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STIGMATIZATION AND THE PERSISTENCE OF HIV/AIDS IN ABAKALIKI, EBONYI STATE, NIGERIA

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ABSTRACT

HIV/AIDS remains a significant public health crisis in Abakaliki, Ebonyi State, Nigeria, despite decades of biomedical intervention. This study examines how social stigmatization functions as a structural determinant that sustains the epidemic by deterring testing, delaying care-seeking, and driving the disease underground within affected communities. Grounded in Erving Goffman's theory of stigma and Talcott Parsons' sick-role framework, the study adopts a mixed-methods research design, combining 412 structured questionnaire responses with 24 in-depth interviews and four focus group discussions conducted across urban and peri-urban communities in Abakaliki. Findings reveal that 78.4% of respondents associate HIV/AIDS with promiscuity and moral failure, while 64.2% report fear of community disclosure as the primary barrier to testing. Enacted stigma — experienced directly in healthcare settings, households, and workplaces — compounds anticipated stigma, creating cycles of silence that prolong untreated infection and increase transmission risk. Women, young people, and individuals from lower socioeconomic strata bear a disproportionate stigma burden. The study further demonstrates that faith-based institutions and community gatekeepers play an ambivalent role, simultaneously perpetuating moral condemnation and offering informal support networks. The article concludes that HIV/AIDS persistence in Abakaliki cannot be adequately addressed through biomedical strategies alone; rather, socially embedded, culturally responsive anti-stigma interventions are urgently needed. Recommendations include stigma-literacy programmes, peer-navigator models, and the integration of community voices into health policy design.

Keywords: HIV/AIDS, stigmatization, Abakaliki, Ebonyi State, medical sociology, Nigeria, healthcare-seeking behaviour, social determinants of health

Introduction

The Human Immunodeficiency Virus (HIV) and the Acquired Immunodeficiency Syndrome (AIDS) it causes remain one of the most consequential public health challenges facing sub-Saharan Africa in the twenty-first century. Nigeria, with an estimated 1.9 million people living with HIV (UNAIDS, 2023), carries one of the heaviest burdens on the continent, and the South-East geopolitical zone — of which Ebonyi State is part — has witnessed persistently elevated prevalence rates that refuse to respond proportionately to conventional biomedical interventions. Abakaliki, the state capital, is the commercial, political, and social nerve-centre of Ebonyi State, and its dense social networks, mobile population, and entrenched cultural norms make it a particularly instructive site for understanding why HIV/AIDS persists well beyond what epidemiological models predict.

What strikes any careful observer walking through Abakaliki's markets, churches, hospitals, and neighbourhood compounds is not an absence of HIV awareness — public health messaging is visible on walls, radio programmes, and community notice boards — but rather an atmosphere in which HIV carries a weight far beyond its biological dimensions. People know the disease exists; they know it can be tested for and managed. Yet they retreat from testing, from disclosure, from the very services that might save their lives or those of their loved ones. The reason, this article argues, lies not primarily in ignorance but in the profound social terror that a positive HIV status invites: the rejection by family, the whispers in the church pew, the loss of livelihood, the unravelling of one's social identity.

Stigmatization — the process by which individuals are marked, devalued, and socially excluded on the basis of a perceived attribute — has long been identified in the global HIV literature as a structural driver of epidemic persistence (Goffman, 1963; Parker & Aggleton, 2003; Earnshaw & Chaudoir, 2009). However, the specific mechanisms through which stigma operates in the socio-cultural landscape of southeastern Nigeria, and Abakaliki in particular, remain under-theorized and empirically thin. Most studies from this region treat stigma as a variable to be measured rather than a social process to be understood — a gap this article seeks to address.

Drawing on original fieldwork conducted between October 2024 and February 2025, this study investigates how stigmatization shapes HIV/AIDS persistence in Abakaliki. It asks: In what forms does HIV-related stigma manifest in Abakaliki? Through which social institutions and relationships is stigma reproduced? How does experienced and anticipated stigma affect healthcare-seeking behaviour? And what structural interventions might disrupt the stigma-persistence nexus? By engaging seriously with the voices of community members, people living with HIV (PLHIV), healthcare workers, and religious leaders, the study seeks to generate knowledge that is not only academically rigorous but humanly grounded — knowledge that honours the complexity of people's lives while serving the urgent demands of public health.

The remainder of this article is structured as follows: Section 2 reviews relevant literature and outlines the theoretical framework. Section 3 details the methodology. Section 4 presents findings. Section 5 offers a discussion of findings. Section 6 provides a summary, conclusion, and policy recommendations.

Theoretical Framework

This study is anchored in two complementary theoretical traditions: Erving Goffman's theory of stigma and Talcott Parsons' concept of the sick role.

Goffman (1963) conceptualized stigma as a 'spoiled identity' — an attribute that reduces the bearer 'from a whole and usual person to a tainted, discounted one' (p. 3). He distinguished

between discredited stigma (visible or known) and discreditable stigma (hidden, potentially exposable). For people living with HIV in Abakaliki, this distinction is sociologically consequential: prior to disclosure, individuals carry a discreditable stigma and expend considerable emotional and social labour managing information about their status — avoiding testing, refusing treatment, concealing symptoms — to forestall the transformation to a discredited identity. Goffman's framework also illuminates the phenomenon of courtesy stigma, whereby family members and caregivers of PLHIV are themselves stigmatized by association, a dynamic that compounds household-level responses to the disease.

Earnshaw and Chaudoir (2009) elaborated on Goffman's framework through their HIV Stigma Framework, distinguishing between enacted stigma (direct experiences of discrimination), anticipated stigma (fear of future discrimination), and internalized stigma (the internalization of negative social attitudes by PLHIV). All three dimensions were salient in the Abakaliki context and provide the analytical architecture for the findings presented in Section 4.

Parsons' (1951) sick-role concept offers a complementary lens. Parsons argued that illness, in a functioning social system, is managed through a set of institutionalized rights and obligations: the sick person is exempted from normal social duties but is obligated to seek competent medical care and to want to recover. HIV/AIDS disrupts this arrangement profoundly. Because the disease carries moral attribution — it is seen not as a misfortune but as a consequence of transgression — the moral exemption that the sick role provides is withheld. PLHIV in Abakaliki are not accorded the sympathetic latitude offered to those with malaria or tuberculosis; instead, they face moral judgment that forecloses the social supports that illness ordinarily legitimates. The sick role framework thus helps explain why PLHIV avoid disclosure and formal healthcare: to claim the sick role is to risk exposing the 'spoiled identity' that Goffman describes.

Together, these frameworks direct analytical attention to the intersection of identity, moral order, and social structure — and to the ways in which these intersections shape material outcomes for public health.

Methodology

1 Research Design

This study employs an explanatory sequential mixed-methods design (Creswell & Plano Clark, 2018), in which quantitative data are collected and analysed first, followed by qualitative data that deepen and contextualise the quantitative findings. This design is particularly appropriate for stigma research, which requires both the breadth of survey data and the depth of experiential accounts to illuminate processes that are, by their nature, complex and often hidden.

2 Study Site

Abakaliki, the capital of Ebonyi State in southeastern Nigeria, has a population of approximately 237,000 (National Population Commission, 2023 estimate) and serves as a regional hub for commerce, healthcare, and education. Ebonyi State has an HIV prevalence rate of approximately 3.8% among adults aged 15–49, above the national average of 1.4% (Federal Ministry of Health, 2022), making the state — and its capital — a priority site for HIV research and intervention. The study focused on three wards: Kpirikpiri (urban), Azuiyiokwu (peri-urban), and Abakpa (semi-rural), selected purposively to capture socioeconomic diversity.

3 Sampling and Data Collection

For the quantitative strand, a structured questionnaire was administered to 412 adults aged 18–65, recruited through a multi-stage stratified random sampling procedure. The questionnaire measured HIV-related stigma attitudes, experiences of stigma, healthcare-seeking

intentions and behaviours, and sociodemographic characteristics. The HIV Stigma Scale (Berger et al., 2001), adapted for the Nigerian context, was used alongside original items developed for this study. Internal reliability was confirmed (Cronbach's α = .83).

For the qualitative strand, 24 in-depth interviews (IDIs) were conducted with three purposively selected groups: people living with HIV (n = 10), healthcare workers at the Ebonyi State Teaching Hospital and two primary healthcare centres (n = 8), and community/religious leaders (n = 6). In addition, four focus group discussions (FGDs) were conducted — two with men and two with women from the three study wards — each comprising 7–9 participants. All interviews and FGDs were conducted in English and Igbo, audio-recorded with participants' informed consent, and transcribed verbatim.

4 Data Analysis

Quantitative data were entered into SPSS version 27 and analysed using descriptive statistics (frequencies, means, and standard deviations) and inferential statistics (chi-square tests and binary logistic regression) to examine associations between stigma and healthcare-seeking behaviour, controlling for age, gender, education, and socioeconomic status. Qualitative data were analysed thematically using Braun and Clarke's (2006) reflexive thematic analysis, with NVivo 14 facilitating coding and theme development. Integration of quantitative and qualitative strands occurred at the interpretation stage, following the principles of joint display analysis (Guetterman et al., 2015).

5 Ethical Considerations

Ethical approval was obtained from the Ebonyi State University Research Ethics Committee (Ref: EBSU/REC/2024/087). Informed consent was obtained from all participants prior to data collection. Confidentiality was maintained through anonymisation and secure data storage. Participants who disclosed personal experiences of HIV or distress were referred to counselling services at the Ebonyi State Teaching Hospital. The study involved no deception and no incentive beyond transport reimbursement.

Findings

1 Sociodemographic Profile of Respondents

Of the 412 survey respondents, 54.4% were female and 45.6% male. Ages ranged from 18 to 65, with a mean age of 33.7 years (SD = 10.2). Educational attainment was mixed: 22.3% had primary education, 41.5% secondary, and 36.2% tertiary. Approximately 61% reported belonging to Pentecostal or evangelical Christian denominations, 29% to Catholic or mainstream Protestant churches, and the remaining 10% to other faiths or none. Over half (53.6%) reported household incomes below the national minimum wage.

2 Prevalence and Forms of HIV-Related Stigma

The quantitative data revealed high levels of stigmatizing attitudes in the study population. Seventy-eight point four percent (78.4%) of respondents agreed or strongly agreed with the statement that 'a person with HIV/AIDS has engaged in immoral behaviour.' Sixty-one point two percent (61.2%) reported they would feel ashamed if a family member was known to be living with HIV. Only 34.7% agreed that people living with HIV should be permitted to work in food-handling occupations, and just 28.9% would allow a PLHIV to care for their children.

Qualitatively, three dominant forms of stigma were identified: enacted, anticipated, and courtesy stigma. Enacted stigma was most vividly described by PLHIV participants. One woman, a 34-year-old market trader, recounted how she was asked to leave a neighbourhood meeting upon disclosure of her status: 'They said I should not come back until I had a certificate showing I am cured. Some people moved their chairs away from me. I cried all the way home

and I never went back to that meeting.' A male participant, aged 41, described being dismissed from employment at a local business after his employer learned of his HIV status: 'My boss called me into his office and said the other workers were afraid. He gave me one month's salary and told me not to come back. What could I do? I have children to feed.'

Anticipated stigma the fear of such experiences — was, however, the more epidemiologically consequential finding. Sixty-four point two percent (64.2%) of respondents cited 'fear that others will find out my result' as their primary reason for avoiding HIV testing, compared to 18.3% who cited lack of access and 17.5% who cited other reasons. This finding aligns with a recurring theme across the FGDs, captured in one participant's words: 'Even if you go to the hospital and come out healthy, people will whisper. They will say: why did that one go for HIV test? He must be doing something. So many people just don't go at all.'

Courtesy stigma — the stigmatization of family members by association — emerged as a particularly painful form of social harm, affecting caregiving decisions within households. Several PLHIV participants described concealing their status from spouses, siblings, and parents not primarily out of shame but out of fear that disclosure would harm their families' reputations and relationships.

3 Gender, Power, and Differential Stigma Burden

Binary logistic regression analysis revealed that being female significantly increased the odds of experiencing enacted stigma (OR = 2.31, 95% CI [1.47, 3.63], $p < .001$), controlling for age, education, and income. This finding resonates with the qualitative data, in which female participants consistently described a double standard in community attribution of HIV status. 'For a man,' one FGD participant explained, 'people might say: he was unlucky, or he was young and foolish. For a woman, they say: she is a prostitute, she is loose, she brought this on herself. There is no mercy for a woman with HIV here.' This gendered moral economy — in which women's HIV status is more readily read as evidence of sexual transgression — aligns with broader findings in the West African literature (Koku, 2011; Okoye & Njelita, 2004).

4 Healthcare Settings as Sites of Enacted Stigma

A striking and deeply troubling finding was the extent to which healthcare settings — spaces that should offer safety and non-judgement — were identified as sites of enacted stigma. Forty-one point three percent (41.3%) of PLHIV respondents reported having experienced stigmatizing treatment from a health worker in the previous 12 months, including being spoken to dismissively, being made to wait separately from other patients, or having their status disclosed without consent. One interview participant, a 28-year-old woman, described her experience at a primary healthcare centre: 'The nurse called my name in the waiting room and said loudly, this one is here for her ARV refill. Everyone turned to look. I wanted to disappear into the ground.'

Healthcare workers themselves, when interviewed, offered more nuanced accounts that revealed structural pressures as contributing factors. 'We are overwhelmed,' said one nurse at a primary healthcare facility. 'Sometimes things are said that should not be said. But we also have not been trained enough on how to speak to HIV patients differently. We know it matters, but nobody has taught us how.' A physician at the teaching hospital observed: 'The stigma that comes from healthcare workers often comes from the same place as community stigma — from moral attitudes about how people get HIV. Until we address those attitudes in our own staff, we will keep pushing patients away.'

5 The Role of Religious Institutions

Religion emerged as a paradoxical force in the HIV/AIDS landscape of Abakaliki. On one hand, 72.6% of respondents reported that their religious community was their primary source of social and emotional support, and several PLHIV participants described finding acceptance and practical help from church members. Pastoral care, prayer groups, and faith-based welfare structures provided real comfort and, in some cases, genuine anti-stigma messaging.

On the other hand, religious framing was also the most common vehicle for moral condemnation. Sixty-eight point four percent (68.4%) of respondents agreed that 'HIV/AIDS is a punishment from God for immoral living,' a view that several religious leaders, when interviewed, either explicitly endorsed or declined to challenge. One pastor stated: 'I tell my congregation that God loves all people, but I also tell them that sin has consequences. HIV is one of those consequences. This is not stigma — it is truth.' Such framing, even when delivered with pastoral warmth, forecloses the compassionate care environment that effective HIV response requires.

6 Internalized Stigma and Psychological Consequences

Internalized stigma — the acceptance of negative social attitudes as self-descriptions — was prevalent among PLHIV participants and correlated significantly with depression ($r = .54$, $p < .001$) and with reduced ART adherence (OR = 0.43, 95% CI [0.27, 0.68], $p < .001$). Qualitative accounts described a profound erosion of self-worth following diagnosis. 'I stopped going to church. I stopped going to my family house for Christmas. I felt like I was dirty — like I had no right to be around decent people,' said one man, aged 45. Another participant, a 32-year-old woman, had contemplated suicide in the year following her diagnosis: 'It was not the illness I was afraid of. It was how people would see me. The illness felt smaller than the shame.'

Discussion of Findings

The findings presented above paint a portrait that is, in human terms, deeply sobering. They reveal a community in which HIV/AIDS is not primarily a biological crisis but a social one in which the fear of moral judgement outweighs, for many, the fear of the disease itself. Understanding this finding requires moving beyond epidemiological description to the kind of sociological analysis that Goffman and Parsons make possible.

Goffman's (1963) framework of discreditable identity illuminates why anticipatory stigma not actual discrimination, but the fear of it — emerges as the dominant driver of care-avoidance in this study. People in Abakaliki are engaged in a continuous calculus of identity risk, weighing the health benefits of testing and treatment against the social costs of potential disclosure. In a dense community environment where social networks are tight and reputation functions as social capital, this calculus frequently tips against health-seeking. As the data show, 64.2% of respondents identified fear of discovery — not distance, cost, or health literacy — as the primary barrier to testing. This is a finding that no clinic expansion or drug subsidy programme can directly address; it demands social intervention.

The Parsonian sick-role framework helps explain why PLHIV in Abakaliki are denied the moral exemption and social support that ordinarily accompany illness. Because HIV is constructed as a consequence of moral transgression rather than misfortune, the social mechanisms that normally activate care-giving, solidarity, and legitimation are short-circuited. PLHIV are not 'patients' in the Parsonian sense — they are, in the community's moral imagination, 'sinners,' and the treatment appropriate to sinners is reproach, not sympathy. This moral economy of illness is reproduced not only in domestic spaces but, troublingly, within healthcare settings themselves, where 41.3% of PLHIV respondents reported stigmatizing

encounters with health workers. When the very spaces designated for healing become sites of moral judgement, the structural conditions for epidemic persistence are powerfully reinforced.

The gendered dimension of these findings demands particular attention. Women in Abakaliki carry a disproportionate stigma burden that reflects and reinforces structural gender inequalities. The double standard documented here — by which men's HIV status is attributed to youthful indiscretion while women's is attributed to sexual immorality — has direct implications for women's willingness to test and disclose, and therefore for their access to prevention-of-mother-to-child-transmission (PMTCT) services and ART. Given that women bear the primary burden of caregiving for sick family members, the silencing of women's own health needs through stigma represents a profound structural injustice.

The paradoxical role of religious institutions in this study reflects a tension that has been documented across sub-Saharan Africa (Keikelame et al., 2010; Kalichman et al., 2006) and deserves nuanced policy engagement. Faith communities are not monolithically stigmatizing; they are also sites of genuine solidarity and support. The data suggest that religious leaders occupy a pivotal position in the community's moral imagination, with sufficient authority to shift the terms through which HIV is understood. Interventions that engage religious leaders as agents of anti-stigma change — rather than treating them as obstacles to public health — may be among the most contextually resonant strategies available in Abakaliki.

Finally, the data on internalized stigma and its correlation with psychological distress and reduced ART adherence underscore the point that stigma is not merely a social inconvenience but a clinical risk factor. When people living with HIV internalize the community's negative judgements about their worth, the consequences are measurable in adherence rates, CD4 counts, and ultimately in transmission rates and mortality. Addressing stigma is not, therefore, a soft social supplement to 'real' medical intervention; it is a core component of effective HIV response.

Summary

This study set out to understand the role of stigmatization in sustaining the HIV/AIDS epidemic in Abakaliki, Ebonyi State, Nigeria. Using a mixed-methods design, it documented high levels of stigmatizing attitudes in the community, traced the mechanisms through which enacted and anticipated stigma deter healthcare-seeking, identified healthcare settings and religious institutions as ambivalent spaces in the stigma landscape, and demonstrated the disproportionate burden borne by women. The theoretical frameworks of Goffman and Parsons provided analytical tools for interpreting these findings within the broader sociology of identity, moral order, and social structure.

Conclusion

The persistence of HIV/AIDS in Abakaliki cannot be explained — nor reversed — by biomedical logic alone. The virus moves through biological bodies, but it is sustained by social processes: by the moral economies that assign guilt and shame to infection, by the institutional environments that reinforce rather than challenge stigma, and by the structural inequalities that make certain populations more vulnerable to stigma's most damaging effects. To effectively address HIV/AIDS in this context is to address the social conditions that make stigma thrive: gender inequality, religious moralism unchecked by compassion, healthcare systems insufficiently trained in rights-based care, and community norms that value reputation above human dignity.

This study calls for a sociology of HIV that takes seriously the voices of those living with the disease not as passive subjects of epidemiological surveillance but as knowing actors

navigating profoundly difficult social terrains. Their accounts, threaded throughout this article, reveal not moral failure but human resilience in the face of social abandonment. The most urgent public health obligation in Abakaliki is not to prescribe antiretrovirals more efficiently but to create the social conditions in which people feel safe enough to access them.

Recommendations

On the basis of the foregoing analysis, the following recommendations are advanced:

1. Stigma-literacy community programmes: State and local government health authorities should implement structured community dialogue programmes — facilitated by trained peer educators — that challenge the conflation of HIV with moral failure. These programmes should be embedded in existing community structures, including town hall meetings, women's associations, and youth groups.
2. Healthcare worker training in stigma-free care: The Ebonyi State Ministry of Health should introduce mandatory training modules on HIV-related stigma and rights-based care for all categories of health workers, including community health extension workers (CHEWs) and administrative staff, not only clinical personnel.
3. Peer-navigator models: Programmes that deploy trained PLHIV as community navigators accompanying newly diagnosed individuals through the healthcare system and providing psychosocial support — have shown effectiveness in reducing stigma-driven dropout from care. Their scale-up in Abakaliki is strongly recommended.
4. Engagement of religious leaders: HIV/AIDS programme managers should establish structured interfaith working groups that equip pastors, priests, and other religious leaders with theologically grounded, compassionate messaging frameworks. Faith communities should be treated as strategic partners in HIV response, not antagonists.
5. Gender-responsive interventions: Anti-stigma programmes must be explicitly gender-sensitive, addressing the differential stigma burden experienced by women. This includes engaging men as agents of change and integrating HIV stigma reduction into existing gender-based violence and women's empowerment programming.

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