



CHALLENGES FACED BY PEOPLE LIVING WITH HIV (PLWHIV) IN THE DSCHANG HEALTH DISTRICT, CAMEROON

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ABSTRACT: Background: Regarding the 2011 – 2015 world AIDS day, stating that, Zero AIDS related Deaths, Zero new infections and Zero stigma and discrimination by 2020. How can this target be met in the mist of HIV related challenges? This is a negative stimulus on the public health sector to forge things towards the positive direction to better reduce these challenges. **Objectives:** This led to the necessity of this project, which at the end it permitted the determination of challenge faced by PLWHIV in the Dschang health district. **Material and methods:** This study was purely a qualitative research using conventional content analysis. Data collection was through in-depth interviews, and participating observation. Data was collected till saturation point and analyzed by thematic analysis. **Results:** In a general manner we have proofed that despite the interventions, PLWHIV in the Dschang health district are still facing challenges like stigma and discrimination, rejection, non-adherence to treatment, risky behaviours for infection, socioeconomic difficulties and nondisclosure which are barrier to PMTCT and ART. Support group was found to be a good coping strategy. **Recommendations:** Support groups for PLWHIV should be offered as a fundamental part of HIV services.

KEYWORDS: Challenges Faced, PLWHIV, Dschang, Cameroon

INTRODUCTION

Acquired Immune Deficiency Syndrome (AIDS) was first recognized as a new disease in 1981 when increasing numbers of young homosexual men succumbed to unusual opportunistic infections and rare malignancies (CDC, 1981) (Greene, 2007). Since the beginning of the HIV epidemic, more than 70 million people have been infected with the HIV virus and about 35 million people have died of AIDS. An estimated 0.8% [0.7-0.9%] of adults aged 15–49 years worldwide is living with HIV, not forgetting that 1.1 million people died of aids related diseases worldwide in 2015. Sub-Saharan Africa remains most severely affected, with nearly 1 in every 25 adults (4.4%) living with HIV and accounting for nearly 70% of the people living with HIV worldwide (UNAIDS, 2015).



In Cameroon, there were six new infections per hour, approximately 141 per day, 4,276 every month, and 51,315 per year (CNLS/GTC, 2010). According to UNAIDS, Cameroon harbors about 620 000 [550 000 - 690 000] PLWHIV, with a prevalence rate of about 4.5% [3.9% - 5.0%] adults aged (15 to 49years). There are about 580 000 [520 000 - 650 000] adults aged 15years and over living with HIV and about 340 000 [310 000 - 390 000] Women aged 15 and over living with HIV, about 39 000 [34 000 - 44 000] children aged 0 to 14years living with HIV. It is important to note that Cameroon registered about 33 000 [30 000 - 36 000] HIV related deaths, living about 310 000 [290 000 - 350 000] children aged 0 to 17 years orphans (UNAIDS, 2015).

Multiple sexual partners, low condom use, low status of women regarding decision making during sex, high Prevalence of other sexually transmitted infections facilitate HIV transmission through unprotected sexual relationships, harmful socio-cultural practices and migration (Allanise Cloete, 2010). The principal mode of HIV infection in Cameroon is through sexual intercourse. About 6% of new infections are from mother-to-child transmission, and about 4% of new infections come from the blood supply and other accidental transmission (CNLS/GTC, 2010).

Whatever the situation may be as regards transmission, as people living with HIV/AIDS (PLWHIV) now live longer and healthier lives due to the greater availability of antiretroviral (ARV) treatment, the urgency of including behaviour change strategies for PLWHIV into the public health system becomes an imperative to curb the further spread of the disease and also to prevent re-infection (Krepaz, 2005). Although antiretroviral treatment has reduced the toll of AIDS-related deaths, access to therapy is not universal, and the prospects of curative treatments and an effective vaccine are uncertain (Barouch, 2008) (Richman, 2010). Thus, AIDS will continue to pose a significant public health threat for decades to come. Moreover, where ARV treatment is readily available decreasing HIV/AIDS morbidity has been paralleled by increasing HIV/AIDS infection rates suggesting that prevention programs targeting only HIV-negative persons may be inadequate to curb the HIV epidemics (Colfax, 2004). Behaviour change strategies tailored to the specific needs of PLWHIV are termed positive prevention. In 2007, the country made antiretroviral (ARV) treatment free, in part to fight a common belief that people with HIV were condemned to death, despite the government's efforts to make ARV treatment free, decentralize treatment centers and establish HIV/AIDS support programs for clients, there are still widespread myths of stigma and discrimination associated with the disease as we speak. Though a more efficient allocation of funds as well as continuous communication on prevention methods is therefore prescribed to reduce the number of HIV infections to zero, as stated in the 2011-2015 World AIDS Day themes, how true can this be in the mist of challenges?

Qualitative methods have become important tools within this broader approach to applied research, in large part because they provide valuable insights into the local perspectives of study populations. The great contribution of qualitative research is the culturally specific and contextually rich data it produces. Such data are proving critical in the design of comprehensive solutions to public health problems in developing countries (international, 2005). In the main time, this study steps in as one of the few qualitative research that brings out the challenges faced by PLWHIV which has as aim to develop strategies to ease the challenges faced by PLWHIV, the possible barriers to treatment and PMTCT.



MATERIALS AND METHODS

The study was a qualitative research using conventional content analysis.

This study was carried out in the Dschang Health District. With study population being health personnel in the various HIV help desk and PLWHIV in the Dschang health district. Data was collected in the month of May 2016 to August 2016 in the aforementioned sites.

The sampling technique that was adopted for choosing participants was the non-probability sampling technique with the use of a purposive sample for PLWHIV and exhaustive for health personnel or health workers.

Data Collection and Statistical Analysis

On daily bases at the various HIV help desk with the help of a well-structured interview guide and a dicta-phone interviews were conducted under conducive and confidential conditions by the researchers. The main objectives of the study were disclosed and the anonymous nature and participants well clarified in order to get the consent of participants. The interviews were orientated toward perceptions and experiences of their daily life and with the help of probing by the researcher the level of required information was obtained.

Participating observation on the general environment and functioning of the help desk, the comportment of health personnel and HIV clients were done with the help of an observation guide.

We had an interview guide which was orientating our semi-structured interviews to the target, an observation guide for a proper participating observation and a dicta-phone which was used in recording during interview in order to facilitate transcription and analysis.

Data Collection

After depositing the protocol at the Ethical Committee, a pre-test was done in the Penka Michel Health District. This was then followed by data collection proper for two months. In each HIV help desk, the authorization from the district was presented to the General Supervisor or director. When a pass was given, we then proceeded to data collection. An informed consent was administered to the target. When he/she agreed, we then started our interviews which were auto-recorded using a dicta-phone. These interviews were closely followed with keen observation of the entire system.

NB: data was collected till saturation point.

Data Quality Assessment

The pre-tested interview guide was administered only by the Principal Investigator in order not to compromise the quality of the data collected. At the end of each day, recorded interviews were transcribed and typed as well in the participant's own words.

Data Analysis Procedure

Data was mainly analysed using thematic analysis. The following steps were taken to analysed the data: transcripts were coded using the participants' own words and phrases and without



preconceived classification; the participant's language or phrases were examined, categorized and recurrent themes were identified. Recurrent themes are the similar and consistent ways people think about, and give accounts concerning particular issues. These were then coded with a key word or phrase that captured the essence of the content, and will be taken to constitute emergent themes

Ethical Consideration

This protocol was submitted to the National Ethical Committee in Yaoundé for Ethical Clearance (N^o2016/08/780/L/CNERSH/SP).

An authorisation was obtained from the District Medical Officer. The General supervisor of each HIV help desk was contacted and an authorization obtained before entire commencing with data collection in the various areas of jurisdiction.

RESULTS

Features of PLWHIV and Personnel

During the study period, a total of 94 semi-structured interviews were conducted. These interviews were backed up by individual and site observations. Participants were recruited from the Dschang health district on the basis that they were on antiretroviral therapy in any one of the 3 therapy centers or health personnel in any of the latter.

The Concepts and Perceptions drawn from PLWHIV and Health Workers

Interviews with 87 PLWHIV and 7 health professionals helped us to access the complete information. The main themes were stigma and discrimination, disclosure is a sensitive issue, rejection, risky behavior for HIV infection, socioeconomic context and support groups as a coping strategy.

Stigma and discrimination

The participants mentioned many painful experiences which resulted from being labeled as HIV/AIDS-positive clients and hence discrimination. Discrimination and denial range from refusal by their partners, physical violence and rejection from society, loss of employment, financial difficulties and others. This category boiled down into social stigma and Auto-stigma.

- ***Social stigma***

The participants claimed that social stigma caused them to be judged wrongly in their social relations. To female participants it appears to imply failure to her traditional duty of care giving and moral Guidance, following what some participants said.

“I had to divorce because my co-wives started calling me names because only my husband and I were victims, I could not stand the stress and shame”. (A 48-year-old HIV+ woman).

“I have lost my respect in my community the least problem I have with somebody he will say, an AIDS patient like you, are you not ashamed?” (A 35-year-old HIV+ woman).



Labeling as prostitutes and sexual deviant, stigma was important and agonizing for the participants. They understood that most of the people in the society think that HIV originates from sexual deviances and matches immorality.

“HIV is a shameful thing, an open sign of adultery, my wife is aware just due to the intimacy we share, the day I was told if not for the fact that I was a man I should have committed suicide”.(a 65years old HIV+ man)

- ***Auto-stigma***

Self-stigma affected PLWHIV more than social stigma. Participants revealed that self-stigma lead PLWHIV to the feeling of self-blame and sometime suicidal attempt.

“I can’t any longer work because I can’t stand the shame working as a health worker. How will I talk to a patient about HIV?” (A 48 years old HIV+ woman)

Disclosure is a Sensitive Issue

Findings confirmed that secrecy/fear of disclosure was killing PLWHIV faster than the infection itself, the numerous status advantages of HIV disclosure (especially women).

“I do not have a boyfriend because I do not know how to start tell a guy about my condition, it is so painful and the entire thing is above me” (A 30 years old HIV+ woman).

These include abandonment and relationship termination, stigma and discrimination and emotional abuse. And this had kept them in dilemma whether to disclose their status or not. The majority (95 %) of participants agreed that disclosure was a sensitive issue. Fear surfaced, such as reaction of partners, family, friends, in-laws and the impact of disclosure on their children.

“I do not want people to know because I don’t want to traumatize any one including my children.” (A 30 years old HIV+ woman).

Findings confirmed that not disclosing the status is associated with more deterioration of their health status. Firstly PLWHIV hesitate and fear to receive the care and treatment needed for them. Secondly they themselves develop self-blame and suicidal feelings.

“Most people do not even want to pronounce the word HIV because there is auto culpability and the patient still does not believe why he/she should be a victim”. (Health worker-masculine).

Rejection

The participants claimed that as they were identified as PLWHIV (social patient) in the community, they faced isolation from family members, relatives and friends, and even social separation, loneliness, hopelessness, social rejection and home-leave. Rejection was sub divided into two forms.

- ***Self-isolation***

The participants reduced and cut their social relations and kept away from the community. They ran away from stigma and concealed their status.



"Now I just prefer to stay in my own small corner and take care of my children" (a 43 years old HIV+ woman)".

"Discrimination was not supposed to exist but since PLWHIV are auto stigmatise, they create situations because to them, they are different" (Health worker-masculine).

- **Social rejection**

Most participants described the differences in treating women after their disclosure. The participants mentioned friends and community awareness as one of the most humiliating experiences.

"I attended a funeral where an HIV+ woman shared food and those that new her status refused to eat, only strangers and ignorant people ate from her" (Health worker-masculine).

"We went to a village to visit an orphan who is living with her aunt, on our greatest surprise we notice that his bathing bucket, plates and so on were separated" (Health worker- woman)

Behaviors at Risk of HIV Infection

Several concerns were raised relating to risk factors for HIV infection, such as sexual vengeance by those infected.

"I know a girl who said she is going to distribute it and she is doing so, she flirts with men here and there. I tried talking to her but she wouldn't listen to me". (A 61 years old HIV+ woman)

Gender violence was also mentioned as a potential risk factor for women:

"We do recognize that there's a big problem in this community with violence against women and disempowerment of women, the women that we see don't actually have a choice as to what happens with their own sexuality and sexual patterns" (Health worker- woman).

Participants felt that it was difficult to change risky behaviours. The use of condoms remained problematic due to the unknown HIV status in relationships/partners, hence the negotiation of condom use also became challenging.

"I usually sleep with my husband without using or asking him to use a condom because I really cannot stand telling him, except he comes to the hospital" (A 34 years old HIV+ woman).

Socioeconomic Context

Participants spoke of current socioeconomic circumstances as a challenge to living positively with the virus. Likewise, PLWHIV in a support group and health workers expressed concern that PLWHIV might have other more pressing problems that they faced on a daily basis (like unemployment, poverty, domestic violence), so that in contexts where concerns regarding survival from day to day were paramount, HIV status could be considered secondary:

"People come into the group because they are HIV-positive, they come to the support group, but many times the HIV status is almost secondary in the support group, it's like a whole lot of other issues that come out about poverty and about unemployment, about domestic



violence, about child support, just everything else but the HIV status.” (A 48 years old HIV+ man).

These findings suggest that in the context of unemployment, poverty, and lower socioeconomic status, HIV status becomes a secondary concern to PLWHIV.

Non Adherence to Treatment

Our findings were in line with non-adherence to treatment as one of those challenges that could be a near death syndrome for PLWHIV in Dschang health district. The reasons for such behaviors which included, forgetting, lack of fare to get to the treatment center, religion, secrecy and discordant couples.

“This HIV stuff is what I do not understand; my husband is HIV negative and doesn’t use condoms with me for the past 7years. I even abandoned the treatment it was only when I felt sick and death threatened me that I had to restart treatment” (A 32 years old HIV+ woman).

Support Groups as a Good Coping Strategy

All participants who are members of any support group highlighted the importance of support groups to deal with the multidimensional effects of stigma and discrimination. They advocated the role of support groups which provide opportunities to rehearse disclosure and where women become empowered to value themselves. Some participants also stated the importance of support group as a coping strategy. Health workers pointed out that support group can play an important role in it bringing wide range of women in a common place with a common situation and they also advocated support groups as the most important psychological intervention for women living with HIV/AIDS.

“Most of our patients testify the importance of support groups in their life, with those in the same situation sharing their experiences and as such they are inspired”. (Health worker-masculine).

DISCUSSION

This qualitative study of challenges faced by PLWHIV observed that PLWHIV in the Dschang health district are experiencing challenges like; high levels of stigma and discrimination, non-disclosure, rejection, risky behavior for infection, non-adherence to treatment and socioeconomic difficulties. Support groups were found to decrease isolation and feelings of shame, increase the network of friends to mingle with, create mutually empathetic relationships, improve self-care behaviours, and decrease risk behaviour for re-exposure to HIV.

Our finding proved that health workers in the Dschang health district showed positive behaviours towards PLWHIV.

One of the biggest challenges and a mother to other challenges for PLWHIV identified in this study was multidimensional stigma which was subdivided into social and auto stigma. Lekganyane’s study tie with our findings that stigma inevitably led to discrimination (Lekganyane, 2012). It started from a cycle through which people talked about the fear of their



disease and infection disclosure. In the same perspective a study conducted in South Africa confirmed four kinds of stigma including discrimination, expected stigma, self-stigma, and secondary stigma (Deacon, 2005). Also, Gaudine (Gaudine, 2010) described four themes about stigma: separation from others, the experience of rejection, anger of being viewed as a social patient, and disease concealment. These stigma themes included three important aspects, as shame and shyness, different behaviors, and stigma due to the fear of transmission and recall. Liamputtong, described three kinds of stigma associated with AIDS: self-stigma, perceived stigma and enacted stigma (Liamputtong, 2009).

It is worth mentioning that gender also plays a strong role in experiences of stigma. AIDS-related stigma for women is intensive because of their subordinate role in society (Gibson, 2005) (Soskoline, 2003). These aforementioned studies conducted in Khayelitsh and Cape Town revealed that AIDS-related stigma is a barrier for women accessing free voluntary counseling and testing and prevention of mother-to-child transmission (PMTCT) services. For example, mothers who are HIV-positive find it difficult to comply with medical advice to formula feed, because of the fear of having their HIV status exposed. On the other hand, once diagnosed HIV-positive, men avoided seeking help, treatment, or support, for fear of stigma. Such behaviour was seen as related to the male. Most female participant reported that their partners do not like coming to the hospital, others do not adhere to treatment and others completely refuse treatment. Hence, AIDS-related stigma remains one of the barriers to curb the further spread of the disease amongst people who are aware of their HIV-positive status (Peltzer, 2004). Thus, in our Dschang context, AIDS-related stigma poses a major challenge to the efficacy of risk reduction interventions for PLWHIV and other risk groups.

This study buys the idea that by taking cultural backgrounds into account, women are exposed to more stigmas. Women living with HIV are blamed of sexual deviances and adultery. Several studies have shown that women have been more vulnerable to stigma, especially when HIV/AIDS is mentioned as a transmittable sexual disease (Cullinane, 2007) (Vanlandingham MJ, 2005). HIV/AIDS is judged negatively since it is attributed to the immoral behaviours of prostitutes. Stigma may appear because of sexual misuses or adultery. It may cause rejection and degradation (Thomas, 2006). Nevertheless, it worth mentioning that our findings confirm that people are presently more positive to HIV related stigma compare to the past but the level of auto stigma remains high.

Regarding our findings on HIV disclosure, it is dependent on perceived AIDS-related stigma, this is in harmony with the study of (Derlega, 2002), in this study, closely linked to stigma were issues of disclosure. Due to the persistent nature of AIDS-related stigma participants expressed fears of disclosure that might lead to rejection by their families or partners, or losing their jobs. It should be noted that non-disclosure gave room for risky behaviours; participants felt that it was difficult to change risky behaviours. The use of condoms remained problematic, especially for men, with myths and notions of cultural barriers prevailing. Disclosure for participants was problematic, hence the negotiation of condom use also became challenging, particularly if the HIV positive status had not been disclosed.

Findings suggest that in the context of unemployment, poverty, and lower socioeconomic status, HIV-status becomes a secondary concern to PLWHA. These findings were similar to those in a study conducted in Cape Town, findings revealed that AIDS was only one of the major social stressors threatening people living in everyday poverty (Kalichman, 2003),



It worth noting that, this study highlighted the role of support groups as good coping strategy. Findings were harmonious with those of (Metcalf, 1998) (Paudel, 2015) (Thomas N. , 2009). These studies pointed out that support groups are mainly associated with decreasing isolation and feeling of shame and increase network of friends to mingle with.

CONCLUSION

In a nutshell, life with HIV is challenging and dealing with these challenges is never easy for PLWHIV especially in a low socioeconomic context. Support group proved to be a good therapy/coping strategy for PLWHIV.

Rolling out stigma rejection, non-disclosure, socioeconomic difficulties and non-adherence to treatment which are some of the challenges hitting hard on PLWHIV in the context of HIV/AIDS requires commitment at all levels including governments, civil society, communities and individuals. HIV/AIDS is much more than a health problem. It touches human conditions, human security, human rights and social and economic development. A human rights framework is essential to encourage a reduction in HIV/AIDS-related stigma and discrimination. As an essential human rights issue, gender equality can be at the forefront of development and security as well as building healthy populations.

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