

10

THE STIGMATIZATION OF PEOPLE LIVING WITH HIV/AIDS

Lawrence Adeokun,* Prosper Okonkwo,†
and Oladapo A. Ladipo*

The HIV/AIDS epidemic is less advanced in Nigeria than in East African and southern African countries, and so the issues relating to stigmatization and discrimination of people living with HIV/AIDS (PLWHAs) have not been as fully explored in Nigeria. Information on the stigma of AIDS in Nigeria has been limited to a number of abstracts published in international HIV/AIDS conference proceedings (1). The themes that emerge most often in those abstracts include victims' perceptions of the stigma (2); battles against workplace discrimination and consequent encounters with judicial prejudice (3); and the reluctance of PLWHAs to share their test results because of the stigma attached to AIDS (4).

Other themes include the role PLWHAs may play in prevention programs as well as the role of counseling in reducing stigma (5). The understanding is that PLWHAs have largely transcended the fear that others have of AIDS and that meeting a PLWHA humanizes the epidemic (6). The theory that training can reduce the stigma of AIDS is explored (7), as is the belief that faith-based organizations are well placed to promote stigma reduction through their repeated contacts with members (8). Health providers' anxiety about their personal safety is also mentioned (4).

In effect, discussions about the stigma of AIDS have primarily focused on the concerns of PLWHAs and only marginally on other actors in the production, perpetuation, and reduction of

*Association for Reproductive and Family Health, Ibadan, Nigeria

†AIDS Prevention Initiative in Nigeria, Ibadan, Nigeria

stigma. Yet for a holistic view of stigma to be gained, these other actors must be included in the framework of analysis. This chapter therefore presents findings from an HIV surveillance survey conducted in four Nigerian markets. This survey explored the impact of behavioral change activities on stigma, discrimination, and related issues. Placing the data and interpretation in proper context, however, requires an elaboration of the various actors and forms of stigma, discrimination, denial, and shame. It is against this background that the significant changes in indices of stigmatization and discrimination over the one-year project period can be fully appreciated.

BASIC DEFINITIONS

Stigma, Discrimination, Denial, and Shame

Stigma is the sign or mark placed on a person or group that sets them apart as different from the rest of society. The stigma attached to individuals can be extended to those who associate with them (9). The stigma that a person carries becomes a liability only when society declares it so. The same label or trait may be considered a deviation from the norm in one culture and may be within the acceptable range of what constitutes the norm in another culture.

The result of carrying a stigma is devaluation by others and discrimination through the withdrawal of rights and privileges to which that individual or group may otherwise be entitled. Discrimination is the societal response to the negative value attached to the stigma an individual may carry.

The stigma is not necessarily prejudicial; it is the adverse reaction of people to the stigma that creates offense. There are, of course, instances in which the stigma is “foreign” to the host community and consequently looked upon as a deviation from the norm. This is the basis for the pity, revulsion, and other reactions that some people have toward those with physical appearances considered odd or distorted.

Stigma may take a tangible form when there are manifestations of the condition of stigma. In Yoruba culture, for example, being albino is an obvious departure from the norm. Despite the frequency of twinning among the Yoruba, twins also are stigmatized. In the instance of HIV/AIDS, the assumption of HIV infection — and thus the stigma — may be false, or the stigma may be based on reliable information, such as when a PLWHA discloses his or her HIV status.

The measurement of stigma can be problematic because stigma takes so many forms. When the form is tangible, the prevalence of stigma can be measured. In the case of an intangible form, however, only the proxies of stigma can be measured. For example, the number of people suffering from a medical condition can only be measured when the diagnosis is readily available. In the same way, the measurement of stigma depends on the form.

In addressing proxy measures, the reaction of people to propositions about stigma can capture the perceptions and attitudes of respondents to the stigmatized condition, tangible or intangible. In the same way, discriminatory attitudes can be measured in responses. The fact that such measurements may be flawed — because of a social desirability bias in the responses people give to discriminatory propositions or scenarios — must be taken into consideration when analyzing the information (10).

For negative attitudes to change, the mindsets of the various stakeholders in what Goffman calls “the mending of the damaged self” must be considered (9). The stigma lies with the “victim,” but the resulting discrimination comes from others. Denial and shame are the strategies available to victims in avoiding or bearing the brunt of the discrimination attached to their stigma.

The effects of HIV-related stigma and discrimination are often so severe that most members of society fear them (11,12). Potential victims can prevent or avert stigma and discrimination by going into denial. The denial of a stigmatized condition such as HIV/AIDS may be experienced by those who have not been tested irrespective of their assessment of their vulnerability. Denial is more pronounced in those who have tested HIV positive but fear the stigma attached to their HIV status.

The basis of denial of a trait and the individual’s associated shame change constantly in response to shifts in societal values. This is particularly true of traditional societies as they move to modernization and globalization. Changes in the sexual behavior of young people challenge traditional society, as the culture must adapt to the new reality that the ideals of virginity, premarital celibacy, and modest dress codes may be altered by external values.

When denial no longer serves as a protection — either because the confidentiality of the infection has been broken or the symptoms of disease have become apparent — then shame becomes the next logical mechanism available to the infected and affected. This self-imposed sanction reflects the victim’s perception of the degree of the physical or moral deviation from the norms of the society. In effect, the more the victim shares the public’s view about the stigma, the greater the shame he or she feels.

People who suffer from tuberculosis, weight loss, or certain types of cancer may be rightly or wrongly suspected of being infected with HIV. At this stage the sense of shame and fear of discrimination may lead the victim to withdraw from friends, relatives, and society and even, in some cases, to contemplate suicide. Individuals who have experienced rejection, isolation, and aggression are at high risk of psychiatric symptoms. Psychological stress and fear of AIDS may hamper social and occupational functioning (13), thus enhancing the effects of shame. In a study in Zimbabwe, 9% of respondents stated that they would commit suicide if they found they were HIV positive (14). The victim reciprocates the rejection of society (15).

REASONS FOR THE STIGMA OF AIDS

In 1988, early in the course of the epidemic, AIDS was considered invariably fatal. The predominant impression was that HIV infection was the result of deviant and stigmatized behavior such as homosexual practices, sex work, and drug use (15), as well as sex outside marriage and promiscuity. The identification of already stigmatized groups as “high-risk” increased their vulnerability to stigmatization and discrimination (16). As early prevention programs were being developed, it seemed logical to start with these “high-risk groups.” Consequently, prevention messages placed additional distance between PLWHAs and the rest of the community, giving the impression that HIV prevention did not concern the larger community (9).

Another basis of stigma and discrimination in the early stages of the epidemic was the prevailing myth that HIV could be contracted through normal social contact. In Uganda, for example, it was believed that

if one person in a family had AIDS, the rest of the family would become infected. Consequently, many community members terminated social relationships when a person's HIV status became known (17).

The blame of women and sex workers for the spread of HIV and other sexually transmitted infections (STIs) has resulted in considerable discrimination against them (18). Criminal sanctions that seek to regulate the sex industry, however, tend to cause sex workers to operate secretly and therefore out of reach of intervention efforts (19).

Men who have sex with men (MSM) had their own concerns about stigma before the HIV epidemic. Early HIV prevalence rates among MSM heightened that sense of insecurity. Because of this anxiety, MSM in Trinidad kept quiet about their sexual orientation and HIV serostatus (20,21). The same association of sexual orientation with HIV infection resulted in the reluctance to share HIV test results in Chile (22).

There is a prevailing notion that PLWHAs are morally irresponsible. This view was observed among some Kenyan medical students, which suggests that medical knowledge of the epidemic does not fully address the fundamental issues of moral sanction and stigma (23). In the general population, in contrast, outright myths about the spread of HIV can fuel considerable stigma. A significant proportion of the population may not know that most HIV-positive people appear and feel well. Many believed that HIV could be transmitted by sharing a public toilet. And as recently as 2003 one in ten respondents surveyed in markets in Oyo State believed mosquitoes could transmit HIV (24).

In the absence of general HIV testing, speculation about the status of individuals can form the basis for stigmatization and discrimination. In high HIV prevalence settings, the death of spouses within a year or two of one another has been taken as rough confirmation that they both died of AIDS (24).

The justifications for stigmatizing PLWHAs vary, as do the patterns of stigma and discrimination they elicit. Those who view HIV as a contagion may reject PLWHAs in forms ranging from the benign to the harsh. Understanding the relationship between the justification and the pattern of stigma is a prerequisite for tailoring stigma-reducing interventions to the social and cultural realities of the situation. The goal of such interventions is to change stigmatizing attitudes and behaviors of members of the target group and thereby reduce or eliminate the negative impacts of stigma. The interventions may include planned activities such as those involved in multimedia-based behavior change communication programs.

SEQUENCE AND FORMS OF STIGMA AND DISCRIMINATION

The advent of voluntary counseling and testing (VCT) prompted the institutional discriminatory treatment of PLWHAs by hospital staff (25). In 1992, a Taiwanese mother who gave birth to an HIV-infected infant went abroad to escape the institutional harassment she received (26). The discriminatory responses from friends and family when they learn of someone's HIV status can be equally devastating. A bisexual man hospitalized for *Pneumocystis carinii* pneumonia in Taiwan committed suicide the night before discharge because his family and landlord were not sure they wanted him home (26).

The economic hardships associated with AIDS also can predominate (27). The intermediate stages of economic deprivation parallel the progression from HIV infection to AIDS-related conditions to the full

development of AIDS. That deprivation is hastened when an employer abrogates an HIV-infected employee's rights to employment, insurance, and similar formal support systems.

In one instance, a PLWHA stated that the stigma of AIDS had forced her to resign from her job as a nurse in a private clinic and go into hiding (28). (It is worth speculating that this could have been as much a reaction to the shame she felt as to the sense of stigmatization and discrimination she experienced from colleagues.) Next, at the family level, she was denied inheritance and, although she had two young children, was shut out by her own relatives when she tried to return to her hometown. This is a typical example of the vulnerability of females who relocate from their biological homes to their marital homes. After spending three years homeless, she returned to her relatives in 1994 and forced them to accept her. This can be described as the stage in which those targeted by stigmatization and discrimination fight back in desperation. Later, she joined a group of HIV-positive people called Christian Service Lilongwe, obviously expecting it to be a support group. But the group later rejected her because she decided to go public about her status. Apparently, they feared her revelation would expose them all to stigma. That fear also reflected the sense of shame some members felt about their infection. Similar tales of personal tragedies have emerged over the years (29,30).

A quick review of the stigma associated with smallpox can provide additional insight into the forms of stigma and discrimination. Prior to its eradication in Africa, smallpox was a recurring and deadly annual epidemic and a contagion (31). Despite its ferocity, smallpox—with a 20% to 30% fatality rate—was survivable, even before the advent of vaccination (15). It was neither the deadliness nor its scarring effect on the survivor that formed the basis of the stigma, however. Rather it was the association of the disease with the myth of divine sanction for a spiritual or behavioral infringement that made the disease so stigmatizing. In the Yoruba culture, the disease was named after *Sopona*, the god of both thunder and retribution. Consequently the avoidance of the victim by outsiders was partly a public health response and partly an instinct to place distance between oneself and something considered evil.

Under these conditions, it comes as no surprise that the attitude of the family in which the infection occurred differed from those of other families. For the index family, secrecy provided the first line of defense against social and moral sanctions. The infected person was kept out of sight and cared for until the disease cleared, leaving behind a telltale sign of infection in the form of pockmarked skin. When the episode resolved, the family may well have discovered that other families from whom they had hidden their relative harbored infected family members of their own.

The immediate family made a distinction between the public health response and the social distance response. They may well have put the infected family member in isolation partly to avoid transmission within the family and partly to keep the infection a secret from the public. Total isolation of the victim was often impracticable, however, particularly in the case of children, who needed family members to provide care.

It is in the eradication of smallpox that the most relevant insight into the reduction of stigma can be found. According to Henderson, in Nigeria, the strategy of surveillance and containment of smallpox was found to be better and more cost effective than other strategies (31). This approach required suspected

cases to be quarantined under guard, while all contacts and everyone within a five-mile radius received vaccinations. New stable vaccines and a special needle that protected the vaccine permitted field workers to vaccinate inaccessible populations. Workers used charm, guile, shame, and intimidation to achieve universal cooperation.

The actions of different stakeholders involved in the management of smallpox may offer lessons in reducing the stigma of HIV/AIDS. First, the general view was that smallpox was a visitation on the people. Second, both the infected individuals and their immediate families carried a prevailing sense of shame. Third, the infection was hidden from outsiders. Fourth, the close relatives were prepared, especially in the case of childhood infections, to make an exception to the social avoidance and rejection that could accompany adult infection. Finally, the more severe the outbreak, the less stringent the secrecy attached to infection. Some of these features of the social management of smallpox infection may be applicable to HIV stigma reduction. For example, a study in Uganda found that the higher the level of HIV prevalence, the more open a given population was about HIV infection (17).

CONSEQUENCES OF THE STIGMA OF AIDS ON PREVENTION AND CARE

The consequences of stigma, discrimination, denial, and shame on prevention and care can be viewed from the perspectives of the individual, the society, and the caregivers. In the case of the individual, fear of rejection, discrimination, and even deadly violence can discourage people from taking an HIV test, sharing the results, and complying with treatment even when they learn of the advantages of early detection (29,32). Similarly, the self-imposed sense of shame about HIV infection can affect an individual's ability to take even elementary preventive actions such as condom use (12). For example, a South Pacific woman who knew her husband was having casual sex when away from the family felt too ashamed—presumably of her own helplessness, subordination, and humiliation—to ask him to take precautions against infection (33).

The stigma attached to AIDS not only affects the individual's access to health services and employment, but also their treatment by community, social, and religious groups (34). In Uganda, for example, the earlier notion of AIDS as a terminal condition affected the allocation of resources within the household and the provision of medical treatment (17). The denial of symptoms by a patient or family was common and made resource diversion easier. The fear of stigmatization prevented many HIV-infected rural residents from attending a health center. Instead, they opted for home visits from health workers or care from traditional healers who could be visited at night. An economic consequence of the assumption that AIDS was contagious was a fear of buying produce from a family in which a member was ill. In the political realm, a woman was denied election to a community position because people believed she had AIDS (17).

In response to the fear of stigmatization and social isolation, many PLWHAs avoid becoming involved in community AIDS education even though their involvement would provide a tremendous opportunity

for correcting many misconceptions about the virus and its transmission (17). Individuals who belong to an already stigmatized group are less likely to become involved with HIV prevention programs (20).

Entire families share the impact of the infection and the associated stigma. For example, the community may stigmatize children whose parents died of AIDS. Individual family members also endure emotional and physical stress in caring for those infected, especially when they develop full-blown AIDS (35).

AIDS orphans experience major psychosocial effects on the loss of parents, including stigmatization and learning difficulties at school, social ostracism, low levels of social support, discrimination in all areas of life, and economic hardship. In addition, children who lose their parents to AIDS become fearful of losing other people close to them. They also experience desolation, extreme loneliness, a high rate of concealment as to the cause of parental death, and unresolved grief (36).

Society may use stigmatization and discrimination in defense of norms and values, but the public health consequences of driving the HIV/AIDS epidemic underground are devastating to the health, economy, and social life of the society (34). The stigma may lead people to delay being tested, to keep positive test results a secret, and to avoid using condoms with sexual partners for fear of rousing suspicion of HIV infection (14).

When HIV prevalence rates rise, the increased burden of opportunistic infections and diseases such as tuberculosis, diarrhea, and skin cancers places considerable stress on health care systems (38). An equally exponential pressure is placed on home-based caregivers as the economic ability of patients to access formal health services declines.

Some clinicians, intent on avoiding HIV acquisition, employ strategies that turn out to be stigmatizing and discriminatory of PLWHAs. Their fears prompt health providers to take drastic and punitive measures to contain the epidemic, sacrificing, in the process, the principles of informed consent and confidentiality (38). Many fears they harbor about HIV are based on erroneous information, however, such as the notion that AIDS is a contagion (39). When clinicians become more informed about the relative risks of infection from occupational hazards, they tend to adopt rational universal precautions at work. Their families may remain concerned, however, about the risk of caring for PLWHAs (39).

Another concern of health professionals is the dilemma of maintaining confidentiality while weighing the risks of infection for the patient's relatives and lovers as well as for the health care staff if they are not aware of the patient's HIV status. Attempts at resolving the dilemma may give the impression of stigmatization and discrimination in the treatment of HIV-infected patients (39).

SPECIFIC DETERMINANTS OF STIGMA REDUCTION

It is apparent that various stakeholders to the stigma, discrimination, denial, and shame are open to some common and tailored strategies for stigma reduction. Consequently, it is worth identifying the evidence-based determinants of such a reduction. Fear of the unknown entity and ignorance of the actual—as opposed to mythical—impact of that entity are the two negative factors producing stigmatization and discrimination. Conversely, knowledge, information, enlightenment from anti-stigma campaigns, and interventions coupled with the infrastructure for care and support are the positive factors in stigma reduction.

Since the level of fear appears to correlate directly with the level of ignorance about the transmission of HIV, it may be postulated that the higher the level of ignorance, the higher the concomitant fear of the affliction and those affected by it. Deriving from these postulates, the more educated people are about HIV/AIDS, the less stigma they attach to it. In Kenya, a study found that the stigma medical students attached to HIV/AIDS declined with each additional year of education (36).

Within health care systems, the level of knowledge and the inclination of providers determine whether HIV patients receive any kind of counseling. The quality of counseling also depends on the skills available and the commitment of the providers to the process of counseling (40). Improvements in the training of health providers at both the institutional and community levels will lead to a better and more dignified quality of care for HIV-positive patients.

At the same time that fear and ignorance about HIV/AIDS can prompt stigmatizing and discriminatory behavior, there is evidence that competent counseling can reduce fear, encourage openness, and lead to a proactive attitude to prevention and care (41). The content of such counseling includes assurances of the prolonged life possible to PLWHAs if they treat infections, eat well, get enough rest, keep busy to avoid preoccupation with the notion of approaching death, refrain from alcohol and smoking, and exercise regularly (41). To this array of advice can now be added excellent adherence to antiretroviral (ARV) regimens when available.

Assurances given by long-surviving PLWHAs are particularly potent in reducing the stigma attached to HIV/AIDS. PLWHAs can dispel myths, correct inaccuracies, and instill confidence in the process of VCT. Although relatively few individuals in Nigeria are going public with their HIV status, the multiplier effect of their action often converts many more to a rational view of testing and treatment.

In the absence of the testimony of such individuals, behavior change communication (BCC) is a powerful tool for moving individuals from an initial state of indifference or denial to a more proactive state of agreeing to an HIV test and following through with the necessary monitoring and treatment if appropriate. To be effective, the design and implementation of BCC programs must take into account the social and cultural context of the epidemic; the interventions must then be tailored to that context.

THE MARKET PROJECT

To help elucidate the role of stigmatization and discrimination in the HIV/AIDS epidemic in Nigeria, a biomedical and biosocial research team from the Department of Virology at the University College Hospital and the Association for Reproductive and Family Health, also in Ibadan, conducted an HIV surveillance program in two cities in Oyo State. This survey had several objectives:

- To determine the prevalence and, if at all possible, incidence of HIV infection among those under surveillance;
- To give market agents skills in HIV prevention education, counseling, and distribution of barrier methods in their respective markets;

- To encourage peer educators chosen from among the volunteers to carry out a continuous and systematic outreach program in their markets and communities;
- To conduct regular multimedia BCC activities in the markets and neighboring communities; and
- To refer all HIV-positive people for assessment, treatment, and care to the APIN Plus/Harvard PEPFAR clinic site at the University College Hospital in Ibadan while maintaining linkage with the national ARV program.

Methodology

The project recruited more than a thousand volunteer market agents of both sexes in four major markets in Ogbomoso and Ibadan in August 2003. These volunteers participated in four rounds of VCT as part of HIV surveillance, including STI screening and treatment over a two-year period. Apart from monitoring the rate of HIV spread among the volunteers, project staff referred people who tested HIV positive to appropriate institutions for management and support as well as linkage with the national ARV program.

The volunteers also participated in BCC interventions that promoted HIV prevention and risk reduction, including safer sex practices using the dual protection strategy. The program was based on an adaptation of the health belief model to the circumstances of HIV prevention (24). The methods included periodic promotional campaigns, group assemblies, regular review meetings, health talks on various aspects of the epidemic, distribution of educational materials, development of market-based folk theater, and condom distribution.

When BCC activities were combined with biomedical interventions, HIV infection acquired a new meaning, one that was less discrediting than before the onset of the intervention. The myths that dissipated during the period contributed to the reevaluation of the risk of infection and the feasibility of prevention. In effect, the BCC activities targeted so frequently over the two-year period formed the basis of the expectation that stigmatizing attitudes and behaviors of volunteers as well as of other project market traders would be changed, thus reducing or eliminating the negative impacts of stigma on such elements as adherence to periodic HIV testing, and treatment of PLWHAs.

In effect, while the biomedical methods focused on the objective of deriving epidemiologic data, the target of the biosocial methods were sexual risk reduction, adoption of safe sex practices, and the reduction of stigma.

Measurement Problems of Stigmatization

With BCC activities new in the markets and the Yoruba language limited in its ability to convey the subtleties of some sociological concepts, our major challenge was to devise an instrument that captured the main elements of stigma, discrimination, denial, and shame that various stakeholders in the HIV/AIDS epidemic feel. Stigma, discrimination, and predictors of tolerance reported by respondents can be made. They were chosen in the context of the Yoruba perception of the spiritual, moral, and physical basis of disease (42) as well as on their mechanisms for social distance and avoidance.

Table 10-1.
Stigmatizing Statements, Discrimination Questions, and Predictors of Tolerance

STATEMENTS AND QUESTIONS	
Panel 1: Stigmatizing Statements	
1	HIV-infected people are promiscuous.
2	HIV/AIDS is a punishment from God.
3	HIV-infected people are responsible for their own problems.
4	HIV-infected people are not useful to anyone.
5	HIV-infected people should not be allowed to mix with uninfected people.
Panel 2: Discrimination Questions	
6	Would you sleep in the same room with someone who has HIV?
7	Would you visit someone with HIV/AIDS in the hospital?
8	Would you help carry someone dying of AIDS to an ambulance?
9	Would you tell others if a relative died of HIV/AIDS after a long illness?
Panel 3: Predictors of Tolerance	
10	Mothers stand by their children.
11	Providers are friendly to HIV-infected people.
12	Some tribes are more tolerant of sick people than others.
13	Better-educated people are more tolerant of those living with HIV/AIDS.
14	Some religious people are better able to look after people living with HIV/AIDS.

The first panel of Table 10-1 shows three moral statements about PLWHAs, one negative assessment, and one punitive prescription for PLWHAs. HIV infection is credited to sexual laxity, divine justice, and self-inflicted misfortune. In addition, PLWHAs are stated as not being useful to society, and the judgment is given that they should not be allowed to mix with those presumed to be uninfected.

The next panel is composed of four questions assessing the degree of social and physical contact that respondents are prepared to make with PLWHAs and the extent to which they would be willing to inform people that a relative had died of AIDS. These items are at the root of the integration of family members into the household. These questions seek to tease out whether the common courtesies accorded family members in traditional society in times of illness would be extended to PLWHAs. Asking whether people would sleep in the same room as a PLWHA is consistent with the prevailing living arrangement in which large families share limited accommodations. Because of the large sizes

of bilaterally extended families, the first strains in interpersonal relationships can be manifested in changes in sleeping arrangements. PLWHAs are often hospitalized, especially if they are not on ARV therapy. The AIDS stage is also marked by physical and emotional dependence on others. Access to the basic physical and emotional support from family members is vital to the quality of life of PLWHAs.

Another dimension of stigma is the shame individuals attach to having HIV in the family. Protracted illness is usually associated with HIV infection in high prevalence populations. The respondents' willingness—or lack of willingness—to acknowledge a death from AIDS openly thus becomes a marker for the level of shame attached to AIDS.

In the third panel, five items sought to establish which relationships and institutions were likely to offer support to PLWHAs. Respondents were asked to predict the attitudes of mothers, health providers, ethnic groups, educated people, and religious bodies to PLWHAs.

Data on the benchmark level of prevailing stigma and discrimination attached to HIV/AIDS were collected in August 2003. A general adult population was randomly sampled among traders in the two markets. Each market has an average population of approximately 2,500 people. A total sample of 667

traders was surveyed. The 14-item module required that respondents answer “True,” “False,” or “Uncertain.” Most respondents held strong views and opted for the first two options.

Indices

On each of the first nine items, the percentage responding in the affirmative is a useful index of the extent to which the respondents held stigmatizing and discriminatory attitudes toward PLWHAs. In the last panel, the percentages responding in the affirmative is an indication of the extent of care and support that could be counted upon from the various relationships and institutions.

By comparing the percentages obtained at the baseline and the second survey one year later among two unmatched samples, it is possible to discuss the direction and magnitude of change in the levels of stigmatization and discrimination. This analytical approach is also adopted for testing the impact of three project interventions on stigma reduction.

The possibility of regrouping the items into single indicators was considered but not adopted. The single-item interpretation allowed the elements and basis of stigmatizing and discriminatory attitudes to be easily identified and addressed in anti-stigma BCC activities.

Intervention Procedures

Although this project did not specifically target discrimination as the primary aim, the package of interventions on the HIV surveillance assured that if periodic measurements of stigmatization and discrimination were obtained, they would give an accurate reflection of the extent to which program activities and interventions affected stigma.

The four main project interventions were:

- In-depth training of volunteers on HIV/AIDS with a focus on the role of early detection in the management of infection;
- The implementation of a multimedia BCC intervention that included health talks, risk assessments, and the creation of an amateur drama troupe in each market so the training and learning content could be reinforced in the informal setting of edutainment;
- Biannual participation of volunteers in HIV and syphilis tests based on competent confidential counseling, testing, and notification arrangement and frequent contacts to allow for the discussion of issues arising from those tests; and
- The referral of those testing HIV positive to a reference laboratory for confirmation and linkage with the national ARV program.

Changing Attitudes Toward People Living with HIV/AIDS

As the HIV/AIDS epidemic evolves, two problems emerge in connection with the reactions of the public to those known to be infected. One relates to the prejudices people have about HIV and other STIs in general and the stigma that is consequently attached to HIV infection. The other problem arises from the physical and emotional reactions to PLWHAs as the disease progression makes them more debili-

tated and dependent on others for their basic needs. Stigma reduction and greater tolerance of PLWHAs are consequently desirable outcomes of interventions aimed at prevention and management of the epidemic. It is evidence that those whose identity has been tarnished can then be redeemed and the stain lifted from them (9).

Survey Results

General Levels of Stigmatization and Discriminatory Attitudes

Table 10-2 shows the baseline and year one levels of stigmatizing and discriminatory attitudes toward PLWHAs in Ogbomoso and Ibadan. In interpreting the responses to the five statements in Panel 1, an affirmative is stigmatizing. Consequently, a decline in percentages over the one-year period is indicative of stigma reduction.

In contrast, an affirmative response to any of the four discrimination questions in Panel 2 is indicative of a non-discriminatory attitude toward PLWHAs. Consequently an increase in the proportion of respondents holding non-discriminatory attitudes is the expected outcome of intervention.

An affirmative response to any of the five statements on the predictors of tolerance in Panel 3 is an indication of the reliance that PLWHAs can place on such relationships and institutions for care and support. Differences at the different surveys are presumed to be related to the experiences of the respondents over the intervening period.

Table 10-2 (Panel 1) shows that for all five statements the affirmative proportions declined significantly (p value between 0.0000 and 0.0003). The fact that HIV is mostly sexually transmitted appears to generate a moralistic attitude toward those who are HIV positive. That attitude toward HIV infection was greater among the Ogbomoso sample than among the Ibadan sample. However, the decline in proportions from 52% to 36% and from 30% to 21% in the respective towns is evidence of the erosion of this moralistic attitude in all project markets. These declines are consistent with the working hypothesis that with greater understanding of the alternative channels of infection, and the unintended impact of sexual networking on “innocent” individuals, HIV infection will lose some of its association with promiscuity. There is a corresponding increase in the awareness in both towns that HIV infection may not be the outcome of an individual’s negligence but the outcome of other people’s behavior.

Nearly half of the Ogbomoso baseline sample related HIV infection to divine punishment for wrongdoing. The Ibadan proportion was much less at 38%. There was a noticeable softening of this religious hard line toward HIV infection in both towns by the time of the second survey. The religious influence on the formation of prejudices is also implied in the third stigmatizing statement. Much higher proportions in both towns blamed HIV-infected people for their predicament at the baseline. The follow-up survey showed a considerable softening of attitudes. Ibadan respondents held a less prejudicial position, however, as to the culpability of those who are HIV positive in the matter of their transmission.

The Yoruba meaning of “not useful to anyone” is indicative of the assumption of reduced functionality or social and economic relevance of HIV-infected individuals. It is from this meaning that follows the equally

Table 10-2. Percentage of Affirmative Responses to Stigmatizing Statements, Discrimination Questions, and Predictors of Tolerance at Baseline and at Year 1 Surveys

No.	Percentage agreeing that the following statements are true or answering affirmatively to the following questions	Ogbomoso Baseline	Ogbomoso Year 1	Ibadan Baseline	Ibadan Year 1
Panel 1: Stigmatizing Statements					
1	HIV-infected people are promiscuous.	52	36	30	21
2	HIV/AIDS is a punishment from God.	46	34	38	26
3	HIV-infected people are responsible for their own problems.	71	59	55	42
4	HIV-infected people are not useful to anyone.	84	56	60	37
5	HIV-infected people should not be allowed to mix with uninfected people.	80	58	73	50
Panel 2: Discrimination Questions					
6	Would you sleep in the same room with someone who has HIV?	16	45	35	52
7	Would you visit someone with HIV/AIDS in the hospital?	58	67	58	66
8	Would you help carry someone dying of AIDS to an ambulance?	35	53	40	57
9	Would you tell others if a relative died of HIV/AIDS after a long illness?	53	41	37	41
Panel 3: Predictors of Tolerance					
10	Mothers stand by their children.	85	89	79	89
11	Providers are friendly to HIV-infected people.	73	88	74	93
12	Some tribes are more tolerant of sick people than others.	60	61	56	61
13	Better-educated people are more tolerant of those living with HIV/AIDS.	63	65	61	77
14	Some religious people are better able to look after people living with HIV/AIDS.	54	55	55	56

harsh prescription that those infected should not mix with the rest of society. In both cases, there were substantial declines in the number of people holding prejudicial views of PLWHAs.

In Table 10-2, Panel 2, the increases across the board show that the high levels of intolerance of physical and social contacts with PLWHAs in both towns gave way to the preparedness to make such contacts after the one year of project intervention. The changes in this non-discriminatory attitude to the observance of basic social courtesies to PLWHAs were similar in both towns. The only exception was that although more than half of the Ogbomoso respondents were hesitant about informing people about an AIDS death in the family by the end of the year, there was a 12% decline in the proportion holding back such information. It is on this item of reluctance to be open about AIDS in the family that Ibadan did not register any difference.

Table 10-2, Panel 3, shows that mothers received a high endorsement as reliable sources of care and support for PLWHAs. In both towns, there were significant increases in the impression that mothers remain reliable sources of care and support. Mothers are noted for their filial loyalty; it is a matter of

experience whether this loyalty will stand in the face of the demands AIDS imposes on their physical, economic, and emotional capacities. Similarly, there is a prevailing view that health providers should be free from the prejudices of the public and thus tolerant of the sick. There was a substantial increase in this expectation by the second survey. Just over nine in every 10 expected health providers to show tolerance toward PLWHAs. Although this expectation may or may not be borne out by fact, it does emphasize the assumption that the health system can cope with the emotional demands of the epidemic.

The potential impact of ethnicity on normative attitudes to PLWHAs was largely unchanged in both cities. It would appear that this is a normative view held by the respondents. Education also showed limited change as a predictor of tolerance in Ogbomoso, where approximately two-thirds believed that being better educated made for greater tolerance of PLWHAs.

Faith-based organizations were often cited as potential sources of care and support for PLWHAs. Over half the sample at each survey remained convinced that religious people are well suited to look after PLWHAs. That level remains unchanged over the project period.

Armed with the predominantly favorable improvement in attitudes to PLWHA recorded at the end of a year, the rest of the chapter will explore the contribution of three project intervention elements to those improvements. The three elements hypothesized as critical to the reduction of stigma and discrimination are: participation in the intensive training of volunteers at the start of the project; participation in the sustained multimedia and phased BCC programs; and participation in the VCT exercises. Data on these determinants are presented in the rest of the chapter to show how their associations with reductions in stigma and discrimination.

Training

Awareness creation about HIV/AIDS usually takes the form of campaigns with or without the distribution of educational materials and condoms. These events are additional to the short and compressed messages that are passed on in the mass media. What such activities achieve is an increase in basic knowledge without giving the target population enough information and understanding upon which to fully initiate and sustain behavior change. On this project, that problem was addressed by conducting a five-day training of volunteers on various aspects of HIV/AIDS transmission, prevention, screening, and management of infection. The training alone was evaluated at the end of the five days and it was apparent that some of the volunteers had initiated some changes during the training. The training addressed the issue of stigma and was expected to succeed in changing the negative attitudes of people toward PLWHAs.

Multimedia Activities

During and after the training, the project activities included the use of multimedia. One of the video clips used during the training turned out to be a persistent reference point for viewers about what changed their indifference to the epidemic. Medically explicit videos of STIs and of people at different stages of AIDS development can be powerful in drawing attention to the hazards of risky sexual behavior. Similarly, the use of multimedia BCC intervention and the regular contacts between project staff and the

volunteer market agents over the course of two years were expected to reinforce the positive aspects of training and reduce the negative images of HIV infection and AIDS as incurable and always fatal.

Participation in VCT Exercises

Apart from the training and the BCC interventions, the ultimate goal of HIV surveillance was to recruit volunteers for the four rounds of biannual HIV and syphilis tests. (The project's high ethical standards meant that those who did not benefit from either the training or the BCC interventions could still benefit from the pre- and post-test counseling provided to each volunteer.) These counseling sessions were aimed at helping to reduce the volunteers' stigmatizing and discriminatory attitudes toward PLWHAs.

The Impact of Training on Reducing the Stigma of AIDS

It is often remarked that stigmatization and discrimination are the major barriers to VCT and a culture of openness about HIV status. Project activities increased the understanding and appreciation of the dynamics of the epidemic. Consequently, they should contribute to declines in stigmatizing and discriminatory attitudes in the respective surveys.

Table 10-3 shows the percentages affirming statements or questions at the baseline and follow-up survey cross-tabulated by their respondents' participation or non-participation at the initial training session. Since the interpretation of the direction of change remains the same as for the general level, the following summary statements are adequate for clarifying the findings.

In Table 10-3, Panel 1, those who did not attend the training session were considerably more likely to be moralistic about HIV infection than those who attended. The one exception was that of ascribing the infection to divine justice. There was no significant differences on this item. With reference to the culpability of HIV-infected individuals, training appears to have made people soften their judgmental stances. Similarly, training made people less severe in their assessment of the contributions or involvement of PLWHAs in society. The impact of training on stigma reduction appeared more pronounced in Ibadan than in Ogbomoso.

Table 10-3 (Panel 2) shows that training made a significant difference in the level of non-discriminatory attitudes reported for all items. The only exception was that those who did not receive training in Ogbomoso were more likely to tell others of an AIDS-related death in the family than those who received training. There was no significant difference between the two groups in Ibadan. In both towns, those who took part in the training were slightly more reticent about sharing information about the HIV status of a dead relative. This might be the effect of the greater emphasis that VCT programs place on the ethics surrounding the notification of results. The confidentiality of results may have been extended to the confidentiality of the HIV status of relatives who had died of AIDS.

Table 10-3 (Panel 3) shows that expectations of care and support and tolerance of PLWHAs from some relevant others—such as mothers, health providers, and religious affiliates—are largely normative, as there were no significant differences between those who trained and those who did not. It is

Table 10-3. Percentage of Affirmative Responses to Stigmatizing Statements, Discrimination Questions, and Predictors of Tolerance at Baseline and at Year 1 Surveys by Trainee Status

No.	Percentage agreeing that the following statements are true or answering affirmatively to the following questions	Ogbomosho		Ibadan	
		At training (152)	Not at training (326)	At training (122)	Not at training (377)
Panel 1: Stigmatizing Statements					
1	HIV-infected people are promiscuous.	22	42	15	23
2	HIV/AIDS is a punishment from God.	36	33	25	27
3	HIV-infected people are responsible for their own problems.	39	69	30	45
4	HIV-infected people are not useful to anyone.	41	63	16	43
5	HIV-infected people should not be allowed to mix with uninfected people.	48	63	36	55
Panel 2: Discrimination Questions					
6	Would you sleep in the same room with someone who has HIV?	65	36	80	43
7	Would you visit someone with HIV/AIDS in the hospital?	76	63	90	58
8	Would you help carry someone dying of AIDS to an ambulance?	63	49	85	48
9	Would you tell others if a relative died of HIV/AIDS after a long illness?	34	44	39	41
Panel 3: Predictors of Tolerance					
10	Mothers stand by their children.	93	87	94	88
11	Providers are friendly to HIV-infected people.	90	87	95	93
12	Some tribes are more tolerant of sick people than others.	72	56	59	62
13	Better-educated people are more tolerant of those living with HIV/AIDS.	70	62	78	76
14	Some religious people are better able to look after people living with HIV/AIDS.	64	51	61	55

remarkable that the Yoruba have a perception that some other tribes are less discriminatory of differences in physical appearance or social behavior than other tribes.

The Impact of BCC Participation on Reducing the Stigma of AIDS

Table 10-4 shows the relationship between participation in BCC activities and the levels of stigmatizing and discriminatory attitudes at the follow-up survey in August 2004. Apart from the initial training, the sustained multimedia BCC program served the purpose of encouraging a stage-by-stage management of appreciating and adopting new strategies and lifestyles for prevention and management of HIV infection. The BCC programs builds upon the training by deepening the understanding of participants and offering solutions to problems associated with HIV testing. Consequently, it is no surprise that the pattern of responses to stigmatizing statements in Table 10-4, Panel 1, triangulates with the findings about training. It also reaffirms the correlation between being at the training and being at the BCC activities.

Table 10-4. Percentage of Affirmative Responses to Stigmatizing Statements, Discrimination Questions, and Predictors of Tolerance at Baseline and Year 1 Surveys by BCC Participation Status

No.	Percentage agreeing that the following statements are true or answering affirmatively to the following questions	Ogbomosho		Ibadan	
		At BCC (185)	Not at BCC (293)	At BCC (164)	Not at BCC (335)
Panel 1: Stigmatizing Statements					
1	HIV-infected people are promiscuous.	20	46	13	25
2	HIV/AIDS is a punishment from God.	33	35	23	27
3	HIV-infected people are responsible for their own problems.	40	72	29	48
4	HIV-infected people are not useful to anyone.	43	64	18	48
5	HIV-infected people should not be allowed to mix with uninfected people.	49	64	35	57
Panel 2: Discrimination Questions					
6	Would you sleep in the same room with someone who has HIV?	61	36	73	42
7	Would you visit someone with HIV/AIDS in the hospital?	75	62	84	57
8	Would you help carry someone dying of AIDS to an ambulance?	61	49	78	46
9	Would you tell others if a relative died of HIV/AIDS after a long illness?	38	42	38	42
Panel 3: Predictors of Tolerance					
10	Mothers stand by their children.	94	86	95	87
11	Providers are friendly to HIV-infected people.	90	87	95	92
12	Some tribes are more tolerant of sick people than others.	67	57	61	62
13	Better-educated people are more tolerant of those living with HIV/AIDS.	68	63	82	74
14	Some religious people are better able to look after people living with HIV/AIDS.	60	53	50	59

Abbreviation: BCC: behavior change communication

Table 10-4 lends credence also to the differentiation between those who took part in project activities and those who did not.

In Table 10-4, Panel 1, it is also clear that those who were exposed to project activities and to the BCC activities in particular gained some insight into the morally neutral circumstances in which people can be infected with HIV and the possibilities for people to live with the infection for years while pursuing their normal economic and social activities. The one domain in which both groups in both towns were less likely to yield ground to superior argument was the religious one. About the same proportion of both groups believed that HIV/AIDS is a punishment from God. The Ibadan groups, however, were less dogmatic about this belief.

For Table 10-4, Panel 2, too, participation in BCC activities proved as effective as training or reinforced the benefits of training in reducing discriminatory attitudes. The reticence about telling out-

siders if a family member had died of HIV/AIDS was retained by those who participated in the BCC activities. In effect, it is worth noting that for those who did not participate in the training, the sustained BCC activities offered a viable alternative to stigma reduction.

Table 10-4 (Panel 3) shows that another benefit of participation in BCC activities is the enhancement of the norms surrounding the notion that mothers, health providers, and educated people make reliable sources for providing PLWHAs with care and support.

The Impact of Participation in VCT on Reducing the Stigma of AIDS

The last determinant of stigma reduction investigated was the impact of participating in the VCT exercises. The decision to take the HIV test once, and especially two to four times in the course of the two-year study, was taken as a major behavior change modification and recognition of the role that VCT plays in HIV prevention and management. It was also expected that those who took the HIV test would have a more tolerant view of people who turn out to be infected.

Panels 1 to 3 of Table 10-5 show the differences in responses by the participation or non-participation of the respondents in the two rounds of VCT carried out during the project year. A comparison of the impact of training with that of VCT participation — Table 10-3, Panel 1, and Table 10-5, Panel 1— shows that in Ogbomoso no significant difference appeared in the pattern of responses between those who trained and those who took part in the HIV tests with regards to stigma statement. However, those who took the HIV tests showed a greater readiness to help carry someone dying of AIDS than those who trained.

In Ibadan, on the other hand, those who trained were significantly more likely to become involved in the care of PLWHAs (Table 10-5, Panel 2) than those who had only been tested for HIV. A confounding factor in this analysis is that the proportion of those who tested without participating in the training was not higher in Ibadan than in Ogbomoso. In effect, an explanation must be sought in the more cosmopolitan trends observed in Ibadan than in Ogbomoso.

When it came to estimating the position of some tribes, social classes, and religious groups about tolerance of PLWHAs, the absence of large differences between groups remained the dominant feature of participation or non-participation in VCT exercises and stigma reduction.

CONCLUSION

When social scientists explore strategies for reducing the stigma of AIDS, they tend to focus on the choice of actors, such as faith-based organizations; the quality of counseling (43); and the human rights of already stigmatized groups (38). Such recommendations, however, are often not evidence based. Other suggestions focus on the choice of methodology, such as the suitability of message content and the encouragement of support groups (9).

In this chapter we used the evidence-based approach to establish some components of project intervention that may individually or collectively contribute to stigma reduction. In addition to demonstrating that training, BCC programs, and HIV surveillance can help reduce the stigma of AIDS, we

Table 10-5. Percentage of Affirmative Responses to Stigmatizing Statements, Discrimination Questions, and Predictors of Tolerance at Baseline and Year 1 Surveys by VCT Participation Status

No.	Percentage agreeing that the following statements are true or answering affirmatively to the following questions	Ogbomoso		Ibadan	
		Those tested (201)	Those not tested (277)	Those tested (171)	Those not tested (328)
Panel 1: Stigmatizing Statements					
1	HIV-infected people are promiscuous.	23	44	13	25
2	HIV/AIDS is a punishment from God.	37	33	23	28
3	HIV-infected people are responsible for their own problems.	41	70	35	45
4	HIV-infected people are not useful to anyone.	34	69	19	45
5	HIV-infected people should not be allowed to mix with uninfected people.	40	69	41	55
Panel 2: Discrimination Questions					
6	Would you sleep in the same room with someone who has HIV?	67	66	68	68
7	Would you visit someone with HIV/AIDS in the hospital?	77	61	81	58
8	Would you help carry someone dying of AIDS to an ambulance?	70	43	73	48
9	Would you tell others if a relative died of HIV/AIDS after a long illness?	37	43	42	40
Panel 3: Predictors of Tolerance					
10	Mothers stand by their children.	92	87	94	87
11	Providers are friendly to HIV-infected people.	88	88	96	92
12	Some tribes are more tolerant of sick people than others.	60	62	60	63
13	Better-educated people are more tolerant of those living with HIV/AIDS.	60	68	79	76
14	Some religious people are better able to look after people living with HIV/AIDS.	56	55	56	56

Abbreviations: VCT: volunteer counseling and testing

identified some of the expectations of the public about where PLWHAs should receive their care and support. In this connection, the faith in health providers as a source of care and solace for PLWHAs will require that clinicians be prepared for this responsibility through training and appropriate logistical support in coping with the physical and emotional demands of the epidemic.

The major outcome of the analysis is the validation of the hypothesis that improved understanding of an epidemic leads to reductions in the stigma of AIDS. The corollary is that detailed training within HIV surveillance provides more understanding than the basics of HIV/AIDS available in the mass media and has more impact on stigma reduction.

Although the evidence is conclusive as to the impact of training, participation in BCC activities, and HIV testing on reducing stigmatizing attitudes, some ambiguity remains about the relationship between each of the three elements of intervention and non-discrimination. The reporting of non-dis-

criminatory attitudes as if they were norms may have been the result of the desire of the respondents to be socially correct. While pronouncing judgment on the morals of an HIV-infected person may be consistent with their understanding of the epidemic, it is another matter to refuse to help a PLWHA. People may have an intellectual inconsistency in their positions, but this is the dilemma of investigating phenomena that are subject to a social desirability bias.

REFERENCES

- Nigerian Institute of Medical Research. *Nigeria's Contribution to Regional and Global Meetings on HIV/AIDS/STIs: 1986–2005*. 2nd ed. Lagos: Nigerian Institute of Medical Research, 2005.
- Okonkwo A. *Attitudes of Journalists Towards People Living with HIV/AIDS in Nigeria: A Personal Experience*. Lagos: Nigerian Institute of Medical Research, 2005:115–116.
- Ahamefule G. *Human Rights Violation: My Experience as a Person Living with HIV*. Lagos: Nigerian Institute of Medical Research, 2005:118.
- Ugo U. Non-disclosure of sero-status due to high stigmatization in communities. Lagos: Nigerian Institute of Medical Research, 2005:224.
- Opara O. The need to make HIV carriers acceptable in the society through HIV counseling. XIV International AIDS Conference, Barcelona, Spain, July 7–12, 2002 (abstract TuPeG5557).
- Sabatier R. Crossing the threshold of fear. *AIDS Watch*, 1988;(3):2–3.
- Obishai A. *Reducing Stigma and Preventing HIV Transmission in Nigerian Health Facilities*. Lagos: Nigerian Institute of Medical Research, 2005:177.
- Okoli Rev., Omeogu CO, Onumonu C. *Faith Based Organizations' Use of Sermons as a Tool for HIV Awareness Creation*. Lagos: Nigerian Institute of Medical Research, 2005:190–191.
- Goffman E. *Stigma: Notes on the Management of a Spoiled Identity*. Englewood Cliffs: Prentice Hall, Inc., 1963.
- Guest G, Bunce A, Johnson L, Akumatey B, Adeokun L. Fear, hope and social desirability bias among women at high risk for HIV in West Africa. *J Fam Plann Reprod Health Care*, 2005;31(4):285–287.
- Anonymous. Standing up to stigma. *AIDS Action*, 2000;47:2.
- Aggleton P. *HIV and AIDS-Related Stigmatization, Discrimination and Denial: Forms, Contexts and Determinants. Research Studies from Uganda and India*. Geneva: UNAIDS, 2000.
- Modesto Meza J, Aguilera A, Avery AE. Psychiatric and social aspects of AIDS: report of 4 cases. *Acta Psiquiatr Psicol Am Lat*, 1994;40(2):146–150.
- Moyo I, Low A, Ray CS, Katsumbe TM, Chisvo D, Mbengeranwa OL, Gumbo N. Knowledge and attitudes on AIDS relevant for the establishment of community care in the city of Harare. *Cent Afr J Med*, 1993;39(3):45–49.
- Koop CE. Individual freedom and the public interest. In: Fleming AF, Carballo M, FitzSimons DW, Bailey MR, Mann J, eds. *The Global Impact of AIDS*. New York: Alan R. Liss, Inc., 1988:307–311.
- Lara y Mateos RM. Stigmatizing diseases: the case of HIV/AIDS. [Enfermedades estigmatizadoras: el caso del VIH/SIDA.] *Investigacion en Salud*, 2000;2(1):13–20.
- Muyinda H, Seeley J, Pickering H, Barton T. Social aspects of AIDS-related stigma in rural Uganda. *Health Place*, 1997;3(3):143–147.
- Maduna-Butshe AC. Women sex workers and the HIV pandemic: stigma and blame in context. *S Af AIDS News*, 1997;5(1):8–11.
- Gasu J. Legal and ethical aspects of sexual health and living with HIV/AIDS. In: *Summary of Proceedings of the 1st African Youth Conference on Sexual Health, Accra, Ghana, September 30–October 6, 1996*. Accra, Ghana: Ghana United Nations Students and Youth (GUNSA), 1996:25–27.
- Sealey G. We are our own worst enemies. In: Reid E, ed. *HIV and AIDS: The Global Inter-Connection*. West Hartford, Connecticut: Kumarian Press, 1995:108–119.
- Nack A. Damaged goods: women managing the stigma of STDs. *Deviant Behav*, 2000;21(2):95–121.
- Astorga Munoz MA. AIDS: the patient's perspective. In: Fuenzalida-Puelma H, Linares Parada AM, Serrano Laertu D, eds. *Ethics and Law in the Study of AIDS*. Washington, DC: Pan American Health Organization, 1992;(530):253–257.
- Baguma PK. AIDS-related stigma, personal risks and career objectives among Makerere medical students. *J Community Appl Soc Psychol*, 1992;2(2):105–112.
- Adeokun LA, Ladipo OA, Odutolu O, et al. Bridging the knowledge-behavior gap through HIV/AIDS surveillance in four markets in Ogbomoso and Ibadan, Nigeria. *Arch Ibadan Med*, 2004;5:59–65.
- Brown L. Facing stigma and discrimination. *Global AIDSLink*, 1999;(57):17,23.
- Chang PY, Lin KC, Chuang CY, et al. Status and trend of HIV-1 infection and AIDS in Taiwan, December, 1991. *Asian Pac J Allergy Immunol*, 1992;10(1):65–68.
- Dying villagers appeal for help. *AIDS Asia*, 2001;3(3–4):12.
- Chinula T. Catherine's story. *Pac AIDS Alert Bull*, 2001;(23):14–15.
- Wright K. The stigma of AIDS. *WIPHN News*, 2000;25:6–7.
- Baggaley R. Zambia: a church where brothers are not brothers. *AIDS Anal Afr*, 1994;4(3):5–6.
- Henderson DA. Smallpox: epitaph for a killer? *Natl Geogr Mag*, 1978;154(6):796–805.
- Anonymous. Stigma, poor health infrastructure blamed for increasing HIV/AIDS cases in Nigeria. *AIDS Wkly*, 2001;16:18.
- Anonymous. Women living with HIV/AIDS: personal histories. Personal statement by a woman living with HIV in the South Pacific. In: Berer M. *Women and HIV/AIDS: An International Resource Book*. London: Pandora Press, 1993:248–249.
- Anonymous. Challenging stigma and discrimination. *AIDS Action*, 2000;(47):1.
- Junaid A. AIDS: young people talk about how AIDS affects family life. Developing Countries Farm Radio Network Package 59, script 5. *Voices*, 2001;(59 Suppl):5.
- Devine S, Graham D. How having HIV positive parents affects the lives of orphans. *AIDSNET News*, 1999;1(3):38–45.
- Raviglione MC, Luelmo F. Update on the global epidemiology of tuberculosis. *Curr Issues Public Health*, 1996;2(4):192–197.
- Hamblin J. *People Living with HIV: The Law, Ethics and Discrimination*. New York: United Nations Development Programme, 1993.
- Delph Y. AIDS: the doctor's perspective. In: Fuenzalida-Puelma H, Linares Parada AM, Serrano Laertu D, eds. *Ethics and Law in the Study of AIDS*. Washington, DC: Pan American Health Organization, 1992:258–263.
- Calderon S. Testing positive in El Salvador: HIV stigma continues, but counseling improves. *Impact HIV*, 1999;1(2):25,27.
- Serunkuuma R. Living with HIV/AIDS: a personal testimony. *AIDS Health Promot Exch*, 1994;(3):7.
- Odebiyi AI. Food taboos in maternal and child health: the views of traditional healers in Ile-Ife, Nigeria. *Soc Sci Med*, 1989;28(9):985–996.
- Miller D, Jeffries DJ, Green J, Harris JR, Pinching AJ. HTLV-III: should testing ever be routine? *Br Med J (Clin Res Ed)*, 1986;292(6525):941–943.