person to undesirable characteristics (label) (Goffman, 1963). HIV/AIDS-related stigma has been a negative factor in the crusade to diminish the prevalence and effect of the HIV/AIDS pandemic. From the inception of AIDS, people have advocated extensive measures including quarantine of HIV infected people in order to protect the populace from the infection. Discrimination has often been rampant. Ostracism, isolation and rejection have been commonplace in the lives of people identified to have AIDS (Carr and Gramling, 2004). HIV/AIDS-related stigma can range from a simple gossip to outright discrimination, resulting in job loss, house evictions, rejection, isolation and even killing of an HIV infected person. It can stem from legislative, employment policies, hospital policies, cultural beliefs, or individual behaviors, thoughts and attitudes (Standing, 1992; Zwi, 1993; Aggleton, 1996). HIV/AIDS-related stigma and discrimination have been linked to misconceptions about the disease, fear of the disease due to its manifestations and fatality, and to the association of HIV/AIDS with stigmatized/marginalized individuals in the community (Herek and Glunt, 1988; Alonzo and Reynolds, 1995; Boer and Emons, 2004).

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Since the beginning of the epidemic, much progress has been made in preventing new HIV infections and in delaying progression of the disease. However, very little has been done to halt the effect of stigma (Piot, 2006). In 1988, a panel convened by the Institute of Medicine concluded "the fear of discrimination is a major constraint to the wide acceptance of many potentially effective public health measures" (Herek and Glunt, 1988). Now, 25 years after the start of the epidemic, the stigma of AIDS is still a hindrance in the fight against the disease. The stigma of AIDS, unswervingly hampers the effective AIDS response, deters people from knowing their HIV status, prevents high risk individuals from receiving needed services, prevents condom use and creates non-compliance with breastfeeding recommendations for HIV positive mothers (WHO/UNAIDS, 2004). Halting the epidemic will involve changing the perceptions of individuals in the community towards HIV and PLWHA.

In Ghana and many countries of sub-Saharan Africa, HIV transmission occurs primarily through heterosexual intercourse. In these countries, HIV/AIDS is widely viewed as a consequence of sexual immorality or immoral behaviors, thus, infected individuals are considered responsible for acquiring the disease. In some cases, the infection is perceived as a punishment given by God to perpetuators of sins like prostitution, promiscuity, drug use or homosexuality (Kaldjian et al., 1998; Ayranci, 2005). Ghanaians are very religious and moral people and have a value system to which they adhere (Awusabo-Asare et al., 2004). They believe that an individual should abstain from sex until marriage and that those who acquire HIV/AIDS through commercial sex work or promiscuity bring disgrace to their families. In Ghana, HIV/AIDS is believed to have emerged from individuals who engaged or solicited commercial sex workers (prostitutes) from Cote d'Ivoire (Yeboah-Afari, 1988; Decosas, 1995). HIV/AIDS is also blamed on foreigners, gay men and the Devil (Prince, 2004). Thus, people who have HIV/AIDS are blamed for the disease. The stigma related to sexual immorality due to cultural values against prostitution, promiscuity and homosexuality coupled with the fear of HIV/AIDS (due to misconception and fatality of AIDS) may be the source of HIV/AIDS stigma in Ghana (Ankomah, 1998; Mill, 2003; Prince, 2004). For example, commercial sex workers have been stigmatized and frequently harassed and humiliated by law enforcement agents (WiLDAF, 2006).

Although there are homosexuals in Ghana (Known MSM Sites, 2008), the only form of sexual transmission of HIV that working documents of Ghana on HIV/AIDS recognize is heterosexual transmission (Republic of Ghana, 2000; Ghana AIDS Commission, 2000; National AIDS/STI Control Programme, 2001). International documents report nothing on HIV transmission by homosexual or bisexual groups in Ghana (UNAIDS, UNICEF, WHO, 2002 Update; UNAIDS, 2006). The Criminal Code of 1960 (Act 29) of Ghana, makes "sexual intercourse with a person in an unnatural manner" a crime (Attipoe, 2008). Although the act does not define what "sexual intercourse in an unnatural manner" means, persons suspected of homosexuality are swiftly punished and incarcerated by law officials (Prince, 2004). Homosexuals (men who have sex with men; MSM) are also harassed, called evil, evicted from their homes and even beaten by members of the community (Prince, 2004). Drug use does not seem to play a major role among MSM in the Ghana Metropolis. Only 2% of MSM reported using methamphetamines or inhaling nitrates (Influencing Factors, 2008). Although a paper on HIV prevention among injecting drug users in developing and transitional countries list Ghana as one of these countries, no data were reported for Ghana and the source of the information was given as unpublished data from WHO, UNAIDS (Ball et al., 1998).

In Ghana, family members are considered ultimately responsible for the behavior of each household member and the family is blamed or praised for the behavior of its members (Hintz, 1987). An individual is linked to a long chain of living and deceased members in his or her family and in his or her town or village (Hintz, 1987). Thus, family members of a person who dies of or lives with HIV/AIDS are also stigmatized. Family members may encourage relatives with HIV/AIDS to remain silent about their HIV status to prevent gossip, social rejection and HIV-related stigma. In some cases, family members isolate relatives with HIV to minimize social contact and/or prevent infection. Identifying the perception of family members towards HIV and family members with HIV/AIDS will be important in designing stigma averting interventions and educational programs for family members.

At the community level, the fear of stigma can lead to the refusal of voluntary counseling and testing (VCT) for HIV, increased gender-based violence and marginalization of high risk individuals (Heyward et al., 1993). Community members may not seek VCT because of the fear of discovering that they are HIV positive and fear of the resulting stigma and discrimination that may accompany their HIV/AIDS positive status. Thus, HIV/AIDS-related stigma and discrimination may have a profound impact on the disclosure (revelation) of HIV status and the subsequent care, support or treatment that HIV positive persons receive (Moneyham et al., 1996; Muyinda et al., 1997; Weiss and Ramakrishna, 2001; Mill, 2003; Carr and Gramling, 2004; Reynolds et al., 2004). In Ghana, HIV positive persons hide their HIV-seropositive status to reduce HIV/AIDS-related stigma and discrimination and to retain the care and support of family members. Ironically, this secrecy hinders uptake of treatment and of support services that can be provided by family members (Mill, 2003). People who feel stigmatized or discriminated against are more likely to have poor health outcomes, socio-psychological problems and suicidal thoughts (Sowell et al., 1996; Reynolds et al., 2004; Bottonari et al., 2005; Katz and Nevid 2005; Sledjeski et al., 2005). Tackling HIV stigma will involve tackling perceptions and values towards sexuality and HIV/AIDS.

Few studies on AIDS stigma among family and community members have been conducted in Ghana. One study conducted by Mill (2003) explored the experience of HIV-seropositive women receiving care in Accra and Agomanya (Mill, 2003). It reported that many HIV positive women felt the need to hide their HIV status due to the perceived shame and disgrace surrounding the HIV infection. HIV counselors also reinforced maintaining secrecy as a strategy to reduce stigma (Mill, 2003). Another study was an in-depth interview with health care workers in the Cape Coast municipality in Ghana (Awusabo-Asare and Marfo, 1997). It revealed that there was general fear of infection among health care workers that resulted from inadequate supply of basic protective items and insufficient information on the sero-status of some patients (Awusabo-Asare and Marfo, 1997). Refusal to treat PLWHA, refusal to work in HIV/AIDS facilities, maltreatment of PLWHA and inequality in treatment between HIV/AIDS infected and uninfected patients were forms of HIV/AIDS-related discrimination shown by health care professionals in health care facilities (Awusabo-Asare and Marfo, 1997). A more recent study examined the effect of HIV stigma on caregivers of PLWHA in Accra. This study observed that caregivers also experienced widespread stigma and discrimination that were exhibited in negative attitudes from close neighbors, relatives and health care workers (Mwinituo and Mill, 2006). As a result, caregivers of PLWHA in the study secretly offered care in order to minimize disrespect and isolation (Mwinituo and Mill, 2006). In this study, we examined the predictors of stigma and the perception (knowledge, attitudes and behaviors) of community members towards PLWHA.