

**PREVALENCE AND PREDICTORS OF HIV-RELATED STIGMA AND  
KNOWLEDGE IN NIGERIA: IMPLICATIONS FOR HIV/AIDS PREVENTION  
INITIATIVES.**

**By**

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**Research Report submitted to the 2002/2003 Takemi Program in International  
Health.**

**Abstract:**

This study measured the prevalence, patterns and predictors of stigmatizing attitudes and beliefs about HIV/AIDS among Nigerian public in the Southern region of Nigeria. Between June and August 2002, a formative research involving qualitative and quantitative interviews was conducted with a random sample of 987 adults in two urban and two rural communities in Nigeria. The study population was from two major Nigerian ethnic groups – Igbo and Yoruba. Respondents were asked about their feelings towards persons living with HIV/AIDS, support for coercive policies, attribution of blame and responsibility for the infection, beliefs about transmission, and knowledge of and intention to use voluntary counseling and testing services and or any other AIDS-related services

There is a mixture of stigma and empathy. There is a strong ethnic differential in stigma attitudes in Nigeria. The Igbo respondents were more likely to show stigma attitudes and behaviors than the Yoruba. Gender differences are evident but not significant. Reasons for stigma and empathy attitudes seem to be the same.

Markers of stigma and overall stigma index are significant predictors of intention to utilize VCT. Implications of the study to on-going ABC efforts in Nigeria are discussed. The study calls for the inclusion of de-stigmatization program as a major component of prevention activities. Well-designed messages should be posted in the media, community halls, health centers and other public places aimed at humanizing the disease and those infected and affected. Care and support programs should address this important aspect of the pandemic.

Three major limitations of this study are) small sample size; 2) non-representativeness of ethnic groups in Nigeria 3) non –inclusion of PLWHAs and their relations in the interviews to document their experiences and coping strategies. These issues will be taken care of in subsequent study. Nevertheless, this provides a baseline to investigate the beliefs and values about HIV-related stigma in health care settings and families; how such stigma affects care, treatment and health-seeking behavior of those affected by the pandemic.

## **HIV/AIDS in Nigeria.**

The first suspected case of AIDS was diagnosed in Nigeria in 1986. Following this, the epidemic escalated rapidly and extensively such that by 1999, a cumulated total of 3.5 million cases had been reported (FMOH, 1999, UNAIDS 1999) with a national HIV prevalence rate of 5.7%. The 1999 HIV Surveillance Survey in Nigeria showed a high level of regional variation with 21 percent in the North Central .Zamfara State in North West region of Nigeria had the lowest rate (3.2%). In Lagos, the country's economic capital, the average prevalence rate is 6.7%. HIV prevalence in the ages 20-24 ranged from 4.2% in the South West to 9.7% in the North Central Zone. Young adults 15-19 are similarly affected with HIV prevalence ranging from 2.8% in the North East Zone to 8.4% in the North Central Zone. In certain areas, Enugu State in the South East for instance, the HIV prevalence had increased from 2.3% in 1995 to 16.8% by 1999. Similarly eight other areas had HIV prevalence rates greater than 10% (FMOH, 1999, USAID, 2002).

The rapid spread of HIV in Nigeria has been accounted for by a number of factors. These include sexual networking practices such as polygamy, high prevalence of untreated sexually transmitted infections, low condom use, poverty, low illiteracy, poor health status, low status of women, stigmatization, denial of HIV infection risk among vulnerable groups (USAID, 2002). The socio-economic impact of the epidemic on the Nigerian society has not been documented but it is becoming apparent that the already fragile health care delivery system is overloaded. There are reported cases of single parent homes

and orphans while the population continues to grow at the rate of 2.8 or more. Hence the projected impact of HIV will have disastrous consequences on the population of Nigeria, Africa and the world (FMOH/NACA, 2001).

Initially, government response to HIV/AIDS pandemic in Nigeria was that of denial, ignorance, pretence and lukewarm-ness. The military governments did not show any appreciable interest and concern. The restoration of civilian democratic governance brought the sign of a strengthened national response to the epidemic. A national program, HIV/AIDS Emergency Action Plan, involving a cocktail of emergency policy mix, which will initially run through 2000-2003. The objectives of the Plan include:

- Increasing awareness and sensitization of general population and key stakeholders
- Promoting behavior change in both low risk and high risk populations;
- Ensuring the communities and individuals are empowered to design and initiate community-specific action plans;
- Ensuring that laws and policies encourage the mitigation of HIV/AIDS;
- Institutionalizing best practices in care and support for people living with HIV/AIDS;
- Mitigating the effect of the disease on people living with HIV/AIDS, orphans and other affected groups;

- Creating networks of people living with HIV/AIDS and others affected by AIDS;
- Establishing an effective HIV/AIDS surveillance system; and
- Stimulating research on HIV/AIDS.

The HIV/AIDS Emergency Action Program (HEAP) is designed to promote a multi-sectoral participatory response to HIV/AIDS prevention and impact mitigation. It serves as an expression of government's interest and commitment to a dynamic and proactive response to the problem of HIV/AIDS (JAAIDS, 2001; NACA, 2001). The framework identifies over 200 activities, which Nigerian Government intends to pursue between 2001 and 2004. Most of the activities are conceived as short-term, high impact interventions that will form the base for a medium-term strategic plan for HIV/AIDS in Nigeria (NACA, 2001). The HEAP initiative intends to respond to the determinants of HIV/AIDS transmission such as social, behavioral and biological factors. Its strategies include preventive interventions, empowerment of women to negotiate safer sex, prevention of mother-to-child transmission, care and support for those infected and affected by HIV/AIDS (NACA, 2001).

Private NGOs are also involved in addressing the problem of HIV/AIDS. USAID and other funding agencies have supported interventions to address the problems of HIV/AIDS. The activities of these private organizations range from advocacy to provision of sexually transmitted disease services ( USAID/IMPACT, 2001).

## **AIDS Stigma**

From the time HIV was discovered, social responses of fear, denial, stigma and discrimination have accompanied it. This has spread rapidly, giving rise to anxiety and prejudices against the groups most affected as well as individuals infected and affected. The stigmatization of individuals infected and affected by HIV and the eventual discrimination, which they suffer, are the tragic consequences of HIV disease (VanLandingham et al 2002). Jonathan Mann in 1987 referred to AIDS stigma as the ‘third epidemic’ while Sabatier (1988) predicted an increase in AIDS stigma and discrimination at the individual, community and national levels. The concept of stigma has been applied to a number of diseases and circumstances such as leprosy, urinary incontinence, mental illness and epileptic (Sheldon and Caldwell, 1994).

Various definitions of stigma have been given. Erving Goffman (1963) defined it as an attribute that —according to prevailing societal attitudes - is deeply discrediting and reduces a person to one who is in some way tainted and can therefore be denigrated. Brown (1993) sees it as a visible or apparent characteristic indicative of some quality, action and circumstance while Stafford and Scott (1986) defined it as a characteristic of persons that is contrary to a norm of a social group or unit while Crocker et al (1998) indicate that stigmatized individuals possess or are believed to possess some attributes or characteristics that conveys a social identity that is devalued in a particular social context. Jones et al (1984) also saw stigma as an attribute that links a person to undesirable characteristics. These definitions imply that one group sees the other as abnormal and should be abhorred. It introduces the concept of “them and us”.

Hence Link and Phelan (2001) postulated that four components of stigma include people distinguishing and labeling human differences; dominant

groups linking labeled persons to undesirable characteristics. Also labeled persons are placed in distinct categories so as to accomplish some degree of separation of 'us' from 'them'. In the fourth category, labeled persons experience status loss and discrimination that leads to unequal outcomes. Researchers have also distinguished between public, enacted stigma (ways in which the general public reacts to a group based on stigma about that group), and self, felt stigma (reactions which individuals turn against themselves because they are members of a stigmatized group). While public stigma manifests in avoidance, social distancing, coercion and non-supportiveness, self-stigma leads to reduced or diminished self-esteem.

Psychologists have identified various cognitive and behavioral structures that comprise stigma, and understanding them is important for designing strategies to reduce stigma and improve access to care, treatment and support. Stereotypes are efficient knowledge structures that govern understanding of a social group (Krueger, 1996). There are sets of stereotypes that are essentially problematic for HIV/AIDS illness. The PLWHAs are seen as being sexually loose, under divine punishment for their immoral behavior; and hence are responsible for their fate. A negative side of stereotype is prejudice which leads to emotional reaction. The behavioral consequence of prejudice is discrimination – a harsher form of stigma. The range of behavioral responses to the public stigma of HIV/AIDS illness include withholding help because the affected person is thought to be responsible for his or her lot in life; avoidance or social distancing; isolation; coercion (mandatory testing) and in some cases public labeling. Self-stigma exists when people are aware of the stigma about their group. They will agree with the stigma and apply it against themselves, suffering diminished self-esteem and self-efficacy as a result. People with diminished self-efficacy due to self-stigma are less likely to apply for jobs or socialize with other people (Goffman, 1963, Link et al 1991, Jacoby, 1994. Watson and Corrigan, 2001).

**Levels of cognitive and behavioral structures that comprise public and self-stigma**

Public Stigma	Self-stigma
<ul style="list-style-type: none"> <li>- Stereotypes: negative beliefs about the group               <ul style="list-style-type: none"> <li>-immoral, loose</li> <li>-Under divine punishment</li> <li>-Dangerous</li> </ul> </li>   <li>- Prejudice: agreement with belief or negative emotional reaction               <ul style="list-style-type: none"> <li>-Anger</li> <li>-Fear</li> <li>-Disgust</li> </ul> </li>   <li>- Discrimination: behavior response to prejudice               <ul style="list-style-type: none"> <li>-Avoidance of social contact</li> <li>-Denial of rights including healthcare</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>- Stereotype: negative belief about self</li>   <li>-Prejudice: agreement with belief or negative emotional reaction               <ul style="list-style-type: none"> <li>-Low self-esteem</li> <li>-Low self-efficacy</li> </ul> </li>   <li>- Discrimination behavior response to prejudice               <ul style="list-style-type: none"> <li>-Fails to interact</li> <li>-Non-access of healthcare</li> <li>-Fails to challenge rights denial</li> </ul> </li> </ul>

Adapted: Watson, A.C and P.W. Corrigan (2001): "The impact of stigma on service access and participation: a guideline for the behavioral health recovery management project."

Stigma often extends beyond the infected to even those who provide care, treatment and support. Herek et al (1996, 1998) have identified the secondary targets of AIDS-stigma to include partners, friends, family members, professional colleagues and volunteers who provide AIDS services. Goffman (1963) called it 'courtesy stigma' because of their close association with AIDS and PLWHAs. The disease does not directly affect them as the case may be. This type of stigma deters professional and volunteer caregivers and advocates from working with PLWHAs. Felt stigma prevents individuals from coming forward for timely diagnosis and treatment and impairs their ability for self-care, to access care or to participate in research studies designed to find solutions. Enacted stigma prevents societies from appropriately addressing health care issues at the community and national levels with the appropriate delivery, funding and support of research, health care services and legal and educational interventions.

## **Background**

The importance of studying the role of stigma in research for control of the diseases has been acknowledged. The WHO has been concerned with the impact of leprosy stigma and exclusive studies of stigma have been supported. The emotional suffering and the barriers to effective care follow from local cultural meanings of the disease. Consideration for the impact of stigma can affect the preference in the utilization of health care services (Pearson, 1988). Thus stigmatizing cultural meanings have serious impacts on the illness

experiences, health seeking and treatment adherence (where available) and contribute to treatment delay for the patient (Morankar et al 2000).

Despite numerous conferences and expert consultations on stigma, little is known about the causes of these negative responses or how best they can be tackled, and the negative health outcomes associated with them (Weiss and Ramakrishna, 2001). Systematic research has not focused on forms and contexts of HIV/AIDS-related stigma and discrimination, its local concepts and determinants. While its negative effects have been acknowledged, research into its role in prevention activities has been lacking in Nigeria. Only anecdotal evidence of stigma, reported by the news media, exist in Nigeria. A comprehensive search of published reports on HIV stigma in Nigeria using various electronic search engines yielded no result, except that in some studies not related to stigma, there are passing comments on the impact of AIDS stigma while no systematic study has actually investigated the relationship. Local non-governmental organizations admitted sigma issue is part of their intervention activities but were not able to show tangible on-going de-stigmatization activities in their programs.

Because it hampers society's ability to respond effectively to HIV/AIDS, understanding and counteracting it will remain a critical public health issue in the country. For current HIV/AIDS prevention initiatives in Nigeria to be effective, there is need for research to illuminate the cultural context of AIDS-stigma in Nigeria. This should describe occurrence of stigma, resistance to it and identifying the ways in which stigma contribute to the spread of the diseases as well as individual responses to it. Understanding this has very important sociological and public health implications. Sociologically it can help us to understand how stigma interacts with other social processes and anticipate its antecedents and consequences. From the public health point of view, it is important to know which social groups are most likely to experience stigma

and its adverse consequences so that limited public resources can be used in the most effective way.

Unfortunately information on stigma in Nigeria has been from anecdotal evidence and sensational newspaper reporting. This has led to widespread assumptions about its extent and distribution, validity of which is difficult to establish. The clear lack of systematic research and intervention on AIDS stigma is a major flaw in AIDS prevention, care and treatment interventions in Nigeria. This study, although a pilot survey, is part of a two phased survey to investigate the impact of stigma on AIDS prevention, care and treatment activities in Nigeria. This first phase investigates the dimensions of HIV-related stigma in the communities and families, and access to voluntary counseling and testing.

### **Literature review.**

Existing studies and commentaries have noted that stigma and discrimination remain a major fact of life for persons living with HIV/AIDS in sub-Saharan Africa. The issue of gender as well as poverty, lack of economic opportunities, limited access to education, information and services, traditional norms and practices exacerbates this. (Kelly, 2003). Panos (2001) reported a study in Zambia, India, Ukraine and Burkina Faso, which found that pregnant women with HIV suffer multiple layers of stigma. They may be devalued because they are women, have HIV and because they are pregnant and have HIV. Moreover in settings where breast-feeding is the norm, the decision by an infected mother not to breast-feed could draw attention to her sero-status placing her at risk of abuse and ostracism (ICRW, 2002). Even the concept of MTCT invites negative reactions since it implies that the woman transfers the virus to the baby. The blame

becomes more accentuated if the child is a male in cultures that place high value on male children (Panos 2001, Collymore, 2003).

According to ICRW (2002), the language that surrounds the epidemic helps reinforce these stereotypes and attitudes. Derogatory terms are used to describe those with the virus. The ICRW study in Tanzania and Zambia found that the choice of terms for HIV were influenced by popular culture and by HIV education messages. Myths and ignorance about the ways in which HIV is transmitted also trigger damaging attitudes. Various euphemisms are used to describe the disease and those affected by it. Its tendency to disfigure one's appearance and to impair one's ability for social interaction is one of the reasons why PLWHAs are stigmatized. Thirdly it is a sexually transmitted disease (Hallman, 1989). This means that society looks down upon it for its connection with immoral behavior (Berk, 1988). Another point is that in the early years of HIV/AIDS, it was associated with individuals on the unpopular fringe of society such as homosexuals, commercial sex workers, and drug addicts. Hence AIDS was and is regarded as God's punishment to these "evil doers". Added to these points are the facts that there is no cure, and it is fatal. These factors combined scared the public to create a stigma associated with the disease as much if not more popular than knowledge about the disease itself. (Herek et al 1998; Omangi, 1997). In fact most of the points were mentioned in the Nigerian study.

Although AIDS stigma is a product of the HIV epidemic, the association of stigma with the disease is not a new phenomenon. History has shown that stigma associated with epidemic illnesses and the social groups linked to them have often hampered treatment and prevention (Herek et al 1996). Thus AIDS stigma displays

continuity with many past epidemics. However in the case of AIDS, the nature and intensity of stigma are shaped by the social construction of the epidemic in different locales. It takes different forms in different societies while the specific groups targeted for AIDS stigma vary considerably across cultures and national borders. The factors affecting this variation include the local epidemiology of HIV, preexisting beliefs and values surrounding sexuality, disease, gender and prejudices toward specific cultural out groups. It is thus an expression of social and cultural norms shaping relationships among people according to some societal norms. (Alonzo and Reynolds, 1995). The stigmatized are usually considered deviant or shameful and as a result are shunned, avoided, discredited, rejected, restrained or penalized.

### **Levels of and Differentials in AIDS Stigma Manifestation**

HIV/AIDS-stigma manifests at various levels of the society, ranging from the family to such public places like health sector, employment places and at religious circles. In developing countries, families and communities are generally supportive for illness management and treatment (Bharat 1996, Ankrah, 1993). However data from some African and Asian countries report both supportive and non-supportive household responses to HIV-positive people while negative responses are more evident in the case of HIV-positive women (Bharat and Aggleton, 1999; Warwick et al 1998) and those whose lifestyles and sexual behavior elicit popular disapproval (Warwick et al 1998; UNAIDS, 2001). The harassing and scapegoating of individuals suspected of being infected or of belonging to a particular group has been widely reported. In extreme circumstances it can lead to acts of violence and murder (Nardi and Bolton, 1991). For

instance, Peterson (1990) reported that CSWs and street children in Brazil have being singled out for violence and abuse while Panos (1990) reported HIV-related murders in diverse countries such as Ethiopia, South Africa, India, etc.

Family responses to infected individuals are heavily influenced by community perceptions of the disease. Those families with PLWHAs may fear isolation and ostracism within the community (McGrath et al 1993). Consequently they may try to conceal an HIV diagnosis, which in turn may cause considerable stress and depression within the family (Bharat and Aggleton, 1999). Despite the fact that the family play an important role in providing support and care for people living with HIV/AIDS, infected family members may still be stigmatized and discriminated against within the home. In this case women are reported to be more badly treated than children and men (World Bank, 1997; Bharat and Aggleton, 1999). Management of stigmatization within the wider community by family members may affect health care utilization and even the quality of care. Lwihula et al (1993) reported that families might shield affected members from the community by keeping them within the house or by protecting them from questioning. Also fear of rejection and stigmatization within the home and local community may prevent people living with HIV/AIDS revealing their sero-status to family members (McGrath et al 1993; Panos, 1990). In Indonesia, Horizons (1999) reported that families in Bali have been found to separate the household items, clothing and personal belongings of PLWHA. Sometimes entire family has experienced rejection by the wider community (Sarjana et al 1999).

Reports also reveal the extent to which individuals are stigmatized and discriminated against by the health care system. There have been reports of withheld

treatment (Panebianco et al 1994), non-attendance of hospital staff to patients left lying in their beds (Ogola 1990, Msini and Mwampeta 1993); HIV testing without consent, breaches of confidentiality, and denial of hospital facilities and medications (Panebianco et al 1994; Daniel and Parker 1990). Many health workers are reported to have expressed negative attitudes to PLWHA and would demonstrate a preference not to treat them. Contributing to the above responses are ignorance and lack of knowledge about HIV/AIDS transmission (Herek et al 1998) and the perceived incurability of the disease. These conspire to make it appear pointless to offer quality care (UNAIDS, 2000). The existence of AIDS-stigma in health care settings is a serious threat to HIV/AIDS prevention care and treatment efforts.

AIDS-stigma has also been reported in the working places (Omangi, 1997; UNAIDS, 2000). There have been reports of termination and refusal of employment. (Panos, 1990). In Zambian workplaces, people with HIV/AIDS were ostracized, isolated and gossiped about. Affected individuals are subjected to mental abuse. Dismissal from work on grounds of sero-status has been noted in some countries namely Thailand, Singapore, Malaysia and Indonesia. Hira et al (1998) reported that in India most businesses had no policy on AIDS and management has adopted the wait and see attitude – waiting to see how many workers became infected and whether this had an impact on productivity. Ditto in Nigeria (Rosen et al 1998). Anecdotal evidence of employment-related discrimination and stigmatization has begun to emerge. Individual cases of job loss, emotional isolation, and denial of employment on the basis of HIV status have been reported in the media but again these are caged in anonymity because of the need to protect the persons involved. The validity of these experiences becomes difficult to

measure. In Nigeria, a high court judge refused to entertain a case brought to her by an HIV-positive woman for fear of ‘spreading’ the disease in her court. In another case, a young man who tested positive in Ibadan City of Nigeria committed suicide because ‘he was not ready to bear the shame’.

The religious sector has also been reported to be instrumental to the perpetuation of AIDS-stigma. In Nigeria, the failings of religious leaders (Christians and Moslems) to date center around the ostracization and marginalization of PLWHA and the refusal of the leaders to turn inward and confront their own attitudes toward the epidemic and the social behaviors associated with the spread of HIV. The leadership interpret the pandemic to be a punishment from God for the sin of the infected.

The stigma attached to the AIDS virus obviously has many far-reaching effects. A person victimized by the disease is further victimized by society. Family, friends and neighbors often alienate HIV-positive people. The surrounding community attacks or ostracizes them and the government balks at the prospect of enacting legislation; but even if enacted, implementation becomes difficult. The mass media unabashedly publishes incendiary lies about the disease, and the medical community does little to combat the lies with their actions. All of these create an environment extremely unfriendly to the victims of the epidemic.

To avoid stigma, discrimination and possible losses, ‘sero-positive individuals attempt to conceal their status, and this causes them to be cut off from social support and needed medical and social services. They may also delay in obtaining medical care or fail to adhere adequately to medical treatment regimens once they enter care. AIDS-stigma can also interfere with PLWHA’s coping and adjustment. The psychological distress

experienced may be exacerbated by self-imposed isolation and experiences with ostracism, hostility and discrimination' (Herek et al 1998). There have been reports of PLWHAs committing suicide in Nigeria. Individuals may blame themselves to the extent that they cease to exert their right to decent treatment and other social benefits.

The perpetrators of AIDS stigma are individuals who express negative attitudes or feelings toward PLWHA or who engage in discrimination or other stigmatizing behaviors (Herek et al 1998). There are two fundamental sources of negative reactions to AIDS victims. The perpetrators may fear certain outcomes directly related to HIV; this results in what is called instrumental stigma. This arises as a result of the fact that AIDS is regarded as a generative and fatal conditions; it is transmissible, hence the affected person is seen as repellent, ugly or upsetting. Any diseases that is degenerative, ugly and repellent and disfiguring is likely to be stigmatized. Symbolic AIDS stigma results from social meanings attached to AIDS. It also represents the use of disease to express attitudes toward the groups associated with it and the behaviors that transmit it. AIDS stigma is also affected by attitudes toward other stigmatized groups associated with HIV in public perceptions.

## **Methodology**

This study was done in two ethnic groups in Nigeria, namely Yoruba and Igbo. This was done by selecting two states in the country representing these two groups and with HIV prevalence rates higher than the national average of 5.4. These two states are Osun State in the Western part of Nigeria with a prevalence rate of 4.7 and Imo States in the Eastern part of Nigeria with HIV prevalence rate of 5.4.

In the two states, both two urban centers and two rural communities were selected. The urban cities are Osogbo in Osun State; and Orlu in Imo State, while adjoining rural communities to the two cities were taken. Each of the cities has all the indices of modernization while the rural areas are relatively homogenous with respect to culture, behavior and perceptions. In cities, there are a number of organizations active in HIV/AIDS prevention activities while in the rural communities, local governments are involved in AIDS campaigns to educate the rural folk about the disease and its prevention methods.

At the first level of the study, qualitative tools of in-depth interviews, key informants and focus group discussions were used to collect the required information from the communities. Respondents were selected specifically to illuminate key issues and concerns in the study. The participants in the qualitative data collection were community leaders, health care providers, adolescents and leaders of faith-based organizations. There were eight focus group discussions with a community health staff and young and adult community members. There were also eight key informant interviews with community leaders, traditional healers, religious leaders, and same number of in-dept interviews.

At the urban sites of the survey, a convenience sample design was used to select the samples for interview. In each household visited, an adult aged 18 years and above was picked and interviewed, after explaining the purpose of the survey. Respondents were asked about their feelings toward persons living with HIV/AIDS, support for coercive policies to handle the spread of the pandemic, likelihood of avoiding those infected with the disease and beliefs about how the disease is transmitted. Additional

questions were asked on awareness of various on-going AIDS prevention programs in the country and willingness to access to any AIDS prevention, care and treatment initiatives like voluntary counseling and testing, prevention of mother-to-child transmission of HIV.

To measure the various indices of stigma, specific questions were asked. *Negative feelings toward people with AIDS* were measured by asking respondents to rate the extent to which they felt angry at, afraid of and disgusted by PLWHA. Four response categories were provided, example, “very angry, somewhat, a little, not at all angry”. *Support for coercive policies* was measured by asking the respondents how much they agreed or disagreed that “people with AIDS should be legally separated from others to protect the public health” and that “the names of people with HIV/AIDS should be made public so others can avoid them” and that “pregnant women and everybody should be made to undergo compulsory HIV testing”. Four response alternatives were provided viz, “agree strongly, agree somewhat, disagree somewhat, and disagree strongly”. *Attribution of blame to infected individuals* were also measured by asking respondents whether they agreed or disagreed that “people who got AIDS have gotten what they deserve or are responsible for their faith or are sexually loose people”. Response alternatives ranged from “strongly agree to disagree strongly”. *Avoidant behaviors* were also measured by asking respondents to predict their own behavior in each of four different hypothetical situations involving potential contact with a person living with HIV/AIDS. The situations were having a close friend or relative who developed AIDS; having a child attending a school where another student was known to have AIDS; working in an office where a workmate developed AIDS and finding out that the owner of a small neighborhood grocery store had AIDS. For each situation, respondents were offered a number of

response alternatives that represented an avoidant response (example not helping to care for the sick friend, avoiding contact with the workmate) or supportive response (e.g., caring for the friend, helping an infected workmate or treating him the same as always). Only a respondent who reports an accepting or supportive attitude on all four of these questions enters the numerator while the denominator is all the people surveyed.

**Analytical Framework**

The scale scores for the stigma measures and stigma index were examined using the Cronbach’s Alpha. All the scores were found to be of high levels of reliability and hence of acceptability. The scale scores were examined using the Analysis of covariance with a number of independent variables to identify the factors that are associated with the scores. Logistic regression was used also to examine the relationship between stigma and intention to use voluntary counseling and testing services.

**Findings.**

**Characteristic of respondents.**

Table 1: Percent distribution of respondents by their characteristics, Nigeria 2003.

<b>Characteristics</b>	<b>Total, N = 987</b>
Mean age of respondents	31.8
<b>Place of survey</b>	
Urban	60.3
Rural	39.7
<b>Ethnic group</b>	
Igbo	55.0
Yoruba	45.0
<b>Sex of respondents</b>	
Male	42.5
Female	57.5
<b>Level of Education</b>	
None	4.2
Primary	16.5
Secondary	32.9
Tertiary	46.5

<b>Religion</b>	
Protestant Orthodoxy	35.9
Roman Catholic church	46.0
Islamic religion	14.9
No/traditional religion	3.4
<b>Marital Status</b>	
Married	50.4
Single	45.5
Separated/divorced/widowed	4.1
<b>Migration experience</b>	
Yes	35.2
No	61.2
NR/DK	3.6
<b>Access to Media</b>	
% Own radio	90.4
% TV	81.7
<b>Frequency of reading Newspapers</b>	
Very often	22.4
Often	29.5
Rarely	32.1
Never	15.7
Don't know	0.4
<b>Frequency of listening to Radio</b>	
Very often	40.1
Often	46.5
Rarely	11.2
Never	1.82
Don't know	0.4
<b>Frequency of TV Watching</b>	
Very often	37.3
Often	34.9
Rarely	22.8
Never	4.6
Don't know	0.4

Majority of the respondents were from the urban areas. The Igbo constituted more than half of the respondents. Fifty six percent were females. There were more respondents with tertiary level of education (46.5%), followed by secondary level (33%). There were also many Catholics, followed by the Protestants. Half of the respondents

were in marital union as at the time of the survey. About one-third of respondents have had migration experience. There is a widespread ownership of media (radio and television). One-third of respondents rarely read newspapers, possibly because of the cost of purchase while radio listening is frequently done, so also watching television. The mean age of respondents was 31.8 years with a standard deviation of 12.95

**Beliefs about HIV/AIDS Transmission.**

**Table 2: Percent distribution of respondents beliefs about HIV/AIDS transmission, Nigeria 2003.**

<b>Responses</b>	<b>Percent, (n = 987)</b>
% Aware of HIV/AIDS	94.9 (937)
% Aware of HIV prevention	84.2 (832)
<b>Mentioned Prevention methods</b>	
Fidelity	66.9 (661)
Condom use	52.2 (516)
Sexual abstinence	46.2 (456)
Avoid sex with prostitutes	36.4 (359)
Avoid sex with one with many partners	20.7 (204)
Avoid sex with multi-partners	18.6 (184)
Avoid sex with homosexuals	18.6 (184)
Avoid sex with drug users	8.2 (81)
<b>Non-sexual methods of prevention</b>	
Avoid sharing sharp instruments	60.6 (599)
Avoid blood transfusion	34.0 (336)
Avoid kissing	14.2 (140)
Avoid injection	9.11 (90)
Avoid mosquito bites	9.6 (95)
Seek protection from traditional healers	2.7 (27)
<b>Other HIV-related beliefs</b>	
% Chances of reducing HIV infection by sticking to one partner	59.9 (592)
% HIV can be gotten from mosquito bites	23.1 (228)
% One can get HIV by sharing food with a person infected with AIDS	18.5 (183)
% Reduce chances of infection by using condoms every time sex is had	59.9 (592)
% Healthy-looking person can be HIV positive	78.7 (778)

% Aware of persons living with HIV/AIDS	45.5 (449)
% Aware of mother-to-child transmission of HIV	84.5 (835)
% Mother-to-child transmission during pregnancy	86.0 (850)
% Mother-to-child transmission during delivery	56.2 (555)
% Mother-to-child transmission during breastfeeding	65.7 (649)
% Ever discussed HIV prevention with partner	61.3 (606)

It is found here there is high level of awareness of HIV/AIDS (95 percent) and of methods of prevention of HIV/AIDS, a reflection of success of years of IEC activities. The reported primary method of prevention is being faithful to ones partner (67%). Other methods mentioned include condom use (52%), sexual abstinence (46.2%) and avoiding multi-sexual partners. In terms of non-sexual methods of prevention of infection, the respondents mentioned avoidance of sharing of sharp objects with an individual (61%) and avoiding blood transfusion (34%).

There is still misconception about HIV routes of transmission. One-fifth of the respondents still believed that HIV can be contacted from mosquito bites while 19 percent believed that AIDS could be transmitted by sharing food with an infected person. Yet 14 percent of respondents believed that avoiding kissing can prevent HIV or any contact with an infected person, an indication that they believe that physical contact with a PLWHA can lead to the infection. These misconceptions reflect emerging challenge to IEC programs. It is well understood by majority of the study respondents that a healthy-looking person can be HIV positive. There is a high awareness of mother-to-child transmission (85%) and this could be contacted during pregnancy (86%), breast-feeding

(66%) and during delivery (56%). About two-thirds have discussed HIV prevention with their partners.

### **HIV-related stigma.**

The survey instrument assessed multiple facets of AIDS stigma. Questions were asked about support for coercive policies for HIV/AIDS such as isolating infected individuals, making public their names, mandatory testing for everybody and pregnant women, attributions of responsibility and blames (that is the belief that PLWHAs are responsible for their fate, they are sexually loose and deserve what they got), beliefs about PLWHAs (that they do not care about infecting others), negative feelings (anger, fear and disgust) and discomfort with and avoidance of PLWHAs in some hypothetical situations like working with a mate who is infected, patronizing a shopper who is infected).

It is shown that seven out of ten respondents, 70%, supported legal isolation of people living with HIV/AIDS and as many as 4 out of ten, 45%, endorsed public disclosure of names of PLWHAs. Eighty-four respondents supported mandatory testing for the public and pregnant women. While a significant proportion of respondents expressed some anger and disgust at PLWHAs, more than half were afraid of infected individuals.

About a third of the respondents believe that “people who are infected are sexually loose”. More than half of the respondents believed that infected individuals are responsible for their illness (55%), have gotten what they deserve (57%). The proportion that believed that infected individuals do not care if they infect others is 58.4 %.

In terms of avoidant behavior and intentions, more than half of the respondents expressed willingness to care for infected relation, more than two-thirds would care for HIV infected work mate. But however, almost all respondents would refuse to buy from a shop owner who is infected. Also, although most respondents expressed willingness to care for a workmate infected with HIV, only 28 percent said they would be comfortable to use the same plate with PLWHA, 26 percent would be comfortable hugging and 8 percent kissing a PLWHA. Only one-fifth could be comfortable to share toilet with an infected person. Forty-nine reported they would feel somewhat or very uncomfortable having their child go to school with a child with AIDS, working in an office with PLWHA or shopping at a neighborhood grocery store whose owner has AIDS

However, though most respondents expressed discomfort to interact with any HIV infected person, about two-thirds expressed comfort to interact with their partners if they were infected, although only one-third would be comfortable eating with an infected partner. Most of those who expressed willingness to interact with their partners even if infected are the married ones who believed that they married for ‘better or for worse’. The singles insisted that they would terminate the relationship if it were discovered that their partners are infected.

AIDS stigma is manifested by a significant majority of the respondents. Table 3 shows that more than two-fifth of the respondents felt very or somewhat angry or disgusted toward persons living with HIV/AIDS, and more than half were afraid of them. Among the Igbo, more than half felt angry and disgusted toward people living with HIV/AIDS while equal percentage of respondents from both ethnic groups were afraid of them because

*“The disease disfigures the person.. And the person will eventually die... In fact you are actually seeing a living ghost. What scares us most is the fatal nature of the diseases. So when we hear that somebody is infected, we are afraid because the person will die sooner or later”. (FGD, Female)*

In terms of support for coercive policies of legal isolation, mandatory testing and public labeling of infected individuals, 72 percent agreed that PLWHAs should be quarantined. Majority of the Yoruba respondents supported quarantining infected individuals than the Igbo so that

*“They will not go about infecting other people...”*

The Igbo respondents were opposed to it because it would heighten isolation and depression for the infected and will bring shame and ridicule to his family, community and friends.

More than two-fifth of the respondents supported public labeling of infected individuals so that *“other people should be aware of them and avoid any contact that should expose them to risk of infection”*. Among the Igbo, half of the respondents supported this view than 39 percent of the Yoruba. There is a noticeable pattern of insincerity, as none of the respondents would want an infected relation’s name to be made public so that the family name will not be tarnished. There is recognition here that most families may have infected individuals but would not like the public to know in order to protect the family name.

Also, over half of the respondents agreed that PLWHAs deserve their illness because they are responsible for the sickness. (55 %). There is not much difference between the two ethnic groups and the two sexes. Also over one-third of the respondents agreed that infected individuals are sexually loose people. More Yoruba respondents

agreed to this than the Igbo respondents (41.4% vs. 36%). However in the in-depth and focus group discussions, more of the Yoruba participants spoke against the view arguing that

*“It is not only through sexual intercourse that one can get the disease...”*

But among the Igbo,

*“It is the sweet thing that is bitter. It is his or her irresponsible behavior. If s/he is not loose, how did s/he come about the infection...”?*

Though in both ethnic groups, the two views are common. Some opposing and others supporting, depicting the extent and depth of the knowledge of the disease transmission.

While most respondents agreed that they should care for the infected and affected individuals, 56 percent would avoid caring for an infected close relation (54% among the Igbo and 34% of the Yoruba respondents). Majority would also avoid a shopkeeper who is infected. Avoidance behavior is also evident if a work mate is positive and a child will be withdrawn from a school where a mate is infected.

### **Symbolic Interaction**

In terms of symbolic interaction with persons living with HIV/AIDS, 51 percent claimed they would be comfortable shaking hands with an infected person (59% in Yoruba and 44% in Igbo). Close to one-third would be comfortable using same plate to eat, hugging an HIV-positive person, and one-fifth would share toilet with a PLWHA.

There is a significant ethnic variation in favor of the Yoruba than the Igbo.

For interaction with a partner infected, about two-thirds said they would be comfortable caring for an infected partner, sitting and chatting together with him or her. More of the Igbo respondents would care for their partners than the Yoruba but more of the

respondents would eat with an infected partner (43%), sleep together (41%). The concept of ‘sleeping together’ was confusing to the respondents. Most of the respondents that answered in the affirmative thought it meant physical sleeping on the same bed. When it was clarified that it meant having sex, almost all rejected that possibility, insisting that once their partner is diagnosed positive,

*“That is the end. S/he will not have sex with me again”, (Male, IDI).*

Some of the female respondents in the focus group discussion responded thus:

*R 1: “I will leave him and look for another person to marry”.*

*R.2: As for me once he is infected, there is high probability that I may be infected. So the little time we have should be lived in peace and love.*

*R.3: If we have not had sexual contact and it is discovered, we will call it quits.*

*R4: If we are married, we will stay together because marriage is for better, for worse. Otherwise, we will end the relationship.*

*R5: I will leave him if confirmed once we are not married but if we are married I will restrict him from having sexual intercourse with me. I will advice him to take drugs, eat good food. I will not allow him to have sex with me again... ”*

**Table 3: Ethnic and gender differentials in levels of stigma measures among a sample of Nigerian public, Nigeria 2003.**

Stigma measures	Total	Ethnic Group		Gender	
		Igbo (East)	Yoruba (West)	Male	Female
<b>1.Negative Feelings</b>					
Angry					
% Very/somewhat	45.3	56.4	32.0*	44.8	45.4
% A little/not at all	54.7	43.6	68.0	55.2	54.7
Disgusted					
% Very/somewhat	49.1	53.5	43.0*	48.3	49.6
% A little/not	50.9	46.5	56.9*	51.7	50.4

at all					
Afraid					
% Very/somewhat	56.3	56.3	56.3	54.6	57.4
% A little/not at all	43.7	43.7	43.7	45.4	42.6
<b>2. Coercive attitudes</b>					
Quarantine PLWHAs					
% Agreed	71.8	67.0	76.9*	69.2	73.8
Mandatory HIV Testing					
% Agreed	85.3	78.3	93.9*	85.2	85.6
Public Labeling					
% Agreed	47.1	50.8	39.2*	43.9	46.3
<b>3. Attribution of Blame</b>					
Gotten what they deserve					
% Agreed	57.3	51.8	63.2	59.4	55.7
Sexually loose people					
% Agreed	38.3	35.6	41.4*	37.8	37.5
Responsible for their illness					
% Agreed	55.4	55.7	55.0	53.8	56.5
<b>4. Avoidant behaviors</b>					
Avoid caring for an infected relation	55.9	53.9	33.9*	63.1	50.3
Avoid infected shop keeper	84.8	86.5	83.0	84.1	85.3
Avoid infected workmate	67.4	72.7	61.6*	65.0	68.9*
Avoid child in school of infected child	53.4	43.0	55.9	51.4	47.7
<b>5. Symbolic contact and interaction: comfortable with PLWHA in</b>					

Shaking hands	50.8	43.5	58.5	58.9	48.1
Using same plate	28.1	15.8	41.3	31.3	25.9
Working same place	48.6	41.9	55.6*	54.4	44.4*
Hugging	25.9	16.1	36.3*	28.4	24.2
Kissing	7.8	5.5	10.2*	8.8	7.1
Sharing toilet	20.8	14.8	27.1*	23.2	19.1
<b>With infected partner</b>					
Caring for him/her	63.1	67.7	58.3*	64.7	62.2
Eat with him/her	33.1	23.4	43.4	33.3	33.1
Sleep together	29.3	17.8	41.4*	33.2	26.4*
Sit and chat together	60.5	61.5	59.5	64.7	62.2
Move together	55.2	55.8	54.5	33.3	33.1

\* Significant at  $p < 0.05$

**Table 4: Multiple regression analyses showing the association between selected factors and stigma measures, Nigeria 2003.**

Stigma measures/ variables	Regression coefficients
<b>Negative feelings</b>	
Place of study	
Rural	-.188*
Urban	
Ethnic group (Igbo)	-.214*
Marital status	
Currently married	-.362*
Single	-.116*
Misconception of HIV transmission	0.329*
Constant	3.85
Prob > F	0.0001
R-squared	7%
Adjusted R-squared	5%
<b>Coercive policies</b>	
Place of study (Rural)	-.319*
Age	0.033*
Education	
None	-.677*
Primary	-.401*

Secondary	-.566*
Religion	
Protestant	0.013*
Catholic	-.152*
Muslim	-.624*
Marital Status	
Currently married	-.213*
Single	.277*
Media access (Yes)	0.383*
Misconception of HIV transmission (Yes)	0.356*
Constant	3.77; p>0.000
Prob > F	0.0000
R-squared	8%
Adjusted R-squared	6%
<b>Avoidant behaviors</b>	
Ethnic group (Igbo)	0.318*
Age	-.0219*
Religion	
Protestant	-.1625*
Catholic	.1843*
Muslim	.1317*
Marital status	
Currently married	-.515*
Single	-.814*
Constant	7.31; p>0.000
Prob > F	0.0020
R-squared	6%
Adjusted R-squared	3%
Attributions of Blame	
Ethnic group (Igbo)	0.489*
Age	0.025*
Educational level	
None	-1.1508*
Primary	-.14095*
Secondary	-.674*
Migration Experience (Yes)	0.414*
Media access (Yes)	0.565*
Non-sexual route of transmission	-.8176*
Constant	4.60; p>0.000
Prob > F	0.0000
R-squared	13%
Adjusted R-squared	11%
Overall Stigma Index	
Ethnic group (Igbo)	1.13*
Age	0.063

Education level	
None	-1.28*
Primary	0.362*
Secondary	-1.397*
Marital status	
Married	-1.039*
Single	0.317*
Media access (Yes)	0.643*
Beliefs about HIV transmission	
Non-sexual routes	-1.745*
Misconception	0.996*
Constant	21.15
Prob > F	0.0000
R-squared	13%
Adjusted R-squared	10%

A regression model was designed to estimate the effects of the significant variables in ANCOVA on the scales of stigma measures. Here the objective is to identify factors associated with the various stigma measures. The individual dummy variables' regression coefficients are interpreted as effects on mean scores of the stigma measures. For negative feelings, the coefficient of the first category of place of study (that is rural residence) equals -.188 and this means that the mean of negative feeling scale for rural respondents are about 81 percent lower than those of the urban respondents controlling for other variables. This is an indication that rural respondents are likely to have negative feelings towards PLWHAs than the urban respondents. The mean of negative feelings for Igbo respondents declined by 79 percent than those of the Yoruba.

For coercive policies, the positively significant variables are age, protestant religion, single, media access and misconception of HIV transmission. These are more likely to support coercive policies for persons living with HIV/AIDS. In the case of avoidant behaviors, Igbo ethnic group, catholic and Muslim respondents are more likely to adopt avoidant behaviors than their dummy groups. Furthermore, the mean scale for

attribution of blame increases for Igbo, catholic and Muslim respondents. Increase in age is likely to increase the mean of attribution of blame for PLWHAs. The older people are likely to blame the PLWHAs for their fate. Those that have migration experience and media access have more likelihood of attributing blame to PLWHAs. Thus migration experience and access to media do not have expected positive effect on stigma measures.

### **Overall Stigma Index:**

The ethnic differential continues to manifest in the overall stigma index. The mean overall stigma index for Igbos is about 1.13 points lower than those of the Yoruba with the same characteristics. With each increasing age, the mean overall stigma index decreases by 6 percent. The mean also increases for the single (31%), those with media access (6.4%) and those who have misconception of HIV routes of transmission (9.9%).

### **Stigma Measures and Utilization of Voluntary Counseling and Testing.**

One major assumption of this study is that stigma measures are major hindrance to access and use of voluntary counseling and testing for HIV status and or any other AIDS prevention, care and treatment program Here we measure the impact of the stigma factors on the intention to use VCT controlling for other independent variables. Table 5 includes the four stigma measures while the Table 6 includes only the overall stigma index.

**Table 5: Logistic regression showing the likelihood of utilizing voluntary counseling and testing services for HIV controlling for socio-economic characteristics and measures of stigma, Nigeria 2003.**

<b>Control Variables</b>	<b>Intention to use VCT services</b>	<b>95% Confidence Interval</b>
<b>Place of residence</b>		
Rural	RC	
Urban	0.813	0.489, 1.352
<b>Ethnic group</b>		
Igbo	RC	
Yoruba	1.04	0.597, 1.813
<b>Sex of respondents</b>		
Male	RC	
Female	0.604*	0.391, .9348
<b>Marital status</b>		
Currently married	RC	
Single	2.303*	1.289, 4.117
No media access	0.528*	.300 , .927
<b>Beliefs about HIV routes</b>		
Misconception	0.475*	.2744, .8224
<b>Stigma Measures</b>		
Negative feelings	0.6082*	.4779 , .7739
Coercive policies	0.8250*	.7300, .93234
Attribution of blame	1.1443*	1.029, 1.272
LR Chi2 (21)	74.42; Prob>chi2 = 0.0000	

Ns = not significant

Seven variables were found to be significant in this model. Urban respondents were less willing to utilize VCT services than the rural respondents. The Yoruba respondents also showed more likelihood to use VCT than their Igbo counterparts. Female respondents were less likely to use AIDS prevention services than their male counterparts. The educated respondents of different categories expressed more likelihood to use VCT services than the reference group, while other religious groups were less likely to intend to use AIDS services than the protestant groups. This seems surprising because in Nigeria, the Catholic Church is fully involved in care and support programs for HIV patients than other religious groups. Single respondents were 2.3 times more likely to express intention to use VCT services than the married. The major concern of

most married people interviewed in this study is what would be their partner's reaction if they are tested and perhaps found positive. Men would deny being responsible for the infection. In most cases the woman is abandoned and even punished by the community. Respondents that had no access to the media are less likely to use VCT, possibly because they have not heard of the existence of such health services. Those with misconception of routes of HIV transmission are less likely to use voluntary counseling and testing services.

In terms of stigma impact on the likelihood of accessing the use of voluntary counseling and testing services, the Table shows that as the score for negative feelings increase, there is less likelihood that one will use the VCT. The same response pattern is observed in the case of coercive policies. However, those respondents with higher scores of avoidant behaviors and attribution of blame are more likely to use VCT services than otherwise. Table 6 shows that the overall stigma index has a negative effect on the likelihood of use of VCT services.

**Table 6: Logistic regression of likelihood of utilizing voluntary counseling and testing services for HIV controlling for socio-economic characteristics and overall stigma index, Nigeria 2003.**

<b>Control Variables</b>	<b>Intention to use VCT services</b>	<b>95% Confidence Interval</b>
<b>Sex of respondents</b>		
Male	RC	
Female	0.6476*	0.4256, .98551
<b>Marital status</b>		
Currently married	RC	
Single	1.8356*	1.058, 2.9735
No media access	0.5355*	.3097, .92605
<b>Beliefs about HIV routes</b>		
Misconception	0.4756*	.3612, 1.0200

<b>Overall stigma index</b>	0.9238*	.8759, .9744
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Ns = not significant

**Discussion:**

There is a general understanding of the meaning of the term ‘stigma’. It is variously associated with social distancing and isolation. It is regarded as name-calling of an individual, a group that makes people to run away from the person stigmatized. It involved attaching negative value to a particular situation. *‘It is a disgrace, stain or blemish’*, participants in focus group discussions commented. Conditions commonly stigmatized according to the participants are epilepsy, mental illness, tuberculosis and HIV/AIDS.

On the consequences of stigmatization, the various respondents indicated the issue of name-calling, social distancing, isolation and depression.

*“Disclosure of HIV status can lead to public labeling. People will abandon you. If you were popular, your best friends will dissociate from you once you are diagnosed to be positive. A baby was recently diagnosed to be positive in the hospital, the father became depressed and vowed never to touch the child”*. (Female, educated, age 30-35; IDI)

*“The stigmatized person will feel lonely and loneliness can cause mental problem – depression, suicidal attempts. You will just discover nobody wants to talk to him or her. The problem of isolation and abandonment worsen the situation”*. Male, educated, age 40, IDI

A group of participants agreed that,

*“Stigmatization can lead to concealment of status so that people will not know. This will deny early medical attention. Concealment of status is one of the reasons why the infection cannot be controlled. A lot of people have the disease but do not want to declare publicly their status”*. – (FGD, women secondary education, aged 40-45).

There is awareness of impact of stigma on economic progress. In terms of economic effect, there will be less patronage of a trader or shop owner infected. Income will be spent on treatment and consultation. This diminishes income and affects the ability to meet other needs of the family. If a married individual, other family responsibilities like children's education will suffer. Consensus of opinion of participants in the focus group discussions is that ,

*“The disease is contagious and people do not want to be infected. By moving closer to the individual, you can easily contact the disease”.*

*“One major reason why HIV infected individuals are stigmatized is because of lack of treatment and care for those infected. People talk of screening, if you go for screening and there is no treatment, you are only creating problem for that person. If there are drugs at cheaper rates, then people will turn up to be tested and if found positive they will rely on the drugs. What is the need of knowing that you will die?”*

A health care provider pointed out that the disease is stigmatized because it is associated with sexual promiscuity and it is assumed that anybody with HIV/AIDS is promiscuous. People will look at you as a sexually immoral person. It is difficult to convince individuals that there are other routes of infection for the disease.

### **Mandatory HIV testing**

There is a general support for mandatory HIV testing, although most of the participants suggested that making the drugs available at cheaper rates in the market will help facilitate the utilization of voluntary counseling and testing services. Testing is further supported on the ground that

*“You will know those that are HIV positive”*

Most respondents recognized another danger in knowing one's sero-status. They pointed out that some individuals will deliberately infect others because these people believe that "they too were infected by others and also that they would not be the only ones to die" Major religious organizations have standing policies that intending couples must show evidence of HIV testing before marriage. This received support from most of the respondents.

*"I think it is highly essential for intending couples because there is no point going into marriage with one of them being HIV positive, and eventually infect the other sero-negative partner and subsequently the baby to be born into the family. What is the idea of bringing an HIV positive baby into the world? What is the need of marrying somebody who will soon die?" (Opinion leader, male).*

There are opposing views to that practice, however. Some other respondents maintained that people can die by any means and hence there is no need for mandatory testing.

*"It is demoralizing to know that you are positive. People will still die whether by AIDS or accident. HIV negative people die; positive people die also. Before you go to VCT centers to test, you did not feel any symptom. After the test, the result is positive and the trauma of knowing that your status will 'kill' you. So why should I desire to know my status" (Female, Opinion leader aged 45).*

### **Coercive policies**

The response patterns in the qualitative data are mixed: some supported policy of isolating sero-positive individuals while others opposed. Those that supported coercive policies i.e. quarantining persons living with HIV/AIDS or public labeling maintained that their view is predicated on the need to

*"Avoid their spreading the virus to others. Some people when they know that they are positive will try to spread the disease to us so that it is not only them that will die. There is the case of a boy who after knowing his status in the hospital had sexual intercourse with about twenty-four girls.*

*When accosted by the police after a tip-off, he said that since he got the infection from someone, he must pass it to others so that not only him will die.” (Health care provider, IDI)*

This is a common view among most of the participants. In the quantitative survey, 58.4 percent agreed that infected people do not mind spreading the virus to others.

A contrary view from a Church leader posited

*“They should not be isolated or quarantined. They should be encouraged because those infected need support from their family, friends and even the church. They should be educated on what to do or not to do now they are infected. We will be in a position to know the level we can be of assistance to them. No, they should not be quarantined”.* (Religious Leader, IDI).

There is also a common belief among the respondents that blame should not be attributed to persons living with HIV/AIDS because sexual intercourse is not the only means of infection. Some people might have gotten the disease through other means like when a girl is raped or through blood transfusion or in a barber’s saloon. There have been reports of armed robbers invading homes and decided to rape the females in such homes instead of robbing. Testing for HIV shows that they are positive. Carelessness can be another source of the infection. The participants in the group discussions agreed that it would be wrong to blame most of the infected people but however noted that ignorance borne out of lack of proper education and confusion being created by the mass media, contribute to the blame. They agreed that education on the various routes of HIV transmission should be intensified in the rural areas. Some church leaders expressed readiness to be trained as peer educators to reach out to their religious adherents. The faith-based organizations are unexplored resource for HIV/AIDS prevention in Nigeria.

## **Symbolic Interaction and Contact**

On Symbolic interaction and contact, two scenarios were presented viz, when somebody is infected and when a partner is infected. Attitudes to the two individuals vary. Most of the respondents insisted that their partners couldn't be HIV positive. However when the question was well explained, the respondents were forthcoming. One group would accept the status and encourage themselves to live well the rest of their lives. They would be encouraged to draw closer to their God since they will die. This group observed with regrets the unavailability of cheap HIV drugs in the market,

*“Though there are no drugs to cure the disease, there are some drugs in the market which can make one live a normal life at least as much as possible but the drugs are expensive and even not in the market.”* (Male community leader, IDI)

For married couples the response is that they will take some steps to protect their children.

*“If we are positive and knowing that it can be transmitted from mother to child, we will stop reproduction. If we have had babies, fine, we will screen them and if any of them is positive, we will as much endeavor to access treatment”.*

For colleagues in the same work environment, the response will be that of empathy and care. The first thing to do if one is diagnosed positive is

*“Not to appropriate blame but to show concern, support and advise on what to be done to manage the situation”* (male health worker, IDI).

In separate focus group discussions with a group of nurses and community leaders, some participants were positive while some were negative on what they will do if their partners were infected

Respondent 1: *“I will leave him and look for another person to marry”*

Respondent 2: *“As for me once he is infected, there is the possibility that I may be infected. So the little time we have to live I will make sure we live together in peace and love”*

Respondent 3: *“If we have not gone far socially and physically, and there has not been commitments, we will call it quits”.*

Respondent 4: *“If we are married, marriage is for better for worse. I will stay with him. But if we are not yet married, I will quit the relationship”*

Respondent 5: *I will confirm the test. Once we are married, I will restrict him from having sexual intercourse with one and will advise him on medication and good diet. I will not also go out to any other man but I will not allow him to have sex with me”*

Other female respondents in a community focus group discussion responded thus:

R1: *The only thing is to continue to pray for such person so that the disease can leave the person”.* This is an indication that some people in the community do not understand so much about the disease .

R2: *I will take care of him and take him to the hospital”.*

R3: *We should not run away from AIDS victims because they are still human beings. We will interact with the person, providing all the necessary emotional and physical support to make him happy.*

R4: *If we abandon an AIDS patient, he can die of depression...”*

For men, their response is thus:

R1: *What can I do? It is incurable. We continue to watch her till she dies...*

R2: *The person has become a masquerade that everybody will be running away from. One cannot move nearer her...*

R3: *I will be giving her occasional advice so that she will not commit suicide. She will be advised to move closer to God...*

R4: *If my wife gets the disease, she will see ‘pepper’. I will disown and disgrace her. I will use all means to discipline her. She is a disgrace.*

What is clear from the excerpts of these interviews is that stigmatizing behavior is based on the belief that HIV is by sexual transmission. There is the belief that PLWHAs

got the disease through their own irresponsible behavior, either through pre-marital sexual activity for adolescents or through extra-marital sexual relations for married people. Thus infected people are regarded as promiscuous, careless and unable to control themselves and hold their body. Even though the respondents maintained that the PLWHAs should be blamed, there is still element of empathy and support especially on the side of married couples that would show support to their partners.

Despite the flurry of AIDS prevention activities in Nigeria since the discovery of the first case of HIV in the country in 1986, AIDS stigma remains an uncharted area of research and intervention programs. What exist in Nigerian literature on AIDS stigma have been references to isolated cases of stigma most often exaggerated by the mass media. Though 80 percent of the sample in this present survey would be sympathetic with an infected individual, more than 50 percent hold negative feelings toward persons living with HIV/AIDS; same percentage believe they have gotten what they deserve, are responsible for their illness and slightly above one-third maintained they are sexually loose. These sentiments are also translated into actions of avoidance of an infected individual (56%), co-worker (64%) and a neighborhood shop owner (15%). Interaction with PLWHAs is possible if one is a partner (especially married partner) but not so possible if a friend is infected. Based on the the scores for the 5-item index of stigma, more than 50 percent of these respondents manifest HIV stigma to some extent. The stigma associated with HIV is promoted by various factors such as fear; the way the disease disfigures the patient, misconception of transmission routes, fatal nature of the disease.

Gender differences were obvious in this analysis, but not significant. Female gender showed more negative feelings to infected individuals than the male respondents. Also more of the women support coercive policies than men. More of the women also attribute blame to the infected than men. In symbolic interaction, the male respondents show more willingness to interact with HIV positive individuals than women. These differences are not significant but they contradict earlier studies, which tend to infer that men show more negative reactions to PLWHAs than women. However in the qualitative data, the women expressed more willingness to interact with an infected partner than an infected workmate. Generally, most respondents would interact with their positive partners than with an infected workmate.

Another significant highlight of this study is the manifestation of ethnic differential in AIDS stigma between the Yoruba in the Western part of Nigeria and the Igbo in the East. The later are more eager to avoid persons living with HIV/AIDS than the former. They also harbor negative feelings toward infected individuals. The Yoruba, on the other side, are eager to support quarantine of PLWHAs, mandatory testing, and attribute blame to infected individuals than the Igbo respondents. The Igbo demonstrate avoidant behaviors in the care of an infected relation, a shopkeeper and a work mate, and withdrawal of a child from a school where a child is infected with AIDS more. In terms of symbolic interaction and contact, the Yoruba respondents are more likely to interact with persons living with HIV/AIDS than the Igbo. These differences are statistically significant.

The level of socio-economic development could account for these ethnic differentials. The Western region of Nigeria is the most advanced part of Nigeria in terms

of infrastructures, education, and non-governmental organizational activities. Since the discovery of the pandemic in Nigeria, NGO activities (both national and international) have been concentrated in the Western cities especially Lagos and Ibadan. The wide gap in the level of perception and attitude by the Yoruba and Igbo could be attributed to this disparity. The Yoruba are more positive and progressive in outlook than the Igbo. However their support for quarantine and mandatory testing for HIV may be explained by the fact that a broad spectrum of the bloc was not interviewed. Hence this may be a result of sampling variability. The two areas selected do not constitute the representative areas of Yoruba and Igbo ethnic groups. The sample could have been biased. This may be also due to educational differences between the samples.

The effect of stigma on public health intervention is clearly shown by the logistic regression. This shows that overall stigma index influences the use of voluntary counseling and testing as the higher the stigma index, the less likely the respondents would use voluntary counseling and testing. This study underscores the need to reduce AIDS stigma and promote compassion toward PLWHAs in conjunction with correct information about risk. Such efforts should be spread out to other parts of the country especially in areas with the higher HIV prevalence rates. There is also the need to provide correct information about HIV through sources that are credible to target audience. The leaders of various religions in Nigerian should be targeted for peer education training. They are a good resource that has not been adequately explored in Nigeria. Their knowledge of HIV/AIDS, progression, transmission and prevention should be updated. Schools and health units should also be educated further.

There should be a deliberate re-orientation of media managers who in most cases contributed to the stigmatization of the disease. An opinion leader in one of the in-depth interviews observed thus

*“They (the media) contributed to this problem. The way they narrated the story of HIV when it started and the picture they showed us still scare us and these have led to the stigma. Before we can accept persons living with HIV/AIDS fully, the media should re-do the harm they have created...”*

Current policies of some religious groups to demand for pre-marital voluntary counseling and testing for HIV should be encouraged, though the fundamental rights of the individuals should not be trampled upon.

The societal elites should also be addressing their colleagues and associates. Interacting with an infected individual does not transmit the disease unless an “individual goes out of decency, having promiscuous sex all around or getting blood transfusion from mushroom clinics.”

Home videos, radio jingles, news media etc should be mobilized to embark on programs to de-stigmatize HIV. AIDS education should be integrated into the curriculum of teaching in the country from the primary school to the tertiary levels. Further suggestions to address the stigma issues in AIDS prevention include

1. Most intervention programs in the country lack theoretical foundation. Theoretical models should be used to design interventions to change attitudes and demystify the felt threat of HIV/AIDS. Such models as social cognitive theory and labeling theory should be used. There should be direct empowerment of those stigmatized groups such as commercial sex workers and persons living with HIV/AIDS. The current activities of PLWHAs in Nigeria need to be evaluated; their needs

reinforced. The guiding question will be how far has their participation in prevention programs influenced stigma perception and attitudes by the public. Corollary to this is how the active PLWHAs managed their personal and public stigma experience? A recent evaluation of an intervention study in Nigeria did not show any significant impact of involvement of PLWHA in ABC activities contrary to what has been obtained elsewhere. Perhaps, this is an isolated case. There has been suggestion to legislate against stigma but implementation would be a very difficult thing to do. It is possible to legislate against discrimination but not stigma.

2. Care, support and treatment programs should be taken more serious than before.

One point that respondents in this study emphasized was that there was no need to ask people to test to know their status since,

*“there is no drug to treat you if you are infected. Even if there is drug, what is the need to know that you have few years to die. It is a frightening nightmare. Unless people can be empowered to handle post-test status crisis. Knowing status has led some individuals to suicides, suicidal attempts and desperation to infect others”.*

Stigma and discrimination lead to feelings of hopelessness, loneliness, confusion and self-blame. Specific projects should target encouraging PLWHA to band together to encourage one another. Their association will break powerlessness. By bringing them together, this will lessen the burden of their hopeless feelings, confusions addressed by their sharing of experiences. It would not be out of place for government to fund the activities of persons living with HIV/AIDS. But again care should be taken to avoid fakes infiltrating the group for pecuniary motives. The sharing of idea, skills and opportunities can help lessen the burden of the disease,

stigma and discrimination. Coping strategies should be identified and be used according to the demands of the situation.

3. Campaigns should also move from fear to caring for PLWHA. Health personnel at the local level – primary health care centers, maternity homes, should be targeted. The Ugandan TASO model of de-stigmatization should be employed. TASO was a Ugandan NGO that provides support to PLWHAs. It established the slogan of “living positively with HIV/AIDS”. Much of its work was directed towards openness in relation to AIDS; PLWHAs and towards an openness for required behavior changes to halt or reduce the epidemic, such as practice of safer sex. This should form a part of ABC initiatives in AIDS prevention.
4. Efforts should also be made to de-urbanize current prevention activities in Nigeria. Locating VCTs in the metropolitan Teaching Hospitals in a situation where majority lack the resources to utilize health services at the teaching hospitals is counterproductive. Many health units are located in the rural communities. Most infected individuals in the urban cities travel to the rural areas to “die there” or to consult the local traditional healers or utilize the local health center where fee is low. Funders should make it a deliberate policy to ask their grantees to locate projects in the rural areas. Population-wise 65 percent of Nigerians are in the rural areas. In the urban centers, it is easy for infected individuals to access VCT sites; it is pretty difficult to own up to HIV in rural communities where relationship is primary and individuals well known. Village-level interventions spearheaded by local community associations, religious bodies should be encouraged.

5. Campaigns against stigma and discrimination should be upfront, clear and directed. The campaign should require the support of the high profile people in the society. The effect of this will be increasing openness about AIDS and limiting the negative effect of stigma on ABC campaigns. Education campaigns can help people to identify the inaccurate stereotypes about AIDS and replace these stereotypes with factual information. Contact with PLWHAs can yield significant improvements in attitudes about AIDS illness. Studies have shown that members of the general public who are more familiar with an illness are less likely to endorse prejudicial attitudes (Corrigan and Penn, 1999). Efforts also should be made to change internalized stigma. Programs should challenge hurtful attitudes about the self and replace them with beliefs that do not undermine the person's self-esteem.

### **Exploring AIDS Stigma Further.**

Various conferences have called for concerted efforts at addressing the problem occasioned by AIDS stigma. Though the major theme during the World's AIDS day of year 2002 was on stigma and discrimination, there is no tangible programs addressing the problem. The major concern and message is how to prevent further spread of the disease. Prevention, care and treatment programs have been set up such as voluntary counseling and testing services and treatment centers for the prevention of mother-to-child transmission. One does not know how much of the problem of stigma these programs address. It is because of stigma that a lot of people living with HIV/AIDS especially in the rural communities deny status, do not come out in the

open to tell their spouses, friends or families. People do not go for testing because of a number of reasons among which is shame, fear of rejection if they are positive, and claim of invincibility. The downside of this is that a lot of persons living with HIV/AIDS, unaware of their sero-status, continue with risk behavior, thereby spreading further the disease.

Stigma remains a major roadblock to effective response to the AIDS pandemic; understanding and counteracting it is therefore a major public health challenge not only in Nigeria but the whole of sub-saharan African region. To develop effective program, there must be collaboration between social, behavioral and public health specialists to provide necessary information that will guide development of effective programs to combat AIDS stigma. In Nigeria, research is needed

- To document experiences of stigma as well as resistance to it. This will involve studying PLWHAs, affected households and communities, and exploring what structures can be used to adapt to the epidemic
- During the fieldwork, participants in the focus group discussions noted that the fears they have about HIV/AIDS is due to the information from the media in the early stage of the disease. They opined that it could take time for them to be open about the disease and freely associate with infected individuals. Hence research is needed to examine the ways in which the various media – electronic and print, have influenced AIDS stigma. The questions to be addressed in this enterprise include (1) how does media dissemination of HIV/AIDS information affects public stigma of PLWHAs? (2) Do campaigns that increase audience

members' sense of personal risk for HIV also engender stigma for PLWHAs? In other words, how does the current national campaign to prevent HIV transmission engender stigma? (3) How does media report of disclosures of PLWHAs of their status affect public attitudes to people living with AIDS? (4) To what extent do the disclosure of sero-status by individuals affect public responses to AIDS? Providing answers to these questions will help to promote use of non-stigmatizing language, addressing myths that lead to fear, isolation and stigma.

- Research is needed to examine the attitudes of religious leaders to those infected with the diseases; identify religious teachings and values that promote stigma and those that do not; describe individuals religious responses to the pandemic in the various zones, and identify ways to prescribe strategies for ways in which the influence of religious groups can be mobilized and effectively used to reduce AIDS stigma and its consequences.
- This pilot study is a prelude to a study to examine the impact of stigma on AIDS prevention, care and treatment. Research is needed to identify the best strategies for involving health care providers to ensure that they are sensitive to the problems of AIDS stigma and understand how to minimize its occurrence and address its negative consequences. The role of traditional health institutions in the prevention, care and treatment of HIV/AIDS should be investigated. Majority of Nigerians have been

reported of patronizing these traditional healers. Understanding how this institution will play a significant role in reducing AIDS stigma is an important research focus. How do traditional health practitioners address HIV/AIDS-related prevention, care and treatment practices? How can we integrate traditional healers practices with Western orthodox approaches to provide optimal HIV/AIDS prevention and care services? Can such integration help increase the acceptance of VCT, patient well being and reduce stigma? What is the role of traditional health practitioners in relation to stigma and HIV/AIDS? What is the link between provision of care and treatment and stigma reduction?

- Research should also focus on the effect of stigma on persons living with HIV/AIDS as well as those at risk for HIV infection, e.g. CSWs? Research foci should include: a)documenting ways in which stigma affects PLWHAs (example, perceptions and fears associated with stigma, role of stigma on testing decisions, engaging in risk-reduction and physical and psychological well-being, b)developing strategies for mitigating the impact of AIDS stigma and to evaluate their effectiveness
- We should also investigate how stigma affects secondary targets – family, caregivers and advocates, and how they cope with their stigmatization.
- Further study is needed to identify the social psychological processes that underlie AIDS . Such social variables as the effects of interpersonal

contact with PLWHAs, the role of social reference groups in shaping individual attitudes and psychological variables.

- Studies should also examine the effect of HIV infection therapies on stigma reduction. How have the various programs: VCT, MTCT shifted public perceptions of the disease and hence the stigma? Are there new situations of HIV-stigma?

As Herek et al (1996) and Zulu (2001) have noted, “empirical research on AIDS stigma will fill important gaps in current knowledge and provide critical information for the design of strategies for overcoming the effects of stigma. Such a research has a potential for providing a better general understanding of how the many types of stigma function on the individual and social level”. Social, behavioral and public health researchers and NGOs in Nigeria should include de-stigmatization as a major component of their activities. As long as stigma remains poorly understood and widespread, it will prevent the society from effectively responding to the scourge. The ‘D’ in De-stigmatization should be added to the ABC initiatives so that we can have ABCD Approach. In other words, while we actively promote the initiatives for prevention of the disease transmission, there must be added impetus to the need not to stigmatize those already infected.

In addition, action research is needed to evaluate carefully designed intervention programs. Interventions based on current

knowledge should be designed and rigorous evaluations of impact done to determine their effectiveness.

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## **Acronyms**

PLWHAs = Persons living with HIV/AIDS

CSWs = Commercial Sex Workers

IDI = In-depth interview

FGDs = Focus group discussions.

