Olatunji RW, J AIDS Clin Res Sex Transm Dis 2014, 1: 002
DOI: 10.24966/ACRS-7370/100002

HSOA Journal of
AIDS Clinical Research and STDs

Research Article

Stigmatization and Discrimination against People Living with HIV and AIDS: A Study of Rural Dwellers in Kwara State, Nigeria

Rotimi Williams Olatunji[1]* and Kamaldin Abdulsalam Babatunde[2]

[1]Department of Public Relations and Advertising, School of Communication, Lagos State University, 21 Olufemi Street, Surulere, Lagos, Nigeria

[2]Department of Mass Communication, College of Information & Communication Technology, Kwara State University, Malete, Nigeria

Abstract

Acquired Immune-Deficiency Syndrome (AIDS), which is caused by the Human Immunodeficiency Virus (HIV), is a globally dreaded disease. However, stigmatization and discrimination of People Living With HIV and AIDS (PLWHA) has become a major research and policy challenge. The purpose of this exploratory study is to determine the predisposition of rural dwellers in Kwara State, Nigeria, to stigmatization and discrimination against PLWHA. The purpose of this exploratory qualitative is to determine whether or not rural dwellers in selected communities of Kwara State are aware of HIV and AIDS; investigate the attitude of subjects towards stigmatization of PLWHA; as well as determine the predisposition of rural dwellers in selected communities towards discriminating against PLWHA. In-depth interview sessions were held with nine (9) participants, made up of four (4) males and five (5) females who were selected using convenience sampling method from four of the purposively selected villages in the area of study. This study finds that rural dwellers interviewed were predisposed to stigmatizing and discriminating against PLWHA and concludes with appropriate recommendations.

Keywords: Attitude; Awareness; Discrimination; People Living with HIV and AIDS; Predisposition; Stigmatization

***Corresponding author:** Rotimi Williams Olatunji, Department of Public Relations and Advertising, School of Communication, Lagos State University, 21 Olufemi Street, Surulere, Lagos, Nigeria, Tel: +234 834716840; E-mail: rotimiolatunji@yahoo.com; olatunjiirotimi@gmail.com; Rotimi.olatunji@lasu.edu.ng

Citation: Olatunji RW, Babatunde KA (2014) Stigmatization and Discrimination against People Living with HIV and AIDS: A Study of Rural Dwellers in Kwara State, Nigeria. J AIDS Clin Res Sex Transm Dis 1: 002.

Received: August 30, 2014; **Accepted:** October 23, 2014; **Published:** October 30, 2014

Introduction

Acquired Immune Deficiency Syndrome (AIDS), which is caused by Human Immunodeficiency Virus (HIV), is a leading cause of death globally. Although cases of HIV and AIDS are found in almost all regions of the world, people living in low and middle income countries are the regions mostly affected. Recent data released by the World Health Organization (WHO) and published by Federal Resources AIDS.gov [1] show that nearly 70% of all people who are living with HIV in the world live in the sub-Saharan Africa; first cases of HIV and AIDS were reported in 1981. Also, an estimated 3.34 million children worldwide are living with HIV, most of who live in sub-Saharan Africa and were infected by their HIV-positive mothers during pregnancy, childbirth or breastfeeding. More than 700 children become newly infected with HIV each day, while about 2.1 million adolescents are HIV-positive, most are found in the sub-Saharan Africa (Federal Resources AIDS.gov.) [1].

The Central Intelligence Agency (CIA) in The World Fact book [2] states that as at December 2013, South Africa had the highest cases of HIV infection (6,070,800), followed by Nigeria (3,426,600) and India (2,085,000); Kenya (1,646,000), Mozambique (1,554,700), Uganda (1,549,200), Tanzania (1,472,400) and Zimbabwe (1,368,100). Fasuyi [3] states that HIV and AIDS can be contacted or contracted through transfusion of infected blood, sharing of needle or sharp objects that had been contaminated by the blood of infected persons, babies born of infected parents may be infected with HIV during pregnancy and through breast-feeding. Fasuyi [3] maintains that HIV is mostly contract enduring unprotected heterosexual or homosexual relationships with infected persons. It is for this reason that much stigmatization and discrimination has over the years been associated with contract or contact of HIV and AIDS, according to Orija and Oyekale [4].

The HIV and AIDS pandemic has gone through three notable stages, namely: the epidemic of HIV; the epidemic of AIDS; and the epidemic of stigmatization and discrimination [4]. Citing Campbell and Deacon, Orija and Oyelake define stigmatization as the "process of devaluing, labeling, and stereotyping that result in loss of status, unfair and unjust treatment and social isolation" [4]. Famoroti, Fernandes and Chima [5] observe that since the invention of Antiretroviral drugs (ARVs), life expectancy of HIV victims has continued to improve, which has changed the course of the disease from "a rapidly fatal disease to a chronic and manageable disease which invariably improves the quality of life" of PLWHA. In spite of this, stigmatization of PLWHA is on the increase because HIV is perceived to be infectious, generally associated with sexual immorality, homosexuality and drug use ; and AIDS is perceived generally as a life-threatening disease that is associated with a degradation of the body according to National AIDS Trust (NAT) [6].

Moreover, Adeyemo and Oyinloye [7] maintain that stigmatization occurs when the person contacting and contracting HIV is perceived to be responsible for having the disease; when the disease is generally misunderstood by the public, or when it is progressive and incurable, and when the symptoms of the disease

(HIV and AIDS), become difficult to hide. They conclude: "people infected with HIV are often blamed for their condition, and many people believe HIV could be avoided if individuals made better moral decisions" [7]. The first type of stigma, called "felt stigma", occurs within the individual victim who harbors self- negative feelings because of what he perceives to be the likely reactions from others, whereas, the second type of stigma, referred to as "enacted stigma" is the actual experience of stigmatization and discrimination [7]. "When stigmatization turns into action, it becomes discrimination [6]." Discriminatory practices include denial of rights to health, education and employment, and also manifest through involuntary screening of blood for HIV infection in order to deny infected persons access to job, deny them promotion in the work place or excluding them from social protection, or disclosure of HIV status to family members without the consent of victims. There are also discriminatory practices such as outright social ostracism, personal rejection, gossips, direct and indirect discriminatory laws that deprive PLWHA their basic rights [5], NAT [6] and Adeyemo and Oyinloye [7]. In addition, women are often blamed for HIV transmission or the transmission of other sexually transmitted infections: "Many women are blamed for the illnesses from which they and their husbands suffer" [7]. Discrimination and stigmatization against PLWHA, is equally a violation of the fundamental human rights of victims, in particular the right to be free from discrimination, including right to health [8]. The objectives of this study are to determine whether or not rural dwellers in selected communities of Kwara State are aware of HIV and AIDS; investigate the attitude of subjects towards stigmatization of PLWHA; as well as determine the predisposition of rural dwellers in selected communities towards discriminating against PLWHA.

Previous Studies on Stigmatization and Discrimination of PLWHA

Studies on stigmatization and discrimination against PLWHA address several aspects of life, including practices amongst medical professionals [9] Mahendra, Gilboru and Bharat, et al., [10] and Famoroti et al., [5], in the workplace [7] and practices at family and community levels [4,11]. Similarly, Nhamo-Murire, Cambel, and Gregson [12] examined influence of community group membership on stigmatizing attitudes towards PLWHA in selected locations in Eastern Zimbabwe, while Genberg et al., [13] was a comparative study of HIV and AIDS-related stigma in four countries. These studies show that PLWHA encounter stigmatization and discrimination everywhere they turn and in different nations of the world.

Deacon and Boulle [9] came out with a commentary on several studies on stigmatization and discrimination against PLWHA and conclude that health care workers in China showed demonstrated negative attitudes towards PLWHA It was reported further that higher-level medical personnel displayed prejudicial attitudes towards PLWHA in a higher dimension than junior counterparts; medical professionals with more years of education were reported to be more likely to discriminate against PLWHA than those with less number of years of education [9]. The researchers concluded that "Fear of infection rather than HIV knowledge influences willingness of health professionals to interact with PLWHA" [9].

In a related development, Mahendra et al., [10] investigated AIDS-related stigma in health care settings, using a public hospital in New Delhi, India. In-depth-interviews were held with hospital staff and HIV-infected patients. A total of 884 medical doctors, nurses and ward staff participated in the study. Findings indicate several manifestations of stigmatization and discrimination of PLWHA among medical personnel including disclosure of the HIV-status to patients' family members without the consent of victims; burning of the linen of HIV-infected patients; charging HIV-infected patients for the cost of infection control supplies; and the use of gloves only when dealing with HIV-infected patients. Other discriminatory practices against PLWHA include labeling of personal effects as well as official records of HIV-positive patients, and unwarranted use of precautions to prevent transmission, all suggesting that medical workers that are expected to be very knowledgeable about HIV and AIDS are as guilty, if not more guilty than the un-initiated regarding stigmatization of, and discrimination against PLWHA.

The study by Famoroti et al., [5] investigated the level of knowledge, attitude and discriminatory practices of Healthcare Workers (HCWs) in a tertiary hospital in KwaZulu- Natal, South-Africa regarding PLWHA It was a descriptive cross- sectional quantitative survey, with medical doctors and nurses in ARV clinic as target population. A total of 334 medical personnel took part in the study; majority of them (88.3%) are nurses while female personnel are more (87.7%) in the sample. Tests of hypotheses showed a statistical significance between demographic variables and knowledge of HIV and AIDS; occupation and knowledge; and gender and knowledge. In other words, medical doctors were (expectedly) more knowledgeable about HIV and AIDS than nurses; male medical personnel were more empathetic towards PLWHA than their female counterparts, but unlike Deacon and Boulle [9], medical doctors showed more positive attitude to PLWHA than nurses. However, like Deacon and Boulle [9], Famoroti et al., [5] conclude that "there is some evidence of stigmatization and discrimination in the treatment of PLWHA by HCW".

Moreover, Adeyemo and Oyinloye [7] carried out a study in Osun State, Nigeria to determine factors that predispose individuals to the stigmatization and discrimination of PLWHA in the workplace. A total of 275 employees, drawn from five major organizations in the study area, were randomly selected. The study concludes that conservativeness of values tended to be the best predictor of stigmatization and discrimination than gender and age. It recommends the need for advocacy groups, social workers and counselors to continue to reshape or re-structure attitudes of the public in support of PLWHA.

Asante [11] equally investigated the dimension and quality of social and psychological support PLWHA receive from medical officers and care givers in a Ghanaian hospital located in Accra. The sample comprised a total of 107 PLWHA (36.4% males and 63.6% females) who were receiving medical treatment at the malaria unit of the Korle-Bu Teaching Hospital, Accra. The study discovers that females living with HIV and AIDS experienced higher rates of stress, anxiety and depression than their male counterparts; similarly HIV-positive females received less social support from friends and family members than the male sufferers. Asante [11] consequently concludes with suggestions that if needed support is provided to PLWHA, they will be able to cope better with the disease.

A study in Nigeria, [4] investigated stigma and discrimination and willingness to purchase vegetables from PLWHA among rural dwellers. The data were generated from a total of 12,766 individuals drawn from several rural areas in Nigeria. Multi-nominal logistic regression analysis was applied on the data to determine the factors explaining willingness not to buy vegetables from PLWHA. It finds

that level of knowledge about HIV and AIDS among respondents was high since 83.6% had heard about the disease, but a majority (90.2%) had never submitted themselves to HIV testing. Also, a majority (67.8%) believed that one cannot contract or contact HIV through mosquito bites and a majority (68%) would not buy vegetables from HIV-positive vendors. The study concludes that unwillingness to purchase vegetables from PLWHA poses a serious threat to the development of agriculture in Nigeria; it also threatens the economic well- being of HIV-positive persons. This, according to the study, calls for increased public education.

Genberg et al., [13] was an assessment of HIV and AIDS-related stigma and discrimination from households drawn from four different countries including Tanzania, Zimbabwe, South Africa and Thailand. It analyzed negative attitudes and perceived acts of discrimination towards PLWHA. The study discovered that participants who never heard about HIV test manifested negative attitudes towards PLWHA, while lack of knowledge of ARVs was associated with negative attitudes towards PLWHA; and that the more the information, education, and communication about HIV and AIDS is made available, the lower the HIV-related stigma. The study carried out by Nhamo-Murire et al., [12] draws attention to the role of community group membership in the reduction of stigmatization and discrimination against PLWHA. The study relied on data collected on community group membership in Manicaland Province in Eastern Zimbabwe in twelve locations made up of two small towns, tea and coffee estates, forestry plantations, roadside trading settlements respectively, and four subsistence farming areas. The study revealed that persons in community groups were less likely to express stigmatizing attitudes towards PLWHA.

The present study is similar to the one carried out by Orija and Oyekale [4] and Nhamo-Murire et al., [12] in the sense that it investigates stigma and discrimination against PLWHA in rural areas of Nigeria and that the respondents are largely illiterates. It however differs in method of study and scope. The present study determines if rural community dwellers are aware of HIV and AIDS; attitude towards PLWHA and predisposition to stigmatization of PLWHA amongst selected rural community dwellers a local government area in Kwara State, Nigeria. Research design now follows.

Materials and Method

This is a qualitative research that relied mainly on in-depth interview to gather primary data on the subject of stigmatization and discrimination against PLWHA in rural communities. The interview method was adopted largely because subjects were largely un-educated and would otherwise have been assisted to complete self-report questionnaire instrument; and that in-depth interview enabled the researchers to probe deeper into the attitudes and motivating factors behind respondents' dispositions towards stigmatization and discrimination of PLWHA. Key Interview Informants (KII) was selected using convenience sampling since only those who agreed to participate in the study were interviewed.

This study was carried out in Moro Local Government Area, one of the 16 Local Government Areas of Kwara State, Nigeria. The study was limited to one Local Government Area because of the limited scope of the research and also that the selected area is predominantly rural; most of the inhabitants engage in arable farming and cattle raring. Nigeria's population census of 2006 puts the total number of people in Moro Local Government at 108,792. There are five distinct districts in the local government, namely: Malete, Lanwa, Ejidongari, Oloru and Ipaye. The present study was carried out in the Malete division (selected through convenience sampling) and it comprised the following villages:

Jehunkunmi, Ajanaku, Asomu, Gbugudu, Safari, Malete, Safari, Okoru, among others. Simple random sampling (using the ballot method) was adopted for selecting the four villages. As mentioned earlier the interviewees were selected using the convenience sampling method and include a total of nine (9) key informants - four (4) males and five (5) females. Moreover, the five (5) female respondents were mainly house wives of child-bearing age (between 20 to 35 years of age), although they were equally engaged in sundry farming activities.

An interview guide was designed by the researchers who were guided by the research objectives. The open-ended format of interview questions was adopted to allow for flexibility during interview sessions. Items included in the interview guide probed into interviewees' awareness of HIV and AIDS in terms of causes, mode of transmission, and knowledge of available methods of treatment; attitude of PLWHA; and predisposition of interviewees to discriminate against or stigmatize PLWHA.

The objectives of the study were explained and consent of respective interviewee was secured prior to interview sessions. Also, interviewees were assured of anonymity in research report. However, no ethical clearance was secured in view of the limited scope of the research and the non-existence of a competent body within the locale of the research. It was therefore the informed consent of the subjects that was secured prior to the generation of the primary data.

The initial draft of the instrument was presented to colleagues in the respective academic department of the two researchers and certified as comprehensive prior to its usage. Interview guide was pre-tested on another rural community that did not participate in the final research. The manner of interview sessions was face-to-face. Proceedings were first recorded electronically in the Yoruba Language, subsequently transcribed and back-transcribed to ensure that the original meaning intended by interviewees was retained. Salient points raised by the interviewees were adopted and reported in the results section of this study, using either extensive quotation of statements generated from each of the subjects, and a paraphrase where applicable. Respondents were identified using alphabets A- I, to guarantee anonymity of subjects, as previously explained.

Results

Results are presented based on three broad themes of the study: knowledge of interviewees in the selected rural areas about HIV and AIDS; attitude of subjects towards stigmatization of PLWHA; and predisposition of interviewed rural dwellers towards discrimination against PLWHA. "Participant A, B," were drawn from Malete Village; "Participants C and D" were selected from Safari village; Participants "E" and F" came from Okoru village; Participants "G.H and I" were all drawn from Elemere village. Relevant portions of the interview transcripts are cited under each relevant themes of the study.

Awareness of Rural Dwellers on HIV and AIDS

Aspects of the interview guide probed into the knowledge of subjects about knowledgeable about causes, symptoms and treatment of HIV and AIDS. During the interview, the researchers discovered that all nine interviewees had heard about HIV and AIDS as a disease. Every one of them was able to tell us about at least a symptom of the

disease and a method of prevention; although there are some misconceptions about the disease.

For example, "Participant "A" says: I know that HIV and AIDS exist and that it is not good for human beings because I know that it kills. I hear from people that it makes one sick and slim. People get it from others through using utensils of infected person or to cut oneself with sharp object used by infected person. Once infected the person will change facially and will look haggard. I heard that some people do survive it while others die of it. The duration of their death may be 2-3 years before they die. I know this.

Participant F spoke in the same vein: I know you can contract HIV and AIDS through infected sex partner, exchange of sharp object such as blade with HIV-positive persons, or catch it from local manicure or Aboki (Mobile (Hausa) manicure operators). I have not heard of any cured case before but people die of it; and thus it is incurable.

A further reference to the statement made by another interviewee (Participant I) also demonstrates that rural dwellers are aware of HIV and AIDS: I have an idea of AIDS and people say it kills. The body system of infected persons will change. They said it can be contracted through sexual intercourse. The disease is said to be incurable.

Analysis of responses of selected rural dwellers also reveals existing misconceptions about HIV and AIDS. Participants A and D said that HIV is contracted from sexual relationship with dogs; Participant F opined that "one can be infected by urinating on a spot where an HIV-positive victim had urinated"; and Participant I noted that the disease is prevalent among "soldiers in South African".

Again, we sought to find out sources of knowledge about the disease. Responses ranged from information from friends, family members, community health workers and the radio. Interviewees in the rural communities in the present study claimed that they relied mostly on neighbors for information on HIV and AIDS. Talking about the disease, Participant F remarked "They said it can be contacted from sexual partners and from medical operation. People say there is no cure for the disease". When asked to be specific about his sources of information, he was unable to name any. Only one subject told us that he heard about HIV and AIDS through the radio. "I hear from radio that one can get it with your sexual partner if he/she is not faithful and that one can get it from cuts/ wounds of infected persons. I never hear of its cure", says participant F. The foregoing shows that rural dwellers in the area of study are aware of the dreaded disease called HIV and AIDS, although there exists some degree of misconceptions about the disease.

Attitude of Rural Dwellers in Selected Communities towards Stigmatization of PLW HA

Attitude here refers to either a positive or aversive feelings towards PLWHA. Interviewees were asked about their likely feelings to PLWHA and provided varying answers. For instance, one interviewee ("Participant B") noted: I think the person with the disease deserves no love at all from family members because s/he has got what s/he was looking for. One should fear them and show hatred because of what she has brought upon herself.

"I dread to hear about those with the disease because I am scared whenever I hear that someone has it", opined another informant (Participant E), while Participant F, said: "I don't think they (HIV-positive persons) deserve love from anybody because the virus is contracted from illegal act and I don't think I would like them". Corroborating, "Participant I" agreed: "I believe PLWHA deserve no love at all. You see, if it is my wife that is positive I will just disappear one day and that is all. For me, I hate PLWHA." Specifically, Participant E said: I don't believe people with the disease deserve any love and are people one has to do away with and not to relate to. I dread to hear about those with the disease because I am scared whenever I hear that someone has it.

Again, "Participant F", echoes a view similar to that of "Participant E" when she says: "I don't think they deserve love from anybody because the virus is contracted from illegal act and I don't think I would like them". Similarly, "Participant I" agrees: "I believe PLWHA deserve no love at all. You see, if it is my wife that is positive I will just disappear one day and that is all. For me, I hate PLWHA." The foregoing shows that stigmatization of PLWHA does exist among rural dwellers in the area of study.

However, some interviewees (Participants "C", "D", "G", and "H") expressed positive attitude PLWHA. "People with the sickness (HIV and AIDS) deserve love from everybody because they are members of the society and are going through trouble during which time they need our love", observes Participant G. Similarly, "Participant D" agrees: "People with the sickness deserve love from everybody because they are members of the society and are going through trouble time in which they need our love". He concludes: "I do sympathize with these people". In addition, "Participant G" says "PLWHA deserve love and sympathy because of their conditions and we need to give them our love for the time being even though they are going to die". It is observable that rural dwellers with negative attitude towards PLWHA are predisposed to stigmatization of the victims whereas rural dwellers with positive attitude towards sufferers tend to be less inclined towards stigmatization.

Predisposition of Rural Dwellers in Selected Communities towards Discrimination against PLWHA

The last section investigates the predisposition of rural dwellers in the area of study towards discrimination against PLWHA. Items on the interview guide solicited responses on preparedness of rural dwellers to live under the same roof with HIV-positive persons, share eating utensils with victims, offer victims material support and so on. In the opinion of an informant, ("Participant "A"): If a member of my family has it, the person should be given a separate room or house to live. This is to avoid infecting others. I will not eat on the same dinning with the person or even eating the left-over food of the infected person.

Equally, "Participant "B" opinioned, If he or she is a family member, everything must be separated .We can no more eat together or share the same utensils or cloth. I have no love to show - I told you, she has gotten what she was looking for.

Also, "Participant E" concurred: "I will maintain a good distance from the people with the sickness." Another Informant ("Participant F") puts it more powerfully: "I can never stay together with them (HIV-positive victims) in the same house or compound. I cannot share household utensils with these people or eat with them".

"Participant I "equally expressed hatred for PLWHA when he said: I can never live with PLWHA; I told you I will leave my wife if she has it, who else can I stay with if that happens to my wife? You are going back (on this discussion); I can never share anything with PLWHA. I

believe they should be taken to hospital to stay there. I will not show any emotional support for PLWHA not even my wife.

It is apparent that the tendency to discriminate against PLWHA exists among key informants in the rural area where this exploratory study was carried out, although a few of the interviewees exhibited fewer predispositions towards stigmatization of PLWHA. Participant C) enthused:

I don't see anything bad in living with people with HIV/AIDS because they are human beings like us. Just like I don't mind living with them, I am ready to share utensils and other material such as cloths with PLWHA. I personally cannot neglect them for that reason.

Speaking in the same direction, "Participant "D" maintained he did not see anything bad in living under the same roof with HIV-positive persons. He concluded: "I am ready to render any support they need from me as long as I can provide it". Related to the above, "Participant G noted:

I am prepared to live of course with PLWHA. Yes I can share household utensils and eat and play with PLWHA; why wouldn't I do that after all I know I cannot catch it from these things. I believe that the victims deserve true love from us generally as human beings.

Finally, "Participant H" (female), from Elemere Village informed us that she was ready to "live with PLWHA" and share personal effects with victims, and even give financial support to victims, if there necessary. "I will show them my love and caring if that will do", she concluded.

Discussion

A major objective of this study is to determine the level of awareness about HIV and AIDS amongst people living in a rural community in Kwara State, Nigeria. Interview responses above show that the interviewees in the area of study are aware of the dreaded disease called HIV and AIDS; persons who exhibited negative attitude towards PLWHA tended to also stigmatize victims; and are predisposed to discriminating against PLWHA. Through in-depth interview sessions, it was revealed that all interviewees are aware of the HIV and AIDS scourge. This finding is similar to previous findings [4,5,10,11] showing that increased awareness on HIV and AIDS arises as a result of concerted efforts of all stakeholders including advocacy groups, governments and multilateral organizations. Findings reveal that sources of information about HIV and AIDS ranged from the interpersonal to media sources. One of our respondents admitted that she had heard about the disease through the radio. Again, this shows that the radio is an effective medium for dissemination of development-oriented messages to remote parts of any country. Therefore efforts to raise awareness about the dreaded disease through the radio and interpersonal sources should be sustained.

However, awareness about HIV and AIDS may not automatically translate to adequacy of knowledge about the disease. This is apparent to us in the present study arising from our finding that that there exists certain misconceptions about the disease among rural dwellers including the view that the disease can be contracted through human beings having sexual relations with dogs; humans urinating on the same spot with HIV-positive persons, and that the disease is only found amongst soldiers in South Africa. It should be noted that HIV and AIDS is a global scourge that is not limited to the armed forces (in South Africa); there are also pronounced cases of HIV and AIDS and among various professionals, occupational groups, gender and social classes in several countries of the world, but mostly in sub-Saharan Africa where Nigeria closely follows South Africa, with highest cases of HIV and AIDS globally (CIA).What this suggests to us is that interviewed rural dwellers expressed certain misconceptions about HIV and AIDS. Genberg et al., [13] show that the more the Information, Education and Communication (IEC) about HIV and AIDS is made available to a group of people, the lower the HIV-related stigma in such a community. The researchers concluded that: "initiatives which increase discussion about HIV/AIDS in informal settings and within existing networks may reduce negative attitudes towards PLHA" Genberg et al., [13] It is necessary to note that much of the stigmatization of and discrimination against PLWHA may have arisen, in part, from the hazy or partial knowledge people have of the disease, it may also have arisen as a result of fear of contracting HIV and AIDS.

Drawing from the work of Sherif, Griffin [14] identifies the three basic zones of attitude namely the "latitude of acceptance"; "latitude of rejection"; and "latitude of non-commitment" each of which may be located on several scales of a continuum. Thus, on issues considered crucial to a person's well- being, "then ego-involvement is at its highest when fear is deep-seated". However, "Ego-involvement seems to be lower when persons do not dwell on the adverse consequences of an action" Griffin [14]. Hence, Griffin explains that when people care less about an issue, their latitude of non-commitment seems to be wide unlike those who care. However, typically wide latitude of rejection symbolizes high ego-involvement. Persons who hold extreme opinions on either side of an issue often care deeply about it one way or the other.

Attitudes of individuals and groups toward stigmatization and discrimination against PLWHA can oscillate between those found within latitude of acceptance, latitude of rejection and latitude of non-commitment. In this study, interviewees expressed negative attitudes towards PLWHA with statements such as "the person with the disease deserves no love at all from family members"; "I dread to hear about those with the disease because I am scared whenever I hear that someone has it"; "I don't think they (HIV-positive persons) deserve love from anybody because the virus is contracted from illegal act and I don't think I would like them"; "I believe PLWHA deserve no love at all"; and "For me, I hate PLWHA.". This study reveals that persons with aversion for PLWHA, tend to operate within framework of latitude of rejection, may stigmatize and discriminate against them, and may exhibit high ego-involvement on the negative side, thus confirming the position expressed by Griffin [14] on latitude of rejection of negatively perceived phenomenon.

This study has equally shown, as Griffin [14] maintains, that people within the latitude of acceptance of an idea or a phenomenon, such as willingness to accommodate PLWHA, tend to exhibit positive attitude and be dis-inclined towards stigmatization and discrimination against PLWHA. This was expressed through claims such as: "People with the sickness deserve love from everybody"; "I do sympathize with these people"; and "we need to give them our love for the time being even though they are going to die".

We observe further that interview subjects with aversive feelings towards PLWHA tended to stigmatize and discriminate while those with positive feelings did not. Predisposition towards discrimination against PLWHA was shown by the interviewees through remarks such as: "the person should be given a separate room or house to live; "I cannot share the same utensils with HIV-positive persons; and "I will

maintain a good distance from the people with the sickness." According to Genber et al., factors inducing stigmatization and discrimination with regards to diseases (as HIV and AIDS) include perceived disruptive, intrusive, disfiguring and incurable nature of such a disease, along with its perceived high propensity for transmission. In the present study, it is more of the perceived infectious and contagious nature of the disease that explains the stigmatizing and discriminatory attitude towards PLWHA. In a review of researches conducted among Chinese health personnel, Deacon and Boulle [9] observe that "Fear of infection rather than HIV knowledge influences willingness of health professionals to interact with PLWHA". In the present study also, interviewees were predisposed towards discrimination against PLWHA because of the fear that the disease is both infectious and contagious. For this reason, Deacon and Boulle [9] suggested that HIV and AIDS education should be provided to reduce specific fears of infection. It is also to be pointed out that none of our interview subjects identified discriminatory practices against PLWHA as acts constituting gross human rights violation. A publication [8] sensitizes stakeholders on the need to respect the fundamental human rights of HIV-positive persons by reframing from stigmatization and discrimination against PLWHA.

In addition to this, views held by interviewees that HIV can be contracted through "illegal" sexual acts may explain their predisposition towards stigmatization of PLWHA. Key informants seem to see themselves as being morally superior to HIV-positive individuals. One of them said that HIV- positive persons deserve no love because they brought the disease upon themselves through illicit sexual relationships. This confirms earlier works [6,8] and Adeyemo and Oyinloye [7] that PLWHA are often stigmatized and discriminated upon because they are perceived to have contracted the disease through immoral sexual acts.

Limitations of the Study

This is an exploratory study with a highly limited number of interviewees along with the scope of geographical coverage. This implies that the results of the study cannot be generalized. It is suggested that future studies should expand the scope of the present one in terms of geographical coverage, number of subjects and the use of a combination of instruments including self-report, open and closed ended questionnaire and focus group. However, the merit of the present method of study is that it enabled the subjects to disclose their true feelings, dispositions and knowledge about PLWHA in their own words. Also, although a small scale research, the findings of the present study confirms results of other ones that are of larger scale, which shows that stigmatization and discrimination of PLWHA is a critical issue deserving policy and other interventionist measures.

Conclusion and Recommendations

This study shows that interview subjects were aware of the disease called HIV and AIDS but some still have certain misconceptions about the disease. Accordingly, it is suggested that relevant government agencies and media operators should strengthen health awareness campaigns on the disease by providing more accurate information on mode of transmission and treatment of HIV and AIDS.

In addition, this study concludes that fear of contracting HIV and AIDS account in large part for the stigmatization and discrimination of victims. Social judgment theory suggests that the more strongly a person feels about an issue, the higher the latitude of his rejection or acceptance of that issue. Persons with aversion for PLWHA tend to stigmatize and discriminate against PLWHA. Griffin [14] suggests that the implication of social judgment theory on communication campaigns is that awareness campaigns must be aimed at shifting positions from one latitude (of rejection) through the latitude of non-commitment to one of latitude of acceptance. This means that health campaigns to discourage stigmatization and discrimination should initially shift audience positions from one of hostility, through neutrality, to one of accommodation and empathy towards PLWHA.

In conclusion, we recommend that the different levels of government in Nigeria, multilateral organizations, advocacy groups and other stakeholders should provide more accurate Information, Education and Communication (IEC) campaigns, along with effectively coordinated health programs to address the challenge of stigmatization and discrimination of PLWHA. Such communications and programs should equally allay fears on the perceived infectious nature of the dreaded disease. Positive dispositions towards PLWHA has potentials for motivating victims to disclosing their HIV status so that they can promptly access increasingly available facilities and treatment options, with potentials for positively impacting the well-being of HIV-positive persons and public health in general.

References

1. Federal Resources (2013) PEPFAR & Global AIDS: Global AIDS Overview, USA.
2. https://www.cia.gov/library/publications/the-world-factbook/rankorder/2156rank.html
3. Fasuyi OO (2012) Spousal Communication and the adoption of HIV preventive strategies among couples in Oyo State. University of Ibadan, Nigeria.
4. Orija A, Oyekale AS (2012) Stigma, Discrimination and willingness to buy vegetables from people living with HVI (sic) and AIDS. Life Science Journal 9: 2094-2100.
5. Famoroti TO, Fernandes L, Chima SC (2013) Stigmatization of people living with HIV/AIDS by healthcare workers at a tertiary hospital in KwaZulu-Natal, South Africa: A cross sectional descriptive study. BMC Medical Ethics 14: 6.
6. National AIDS Trust (NAT) (2003a) An epidemic of stigma and discrimination. Fact Sheet 1, USA.
7. Adeyemo DA, Oyinloye AA (2007) Pre-dispositional factors in stigmatization and discrimination against HIV/AIDS seropositive persons in the workplace: A case of Osun State, Nigeria. Journal of Social Science 15: 279-292.
8. NAT (2003b) The impact of HIV/AIDS stigma and discrimination. Fact Sheet 2, USA.
9. Deacon H, Boulle A (2006) Commentary: Factors affecting HIV/AIDS-related stigma and discrimination by medical professionals. Int J Epidemiol 36: 185-186.
10. Mahendra VS, Gilboru L, Bharat S, Mudoi R, Gupta I, et al., (2007) Understanding and measuring AIDS-related stigma in health care settings: A developing country perspective. Journal of Social Aspects of HIV/AIDS 4: 616-625.
11. Asante KO (2012) Social support ant the psychological well being of people living with HIV/AIDS in Ghana. Afr J Psychiatry 2: 340-345.
12. Nhamo-Murire M, Cambel C, Gregson S (2013) Community group membership and stigmatising attitudes towards people living with HIV in Eastern Zimbabwe. J Community Health 39: 72-82.
13. Genberg BL, Hlavka Z, Konda KA, Maman S, Chariyalertsak S, et al. (2009) A comparison of HIV/AIDS-related stigma in four countries: Negative attitudes and perceived acts of discrimination towards people living with HIV/AIDS. Soc Sci Med 68: 2279-2287.
14. Griffin EA (2003) A first look at communication theory. McGraw-Hill Higher Education, New York, USA.