Assessment of Workplace Stigma and Discrimination among People Living with HIV/AIDS Attending Antiretroviral Clinics in Health Institutions in Enugu, Southeast Nigeria

EN Aguwa[1], SU Arinze-Onyia[2], F Okwaraji[3], I Modebe[4]

ABSTRACT

Objective: *The onset of HIV/AIDS has increased stigma and discrimination at workplaces, making those with these ailments worried about going to work to avoid being victimized. Most previous works focussed on stigma and discrimination in the communities with little emphasis on what occurs in the workplaces. This study assessed the prevalence of workplace stigma and discrimination among people living with HIV/AIDS (PLWHA) attending antiretroviral (ARV) clinics in health institutions in Enugu, southeast Nigeria.*

Methods: *A cross-sectional descriptive study was done between February and May of 2014 using a self-administered questionnaire to assess 489 PLWHA attending ARV clinics.*

Results: *Out of 489 studied, 255 (52.1%) were females. About 23.7% said being HIV positive had affected their relationship with other workers and 20.7% were blamed for their condition. Some were not given time off to go to hospital (72.5%). The commonest fears of PLWHA were stigmatization/discrimination from other workers (78.1%) and dying from the disease (62.8%). Gender did not significantly affect the way PLWHA were stigmatized or discriminated against in their workplaces. However, those who were employed in private establishments were more likely to have their schedule changed due to their status compared to government employees (*$p < 0.01$*). Other discriminating practices were not significantly different between government and private employees.*

Conclusion: *The prevalence of stigma and discrimination in workplaces is high. Efforts should be made by agencies to reduce such social problems in the workplace since they can affect overall management and productivity.*

Keywords: Discrimination, HIV, psychological services, stigma, workplace

Valoración del Estigma y la Discriminación en el Centro de Trabajo entre Personas Que Viven con VIH/SIDA que Asisten a las Clínicas Antirretrovirales en las Instituciones de Salud en Enugu, Nigeria Suroriental

EN Aguwa[1], SU Arinze-Onyia[2], F Okwaraji[3], I Modebe[4]

RESUMEN

Objetivo: *La aparición del VIH/SIDA ha aumentado el estigma y la discriminación en los centros de trabajo, haciendo que las personas con estas dolencias se preocupen a la hora de ir a trabajar, tratando de evitar ser víctimas. Con anterioridad, la mayor parte de los estudios han centrado su atención sobre el estigma y la discriminación en las comunidades, con poco énfasis en lo que ocurre en los centros de trabajo. Este estudio evaluó la prevalencia del estigma y la discriminación en los centros de trabajo entre personas que viven con VIH/SIDA (PVVS) que asisten a clínicas antirretrovirales (ARV) en centros de salud en Enugu, Nigeria suroriental.*

Métodos: *Se realizó un estudio descriptivo transversal entre febrero y mayo de 2014, con un cuestionario autoadministrado, para evaluar 489 PVVS que asistían a clínicas de ARV.*

From: [1]Department of Community Medicine, University of Nigeria Nsukka, [2]Department of Community Medicine, Enugu State University College of Medicine, Parklane, Enugu, [3]Department of Psychological Medicine, University of Nigeria Nsukka and [4]Department of Community Medicine, Nnamdi Azikiwe University, Awka, Nigeria.

Correspondence: Dr EN Aguwa, Department of Community Medicine, University of Nigeria Nsukka, Nsukka Road, Nsukka 410001, Nigeria. E-mail: enaguwa@yahoo.com

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Resultados: *De 489 pacientes estudiados, 255 (52.1%) fueron mujeres. Alrededor del 23.7% reportó que ser seropositivo había afectado su relación con otros trabajadores, y el 20.7% eran recriminados por su condición. A algunos no se les daba tiempo para ir al hospital (72.5%). Los miedos más comunes de las PVVS fueron la estigmatización y la discriminación por parte de otros trabajadores (78.1%) y la muerte a causa de la enfermedad (62.8%). El género no afectó significativamente la manera en que los PVVS eran estigmatizados o discriminados en sus centros de trabajo. Sin embargo, aquellos que trabajaban en establecimientos privados eran más propensos a que se les cambiara el horario debido a su estado en comparación con los empleados del gobierno (*$p < 0.01$*). Otras prácticas discriminatorias no fueron significativamente diferentes entre los empleados privados y los del gobierno.*

Conclusión: *La prevalencia de la estigmatización y la discriminación en los centros de trabajo es alta. Las agencias deben hacer esfuerzos para reducir estos problemas sociales en los centros de trabajo, ya que a causa de ellos pueden verse afectadas la gestión general y la productividad.*

Palabras claves: Discriminación, VIH, servicios psicológicos, estigma, centro de trabajo

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INTRODUCTION

HIV/AIDS is a pandemic that causes significant morbidity and mortality especially in low and middle income countries (1). The global estimate of AIDS-related deaths in 2011 was about 1.7 million, with sub-Saharan Africa being the most affected (2). Genetic research revealed that HIV originated in west central Africa in the early 20th century (3), but AIDS was first clinically observed in the United States of America in 1981 (4). The first two cases of AIDS in Nigeria were identified in 1985 and this led government to initiate programmes aimed at controlling the disease (5). According to the global AIDS response progress report (6), the prevalence rates of HIV/AIDS in Nigeria showed that about 1.8% of the population was infected with HIV in 1991, 3.8% in 1993, 5.4% in 1999 and peaked at 5.8% in 2001. The report further stated that the HIV prevalence has declined steadily throughout the decade; the current prevalence rate was said to be 3.6% by 2009 (7). This prevalence varies greatly from region to region and there is also a higher prevalence of HIV among females and people of working age (8).

Work is a very important aspect of human activity. It occupies time meaningfully and is a source of livelihood. Hence, people generally look forward to work. However, even within the work environment, there are several factors that may militate against achieving good health. The social environment is increasingly impacting on well-being of workers. With the onset of diseases like tuberculosis, leprosy and HIV/AIDs, stigma and discrimination have increased in workplaces. According to Goffman (9), stigma is an undesirable or discrediting attribute, *eg* physical deformity or disease, possessed by an individual which tends to reduce his or her status in the community. On the other hand, discrimination is an aspect of stigma manifested in the form of exclusion or restriction of expression or marginalization either due to stigmatizing attributes or prejudicial treatment on the grounds of race, age or gender (10). Stigma often leads to discrimination. Social stigmatization and abuse from both coworkers and employers often occur if the person is known to be living with HIV/AIDS (PLWHA).

Some of the causes of HIV and AIDS-related stigma and discrimination in the workplace include ignorance or insufficient knowledge, misbeliefs and fear about HIV and AIDS, links with religion such as the belief that AIDS was a punishment from God and the belief that people living with HIV and AIDS are responsible for their illness (11, 12). Some researchers had categorized HIV and AIDS-related stigma into felt and enacted stigma. For instance, Fiest *et al* (13) argued that felt stigma refers to the feelings that PLWHA harbour about their conditions and the likely reactions from other people around them, whereas Bandstra *et al* (14) opined that enacted stigma has to do with the actual experience of stigmatization and discrimination.

Omololu *et al* (15) argued that enacted stigma was more prevalent in Nigeria and that some of the commonly reported workplace stigma and discrimination among PLWHA in Nigeria include termination or refusal of employment on the grounds of HIV (16), pre-employment or on the job screening for employment, denial of promotion, training or other benefits, breach of confidentiality of medical information including HIV status, and stigma and discrimination in the form of gossips, segregation, rumours, isolation and verbal abuse. It has been found that PLWHA are often depressed, ashamed and afraid to reveal their status for fear of these consequences and occasionally contemplate or even commit suicide (17, 18).

The fear of negative reactions from coworkers and employers may discourage workers from undergoing voluntary counselling and testing (VCT) and seeking available prevention and care services (19). For instance, in a sample of PLWHA, Sayles *et al* (20) observed that about one-third of the respondents reported experiencing high levels of internalized HIV stigma and that most of them had four times the odds of reporting poor access to care. The authors argued that the poor self-reported access to care may be as a result of perceived discrimination and social inequities that are central to the process of stigma. HIV stigma and discrimination have therefore been identified as major challenges to the success of achieving universal access to HIV prevention, treatment, care and support in

Nigeria. In a review of HIV and AIDS-related stigma and discrimination in Nigeria, Monjok *et al* (21) argued that reducing stigma and discrimination among PLWHA will increase both the individual and community acceptance of PLWHA, thereby increasing universal access to care. Furthermore, reporting from Edo state in Nigeria, Agweda and Dibua (22) found that 96.8% of their respondents were of the opinion that stigma can affect the acceptance and care of people living with HIV and AIDS in any society. Another study (19) in South Africa revealed that workers living with HIV/AIDS were more concerned about stigma coming from their coworkers than discrimination by their employers in the workplace. With regards to their coworkers, many of the respondents expressed concern of being ridiculed, isolated or avoided if it was discovered that they were HIV positive. The researchers concluded that HIV and AIDS-related stigma and discrimination can seriously affect the workplace; they therefore advocated for policies and programmes that will address social isolation and ridicule when developing HIV and AIDS stigma reduction activities in the workplace.

In the end, stigma and discrimination continue to undermine prevention, treatment and care of PLWHA. They prevent those with the virus from telling their partners about their status and threaten their access to healthcare. They also increase the vulnerability of PLWHA to physical violence and affect the person's ability to earn a living, making it even more difficult for them to lift themselves out of poverty. To protect PLWHA in their workplaces, HIV/AIDS programmes and policies have been developed. However, stigma and discrimination still present major challenges to the successful implementation of workplace HIV/AIDS programmes and policies. Furthermore, UNAIDS (23) had observed that discrimination, stigmatization and denial have been recognized as important issues to be addressed in the context of HIV/AIDS, especially in the workplace. They further posited that discrimination against PLWHA or those presumed to be infected with HIV/AIDS is a clear cut violation of human rights and should not be encouraged in any society.

Despite the above, there is paucity of data on the prevalence and factors associated with workplace stigma and discrimination among PLWHA in the study area and Nigeria in general (21).

The aim of the present study was therefore to assess the prevalence of workplace stigma and discrimination, factors associated with it and coping mechanisms of PLWHA.

SUBJECTS AND METHODS

This was a descriptive cross-sectional study carried out in Enugu State, southeast Nigeria between February and May 2014. In the study area, there are two government tertiary hospitals (University of Nigeria Teaching Hospital and Park Lane Specialist Hospital) and two mission hospitals (Annunciation Hospital and Mother of Christ Hospital) that run major antiretroviral (ARV) clinics. By simple random method, one hospital was selected from both the government hospital (Park Lane Specialist Hospital) and mission hospital (Annunciation Hospital). In both hospitals, ARV clinics are run three times weekly by medical consultants from different departments: Community Medicine, Paediatrics, Internal Medicine, and Obstetrics and Gynaecology. An average number of PLWHA treated in each of these clinics every week was 150. A calculated sample size of 480 was obtained and this was increased to 500 (250 selected from each of the two clinics) to take care of incomplete or wrongly filled data. Ethical permit was obtained from the Ethics Committee of the University of Nigeria and informed consent obtained from each study participant. Inclusion criteria were patients 18 years or older, who gave written informed consent, must have attended for care at either of the two clinics within the study period and must have had working experience. Participants who met the inclusion criteria were then enrolled consecutively until the sample size was reached.

Data were collected using a pre-tested semi-structured self-administered questionnaire that elicited information on demography and social aspect of work environment. Data were entered and analysed using Statistical Package for Social Sciences (SPSS) version 13. Results are presented as tables and cross-tabulations. Chi-square was used to test for significance.

RESULTS

Out of a total of 500 questionnaires, only 489 were correctly filled and hence analysed, giving a response rate of 97.8%. Out of these, 255 (52.1%) were females. The age range was 22–75 years with a modal age range of 31−40 years. Most (59.5%) were married, while 9.8% were widows/widowers. Also, 24 (4.9%) were either separated or divorced from their partners. All the respondents had working experience, but only 93.0% were currently employed at the time of the study. More (48.5%) of the respondents were government employees and most of the respondents had worked for one to nine years, while 1.2% had worked for 40 years or more (Table 1).

Table 1: Sociodemographic variables of respondents

Sociodemographic variables	Frequency (n = 489)	Per cent
Gender distribution		
Females	255	52.1
Males	234	47.9
Age range (years)		
21–30	104	21.3
31–40	189	38.7
41–50	118	24.1
51–60	67	13.7
61–70	10	2.0
71 and above	1	0.2
Marital status		
Single	126	25.8
Married	291	59.5
Widowed	48	9.8
Divorced/separated	24	4.9

Table 1 cont'd: Sociodemographic variables of respondents

Sociodemographic variables	Frequency (n = 489)	Per cent
Past and present occupational status		
Government employee	237	48.5
Private employee	92	18.8
Self-employed	160	32.7
Present employment status		
Unemployed	21	4.3
Employed	455	93.0
Retired	13	2.7
Total years worked		
1–9	283	57.9
10–19	137	28.0
20–29	51	10.4
30–39	12	2.5
40–49	6	1.2

Age range = 22–75 years. Range of working years in present job = 1–45 years

In terms of social relationship with other workers, 116 (23.7%) said being HIV positive had affected their relationship with other workers. Most commonly, they are avoided by other workers. Also, 20.7% said that they were blamed for their condition. Most (60.9%) would have preferred if their status was unknown to other workers. Their relationship with management affected the PLWHA from accessing drugs (26.8%) *eg* they are not given day off to go to hospital (72.5%). However, in some cases (7.6%), they were given moral support (Table 2). Gender did not significantly affect the way PLWHA were stigmatized or discriminated against in their workplaces (Table 3). However, those who were employed in private establishment were more likely to have their schedule changed due to their status compared to government employees ($p < 0.01$). Other discriminating practices were not significantly different between government and private employees (Table 3).

The commonest fears of PLWHA were discrimination/stigmatization from other workers (78.1%), dying from the disease (62.8%) and losing their job/source of income [31.7%] (Table 4). Only 1.2% claimed they had no major concern. People living with HIV/AIDS had several coping mechanisms: these include adhering to their drugs (81.0%), seeking medical advice early when sick (60.7%), trying to relate well with both management and other workers (53.0%) and joining support groups [46.6%] (Table 5). About 58.1% claimed that

Table 2: Social relationship of the PLWHA and other workers during the working years

Social relationship	Frequency	Per cent
Did your relationship to other workers change since you became infected?		
Yes	116	23.7
No	373	76.3
Effects of HIV on relationship to other workers	n = 116	
They avoid me	83	71.6
They told other people about my HIV status	78	67.2
I avoid them	71	61.2
They call me names	56	48.3
They said I should stop work because of my frequent illness	37	31.9
They blame me for my HIV status	24	20.7
They show increased assistance and understanding	22	19.0
They tell me that I am no longer useful	11	9.5
Would you prefer that other staff members do not know your HIV status?		
Yes	298	60.9
No	191	39.1
Has your relationship with management affected your receiving HIV drugs or going to hospital for treatment?		
Yes	131	26.8
No	358	73.2
Ways in which the management has affected HIV treatment?	n = 131	
They do not give day off to go to hospital	95	72.5
They complain that PLWHA do not give enough time to work	49	37.4
They give me moral support	10	7.6
They are indifferent	20	15.3
Other	3	2.3

PLWHA: people living with HIV/AIDS

Table 3: Relationship between gender/employment status and workplace stigma and discrimination

	Gender and workplace stigma and discrimination				
	Male n = 234		**Female n = 255 (%)**		**χ²** **(*p*-value)**
	(%) Yes	**No**	**Yes**	**No**	
Other workers blame the PLWHA for infection	1 (0.4)	233 (99.6)	2 (0.8)	253 (99.2)	0.26 (0.61)
Other staff avoid PLWHA	19 (8.1)	215 (91.9)	25 (9.8)	230 (90.2)	0.42 (0.52)
Sacked from work due to HIV status	2 (0.9)	232 (99.1)	2 (0.8)	253 (99.2)	0.01 (0.93)
Management has changed schedule of PLWHA due to status even when not at risk of infecting others	55 (23.5)	179 (76.5)	57 (22.4)	198 (77.6)	0.09 (0.76)
Relationship with other staff negatively affected receiving treatment	37 (15.8)	197 (84.2)	51 (20.0)	204 (80.0)	1.45 (0.23)
Satisfied with work	137 (58.5)	97 (41.5)	147 (57.6)	108 (42.4)	0.04 (0.84)
Relationship with management has negatively affected receiving treatment	53 (22.6)	181 (77.4)	78 (30.6)	177 (69.4)	3.92 (0.05)
	****Employment status and workplace stigma and discrimination**				
	Government employee n = 237		**Private employee n = 92**		
	Yes	**No**	**Yes**	**No**	
Has management changed your work schedule due to your status	28 (11.8)	209 (88.2)	33 (35.9)	59 (64.1)	25.39 (< 0.01)*
Has your relationship with other staff affected your receiving drugs or going to hospital for treatment?	37 (15.6)	200 (84.4)	18 (19.6)	74 (80.4)	0.74 (0.39)
Other staff avoid me	15 (6.3)	222 (93.7)	8 (8.7)	84 (91.3)	0.57 (0.45)
Has your relationship with management affected your receiving HIV drugs or going to hospital for treatment?	52 (21.9)	185 (78.1)	28 (30.4)	64 (69.6)	2.60 (0.11)
PLWHA are blamed by other workers for their condition	2 (0.8)	235 (99.2)	0 (0.0)	92 (100.0)	0.78 (0.38)

*Significant

**Self-employed persons were removed from analysis

Table 4: Major common fears of PLWHA about their work

Concern	**Frequency n = 489**	**Per cent**
Discrimination/stigmatization	382	78.1
Dying	307	62.8
Losing job	155	31.7
Cost of treatment	139	28.4
Inability to take care of family	124	25.4
Losing my friends	83	17.0
To get married	1	0.2
I have no concern	6	1.2

PLWHA: people living with HIV/AIDS

despite their condition, they were satisfied with their work. In Table 6, several recommendations were suggested by PLWHA on how to improve work conditions. Some of these include taking drugs regularly (84.7%), avoiding sharps in workplaces (79.6%), HIV testing should not be made compulsory before or during employment (100.0%) and PLWHA should not be sacked due to their HIV status (100%).

Table 5: Coping mechanisms of PLWHA in their workplace

Coping mechanisms	**Frequency n = 489**	**Per cent**
I adhere to my drugs strictly	396	81.0
I seek medical advice early when sick	297	60.7
I try to relate well with both staff and management	259	53.0
I joined support groups	228	46.6
I try to eat well	187	38.2
I maintain good personal hygiene	162	33.1
I pray a lot now	117	23.9
It has been very difficult coping	113	23.1
I keep to myself	98	20.0
I try to live a positive life	89	18.2
I avoid overworking myself	73	14.9
I try to do my job as well as before	72	14.7
I make sure no one knows my HIV status	54	11.0
I avoid injuries while at work	43	8.8
I avoid discussions	34	7.0
I am coping well in my workplace	18	3.7
I eat vegetables a lot	15	3.1
I take permission anytime I want to collect my medications	13	2.7
I am now more dedicated to my work	11	2.2

PLWHA: people living with HIV/AIDS
284 (58.1%) claimed to have been satisfied with their work.

DISCUSSION

This study has revealed the existence of various types of stigma and discrimination among PLWHA in the study area. This is in line with the findings of previous studies that assessed stigma and discrimination among PLWHA in the workplace both in Nigeria and in some other parts of the world. For instance, Adeyemo and Oyinloye (24) had argued that stigma and discrimination present major challenges to the successful implementation of workplace HIV/AIDS programme. In the present study, more than 90% are within working age of less than 60 years. Youths and young adults constitute the greater number of the working population in Nigeria, and this age group has been identified as being more vulnerable to the AIDS epidemic (8). Though more females were enrolled in the study, the difference did not appear significant. A previous report in Benue, Nigeria, showed a much higher proportion of females infected by HIV/AIDS than males [65% *versus* 35%] (25).

About 5% of the respondents were found to be either separated or divorced from their partners. This may be due to the discovery by their partners that they were HIV positive. With regard to stigma and discrimination, 23.7% of the res-

Table 6: Recommendations from PLWHA on how to maintain a healthy work life

Recommendations	**Frequency n = 489**	**Per cent**
To other PLWHA		
They should take their drugs regularly	414	84.7
Avoid sharps in workplaces	389	79.6
Live positive lifestyle *eg* no smoking or taking alcohol	351	71.8
Should pray very often and depend on God	314	64.2
Do not overwork yourself *ie* do only what you can comfortably do always	279	57.1
Seek medical advice when necessary	273	55.8
Join support groups	238	48.7
Avoid disclosure of HIV status to other staff and employees	227	46.4
Always insist on your rights in the office	146	29.9
Maintain a healthy work environment	119	24.3
Always disclose HIV status to others in the office	92	18.8
Accept condition and avoid depression	88	18.0
Avoid too many friends	64	13.1
Avoid mosquito bite	53	10.8
Take moringa seed	21	4.3
Always occupy yourself with work	12	2.5
Avoid kolanut and bitter kola	5	1.0
To management and other staff toward PLWHA		
HIV testing should not be compulsory before or during employment	489	100.0
PLWHA should not be sacked due to their status	489	100.0
HIV status of the staff should not be disclosed	489	100.0
All staff irrespective of their status should be treated equally	489	100.0
They should encourage their infected staff	489	100.0
There should be no discrimination or stigmatization due to their status	489	100.0
They should provide moral and financial assistance to them		
Salaries of PLWHA should be increased because of increased medical cost	466	95.3
PLWHA should be allowed to go for their treatment	441	90.2
Provide access to HIV screening		
Employers should provide social amenities to their staff with HIV	416	85.1
They should show empathy	372	76.1
Reduce workload for PLWHA	353	72.1

PLWHA: people living with HIV/AIDS

pondents indicated that being HIV positive had affected their relationship with their coworkers, while 20.7% said that they were blamed for being responsible for their conditions. This may be because, in Nigeria, people who are HIV positive were usually seen as being sexually reckless and morally bankrupt; their condition is therefore seen as a payback for being promiscuous. In this regard, Omololu *et al* (15) had argued that PLWHA in Nigeria experience stigma and discrimination from their coworkers mainly in the form of gossips, segregation, rumours, isolation and verbal abuse. The study further revealed that 60.9% of the respondents said they would have preferred if their HIV/AIDS status was not known by their coworkers. This may be due to the fear of being ridiculed or even avoided by their coworkers. They may also be afraid of clear cut marginalization and the fear that the news of their HIV status may spread everywhere and even to people who they would not have wanted to know that they were HIV positive. Similar findings were reported by Stewart *et al* (19) in South Africa who revealed that PLWHA were more concerned about stigma coming from their coworkers than discrimination coming from their employers.

About one-quarter of the respondents said the knowledge of their HIV status by coworkers affected them from accessing drugs, while as many as 72.5% said they were not given time off to go to a hospital. This poor self-reported access to drugs and to the hospital visit may be as a result of perceived discrimination and social inequities usually associated with HIV/AIDS stigma. This further corroborates the findings of Sayles *et al* (20) that respondents experiencing high levels of stigma had over four times the odds of reporting poor access to care.

Gender did not significantly affect stigmatization and discrimination of PLWHA in the workplace. This was contrary to an earlier view by Nwanna (26) who observed that women received harsher forms of stigma than men. He posited that this may be because women are wrongfully assumed to have brought AIDS into the family, usually because they were often the first to be diagnosed HIV positive either during antenatal visits or the birth of a sick baby.

People living with HIV/AIDS have many fears relating to or associated with HIV/AIDS. For instance, it was discovered that 78.1% of them had fears relating to discrimination and stigmatization, while 62.8% had the fear of death and 31.7% of losing their jobs. The fear of stigmatization and discrimination commonly expressed by PLWHA had earlier been observed in previous reports. Nwanna (26) had observed that the fear of discrimination commonly noticed among PLWHA may cause them to be less inclined to live freely, declare or acknowledge their HIV status. This fear can equally lead to denial and the adoption of lifestyle that can put other people at risk of contracting HIV. The fear of death seen in PLWHA in this study may be explained by the high level of superstition and ignorance usually associated with HIV in Nigeria. Many Nigerians still believe that HIV/AIDS has no treatment and see the disease as synonymous with death. Certain derogatory terms are used to describe HIV and anybody who has the disease is seen as already carrying a death sentence. Many also see the contracting of HIV/AIDS as a significant index of sexual immorality. Within the study area, such derogatory terms as ‘it must end in the grave’ and ‘the dying disease’ were used to describe HIV/AIDS. These statements can basically reinforce the fear of death seen among the participants in this study. Furthermore, the high unemployment rate in Nigeria can lead to fear of losing their job as this will prevent them from getting money to look after their families and procure treatment for their illness.

Apart from the various forms of stigma and discrimination being experienced by PLWHA in the workplace as noticed in this study, many of them still reported some coping mechanisms available to them to manage their condition. This may be due to the increased awareness being created by both governmental and nongovernmental organizations about HIV/AIDS which might have reduced the level of ignorance and superstition usually associated with HIV. It may also be due to the availability of various HIV/AIDS treatment and counselling centres in the country as well as the availability of drugs that tend to reduce the progression of the disease and those that can lead to the prevention of mother to child transmission of HIV from pregnant women to their unborn children.

RECOMMENDATION

In light of these findings, government should initiate actions that will reduce the high level of stigma and discrimination facing PLWHA in the workplace and introduce regular psychological services that will limit the various fears being expressed by PLWHA as noticed in this study.

Study limitations: This was a hospital-based study and hence does not capture other peculiarities that would have been captured by a community-based study. However, this will be the focus of future research.

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