Stigma in HIV-infected Health Care Workers in Kenya: A Mixed-method Approach

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HIV-related stigma decreases access to HIV testing, prevention, and treatment services. Our mixed methods study explored stigma as perceived, experienced, and managed in a sample of 76 HIV-infected health care workers in Kisumu, Kenya. Stigma was quantitatively measured using the HIV/AIDS Stigma Instrument for People Living with AIDS (HASI-P). Overall, subjects experienced low stigma levels (mean = 7.88, SD = 12.90; range = 0–61), and none of the sociodemographic variables were predictive of stigma. Transcript analysis of 20 qualitative interviews revealed two negative themes (blame, lack of knowledge) and five positive themes (living positively, optimism, empathy, support, changes over time). Three themes emerged on reducing stigma (normalizing, empowerment, leading by example). Disclosure, access to treatment, stigma reduction training, workplace support groups, and awareness of an HIV workplace policy may have contributed to low stigma scores. Qualitative findings corroborated quantitative findings and corresponded to the six domains of the HASI-P.

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Goffman (1963) defined stigma as both a trait and an outcome. As a trait, stigma is a deeply discrediting attribute viewed negatively by society as a failing, shortcoming, or handicap. HIV has had a significant impact on Africa's health care workforce (Tawfik & Kinoti, 2006). According to the United Nations Secretary General Ban Ki-moon (2008), stigma remains the single most important barrier to public action. Consequently, stigma impedes access to HIV treatment services, adherence to antiretroviral therapy (ART), and disclosure of HIV status (Coetzee, Kagee, & Vermeulen, 2011; Holzemer, Uys, Makoae, et al., 2007a). HIV-infected health care workers (HCWs) face a double burden and often choose to suffer in silence, bearing the burden of their illness and fear of stigma (Kyakuwa, 2009; Kyakuwa & Hardon, 2012). The fear of stigma from coworkers and supervisors is a major barrier to testing and accessing HIV care (Holzemer, Uys, Makoae, et al., 2007a; Kyakuwa, 2009).

The lack of responsive workplace policies that discourage discrimination in the workplace is an added concern (Botes & Otto, 2003). Sprague, Simon, and Sprague (2011) found that marked barriers to employment among people living with HIV (PLWH) still exist in Kenya and Zambia. These barriers include discrimination in hiring, loss of promotions, and terminations due to HIV status.

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O'Keeffe (2012) also found that, although HIV workplace policies were in place at most of the facilities in Kenya, HCWs involvement in the development and effective implementation of such policies was lacking. Our mixed-method study was conducted to explore perceived and experienced HIV stigma among HIV-infected HCWs in a rural area of Kenya.

Background

An estimated 35.3 million people are living with HIV globally. Africa is home to an estimated 70% of the new HIV infections in 2012 (Joint United Nations Programme on HIV/AIDS, 2013). HIV-related death is the number one cause of health care personnel attrition in Kenya (Cheluget et al., 2003). The Kenya National Bureau of Statistics (2009) estimates Kenya's total population at 39 million people. The Kenya AIDS Indicator Survey 2012 conducted by the National AIDS and STI Control Programme (NASCOP, 2014) estimated that more than 1.4 million adults in Kenya were living with HIV in 2009. Of the PLWH in Kenya, 70% lived in rural areas. Since 2007, there has been a significant 34% increase in levels of HIV testing among adults ages 15 to 64 years. Despite this increase, an estimated 53% of survey respondents who tested positive were unaware of their HIV infection. This is a significant improvement from 2007 where more than 80% of HIV-infected persons were unaware of being infected (NASCOP, 2014). Kisumu district (now Kisumu County), where this study was conducted, is located in Nyanza province in rural Kenya and has an estimated population of 970,000. Nyanza province has a population of 5.5 million people (Kenya National Bureau of Statistics, 2009) and has the highest HIV prevalence rate (15.1%) in the country, more than double the national prevalence of 5.6% (NASCOP, 2014).

HCWs are among those living with HIV. HCWs play three significant roles in the complex interplay of stigma issues: they are stigmatized, stigmatizers, and de-stigmatizers (Schulze, 2007). In the development and validation of the HIV/AIDS Stigma Instrument–Nurse in five African countries (n = 1,474), Uys and colleagues (2009) concluded that nurses, especially those in Africa, are an excellent and interesting index to monitor levels of stigma in the community for several reasons. HCWs are (a) involved in the care of PLWH, (b) perpetrators or observers of enacted stigma in health care settings, (c) either infected with HIV or exposed to occupational hazards, (d) strategically positioned to serve as agents for decreasing secrecy and HIV-related stigma, and (e) change to their values, beliefs and attitudes can impact the way they deliver patient care (Uys et al., 2009; Vance & Denham, 2008). Understanding the extent and impact of perceived and experienced stigma in HIV-infected HCWs from a mixed-method approach is critical to informing comprehensive stigma reduction interventions in the workplace.

The purposes of our mixed-method study were to (a) describe the extent of HIV-related stigma in a sample of HIV-infected HCWs; (b) explore HIV-infected HCWs management of personal health, stigma experiences, and the HCWs role in reducing stigma; (c) explore the relationship between stigma and key sociodemographic variables; (d) assess whether key demographic variables were predictive of stigma; and (e) link qualitative findings to the six domains of the HIV/AIDS Stigma Instrument for PLWH (HASI-P).

Theoretical Framework

Holzemer et al., (2007a) developed the first conceptual model of HIV stigma in Africa. In this model, the researchers identified two components. Contextual factors are those factors that influence and affect stigma and the stigma process itself. This includes environment, health care system, and agents. The stigma process includes four dimensions: triggers of stigma, stigmatizing behaviors, types of stigma, and outcomes of stigma. Stigma triggers include the element of a marker or difference and may include a variety of factors such as HIV diagnosis or disclosure of HIV status. Stigmatizing behaviors as measured by the HASI-P may lead to consequences such as poor health, decreased quality of life, denied access to care, violence, and poor quality of work life Holzemer et al., (2007a). Holzemer et al (2007a) defined three types of stigma.

- Associated stigma: "incidents that describe stigma against people who work or associate with HIV/