HIV-RELATED KNOWLEDGE AND SOCIAL DISCRIMINATION IN SELECTED LOCAL GOVERNMENT AREAS OF LAGOS STATE, NIGERIA[1]

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Presented as a poster at 5th African Population Conference, December 10 – 14, 2007 at Arusha, Tanzania

Abstract

This paper assesses the manifestations and factors of HIV-related social discrimination within Epe and Lagos Mainland communities in Lagos state. The recent prevalence rate in Nigeria is 4.4%. Besides health consequences, HIV infection has accentuated the experience of social discrimination. Data were collected from a cross-sectional sample of 1,611 from September 2005 to April 2006 through interviews and focus group discussions. HIV-related knowledge is impressive but one-quarter of respondents wanted PLWHA's movements restricted; 43% would not share toilets; cutlery (61%); nor rooms with them (30%); 39% would not purchase goods from them. The findings suggest a discrepancy between HIV-related knowledge and discrimination despite an inverse relationship found among those who knew that a healthy-looking person could be with HIV/AIDS. Other significant predictors are education ($p<0.05$) and place of residence ($p<0.001$). Domestication and enforcement of international legal instruments to protect the rights of PLWHA and comprehensive HIV education are recommended.

INTRODUCTION AND STATEMENT OF PROBLEM

Nigeria is the most populous country in Africa with a population of 140 million people (provisional figure announced in December, 2006). Since the first AIDS case was identified in 1986 about 3.8 million people have been infected by HIV pandemic (FMOH, 2004). The prevalence rate has increased exponentially from 1.8% in 1992 to 5.8% in 2001 (Nigerian Institute of Medical Research (NIMR), 2000; National AIDS & STD Control Programme, (NASCP), 2002) but it is currently experiencing a downward trend since 2003 from 5% to 4.4% in 2005. This indicates that the total number of people infected is 2.86 million (Federal Ministry of Health (FMOH), 2006). Nigeria has one of highest number of people living with HIV/AIDS. HIV/AIDS decimates populations and PLWHA not only suffer the health consequences of the infection but also experience social discrimination (FMOH, 2003; National Population Commission [NPC], 2004). The late 1990s witnessed a paradigm shift from health to social issues which established the implications of social discrimination. Discrimination ravages the social fabrics of the society; translates into human rights violation and is widely acknowledged as one of the major challenges facing successful care and prevention (Parker and Aggleton, 2002). Fear of discrimination may cause individuals living with

[1] This article is an extract from my on-going Ph. D. thesis titled "Social discrimination, social structure and care/support of people living with HIV/AIDS in selected areas of Lagos state, Nigeria.

HIV/AIDS to be less inclined to live freely, declare and/or acknowledge their HIV status (FMOH, 2003). Furthermore, discrimination may cause them stress, low self-esteem, suicide, unemployment, and dislocation.

Discrimination is any form of distinction, exclusion, restriction or unfair and unjust treatment affecting a person by virtue of a personal characteristic. On the other hand, knowledge of HIV infection is the ability to identify correctly the modes of transmission and prevention and being able to know that a healthy looking person can be living with the virus and that AIDS has no cure for now. Also to be considered are the cultural conceptions and perceptions of HIV/AIDS. Cultural values and beliefs may affect the way people perceive PLWHA. Erroneous beliefs and lack of knowledge of HIV/AIDS may promote negative attitudes and behaviours toward people with HIV/AIDS.

Families are the primary caregivers to sick members. However, it has been discovered that not all family responses are positive. Akparanta-Emenogu (2002) reported that a 27 year old PLWHA was ejected from her house by her husband when she tested HIV positive. Another female PLWHA with an 8 month old baby was reported to have been evicted by her husband when he learnt she was HIV+ (Udom, 2004). She went to succour with her family but she was also rejected and abandoned. The 2003 National HIV/AIDS and Reproductive Health Survey (NARHS) revealed that only 22% of South West respondents were willing to share meals with PLWHA, 31% would allow a PLWHA child in school; 11% would buy food from a PLWHA and 31% would work with an infected colleague. The results further showed that the level of discrimination was seen to be low among respondents with higher education and people aged 15 – 19 were found to be the most discriminatory (FMOH, 2003: 84 – 85). Another finding underscored the power of discrimination to extend to the economic realm. In Nnewi, South East Nigeria, a pastor, Reverend Awa Madu stopped buying chicken from a poultry farm when he heard that the manager of the farm was being suspected to be HIV+ (Adirieje, 2003). Furthermore, some churches have been known to mandate prospective couples to have HIV tests done before they wedded.

In view of the above, understanding the manifestations and factors of HIV-related social discrimination within Epe and Lagos Mainland local government areas (LGAs) in Lagos state becomes very germane. There are relatively few empirical data on HIV/AIDS-related discrimination in Nigeria and in the metropolis of Lagos state in particular. Most of the literature related to HIV-discrimination focus on policy and regulatory concerns. Considerably, less attention has been devoted to its correlation with knowledge of HIV infection. It is against this backdrop that this paper is conceived. The questions then are: What are the cultural conceptions and perceptions

of HIV/AIDS in Lagos state? How receptive are the people of Lagos in interacting with PLWHA? What facets of HIV-related knowledge promote discrimination against PLWHA in Lagos state? This article attempts to answer them. Hence, the thesis of this paper is that ignorance promotes intolerance, negative feelings, attitudes and behaviours towards the people living with HIV/AIDS. The paper argues that knowledge of HIV infection, characterized by mode of transmission (sexual intercourse), mode of prevention (use of condoms), knowing that a healthy-looking person could be a carrier and respondents' conception of HIV, plays a role in determining who will or will not discriminate against the PLWHA.

THEORETICAL FRAMEWORK

Theory of spoilt identity

Erving Goffman, is a symbolic interactionist and a well-known social anthropologist whose theory on stigma and discrimination predates HIV epidemic. Goffman (1963) advances that anyone who exhibits a gap between what he/she ought to be, ***"virtual social identity"*** and what he/she actually is, ***"actual social identity"*** (Ritzer, 1996:358) has spoilt his/her identity. This socially constructed identification lays the foundation for discrimination against PLWHA who are perceived to have spoilt their identities. This theory has been criticized by Foucault (1978) and Bourdieu (1979) for focusing on individual attributes rather than on broader social processes, especially from relations of power. It was, therefore, proposed that stigma and discrimination be analyzed within the frameworks of concepts of power, dominance, hegemony, and oppression (Parker and Aggleton, 2003).

Cultural theory

Desclaux (2002) asserts that discrimination against HIV-infected persons is based on myths and misconceptions of HIV/AIDS. According to her, attribution of a "foreign" origin to the disease, compounded by the near-universal representation of others as dangerous, is at the root of forms of exclusion that the perpetrators often defend as a means of protecting their own social group. Also the interpretation of the disease as punishment involves holding PLWHA culpable for their status. She further avers that this is rooted in age-old explanation that a disease is caused by violating taboos, which is punishable by supernatural powers. This explication regards AIDS as the consequence of a failure to observe social norms and patients as guilty persons who have been punished and have to bear the consequences of their reprehensible behaviours. Because of its links with behaviour relating to sex and blood, both carrying high symbolic charges, HIV infection particularly lends itself to this interpretation legitimizing rejection and condemnation. This paper, therefore, is anchored on the cultural theory of Desclaux.

METHODS

Epe LGA, a riverine area, had a population of 101,464 as at 1991 census (NPC, 1997) which is currently estimated to be 107,655 (COMPASS, 2005). It includes a number of isolated villages or settlements predominantly occupied by the Ijebus, a Yoruba sub-ethnic group. The people are predominantly farmers, polygynous, and Muslims. The LGA was chosen because of her high HIV prevalence rate (6.9%) in 1999 (NIMR, 2000) although 2003 estimate was 4.2% (FMOH, 2004)). Factors identified as driving the HIV infection include poverty, promiscuity, low economic status of women, early marriages that lead to early separation, polygyny, changing spouses, skin scarification (FHI, 2001) and fish farming. Fluctuation in fish catch leads to high migration flows among fishermen who leave their wives behind and thereby are predisposed to multiple sexual partners (Elwange and Nahamya, 2005). The LGA has 17 health facilities (COMPASS, 2005).

On the other hand, Lagos Mainland LGA had a population of 273,079 by 1991 census (NPC, 1997) and a current estimate of 615,715 (COMPASS, 2005). Some parts of the LGA are densely populated (such as Makoko, Ebute Metta, Iwaya, Akoka, Ijora and Otto) while others are of low density (e.g. Yaba, Jibowu and Sabo). Lagos Mainland LGA is chosen because of her urbanized status with an admixture of immigrants and in-migrants of different ethnic groups though there is a few rural settlements (Makoko and Iwaya). The LGA stands out because of many features such as the Nigerian Railway headquarters at Iddo, tertiary institutions, military bases and military referral hospitals, motor parks for luxurious buses that harbour long-distance drivers, travellers, students, urchins, area boys, *alaye boys*, drug users, female sex workers and youths. Other predisposing activities to the risk of HIV/AIDS include ear, nose and eyelid piercing, nail cutting and circumcision with unsterilized instruments. Situated in the LGA, are 10 health facilities (COMPASS, 2005). Her HIV prevalence rate is not stated but it is estimated to fall within the range in Lagos metropolis i.e. between 1.7% in Lagos Island LGA and 7.7% in Ikeja LGA, the state capital (FMOH, 2004).

SAMPLE AND SAMPLING TECHNIQUES

Stratified, multistage and systematic sampling techniques were employed to select the households and respondents that were visited. The two LGAs were demarcated into enumeration areas (EAs) as delineated by the 1991 census. A total of 40 EAs (25 from Lagos Mainland and 15 from Epe) were selected by the use of table of random numbers. Then, the streets, quarters and houses were chosen by systematic sampling techniques. Thereafter, a cross-sectional sample size of 1,611 which was proportionally computed based on 1991 census proportions of urban to rural dwellers (93.4% urban to 6.7% rural) and males to females aged 18 years and above (54% of men to 46% of women) in

Lagos State were selected. Hence, there were 870 (783 urban and 87 rural) men and 741 (667 urban and 74 rural) women implying that 161 respondents from Epe and 1,450 from Lagos Mainland were surveyed.

THE RESEARCH INSTRUMENTS

In addition to desk review of secondary data, two modules of semi-structured interview schedules and two FGD guides to correspond to the two study groups were developed. The interview schedule had two sections with 70 questions on the following topics. Section 1 contained socio-economic characteristics while section 2 had questions on the conception and ethnic perception of HIV/AIDS, interactions with PLWHA, symbolic contacts, beliefs about transmission and attitudes towards PLWHA. The interview method was complemented by focus group discussions (FGDs). An FGD guide was developed to correspond to the key questions in the interview schedules. A pre-testing of the research instruments was conducted in Mushin community outside the LGAs under study from September 20 – 24, 2005. Two members of the research team were involved in this pilot study. Based on the report, the interview schedules were modified and the final copies produced for the survey.

DATA COLLECTION AND ANALYSIS

Triangulation method of combining both qualitative and quantitative methods was applied to procure and analyse data. Data were collected from September 2005 to April 2006 using the instruments described above. Eleven experienced research assistants (RAs) were recruited and trained for three days to enhance the quality of the data collected. Data so collected were compiled, sorted out, cleaned, coded and analyzed using Statistical Package for Social Sciences (SPSS) and were also subjected to multivariate logistic regression analysis. There was a total of four sessions of FGDs (two per LGA) disaggregated by gender. The main objective of segregating discussants into gender groups was to prevent domination of the discussions by any particular gender and to obtain different views of men and women about HIV-related discrimination. Six people participated in an FGD session. The RAs who served as moderators and note takers coordinated the discussions. The discussions were tape recorded with full consents of the participants. In Epe, the FGD was conducted in Yoruba while those of the Lagos Mainland were in English language. The discussions were later translated and transcribed.

CHALLENGES OF THE STUDY

One major problem was related to EA maps that were obsolete. Some of the landmarks used as indicators for reaching the localities were unreliable, some could not be found as, they had either been replaced with structures or they had changed. For example, former Army Barracks in Epe

LGA which was one of the selected EAs is the present location of Lagos State University (LASU) Epe campus. Therefore, some of the landmarks were not so useful and identifying the selected starting points became a big problem. The contiguous EAs were then selected. Secondly, level of denial of the existence of HIV infection is still high. Some people did not want to be associated with it and hence refused to be interviewed. It was further reported that Muslims in Epe were uncooperative during the interview because the study period coincided with Ramadan fasting period. They opined that it was sacrilege talking about HIV/AIDS during that period. With the resilience of the research assistants, these problems were resolved as they arose.

FINDINGS

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF THE RESPONDENTS

Based on computed proportions of the sample, a total of 873 (54.2%) men and 738 (45.8%) women were eventually studied as indicated in table 1 below. The ages of respondents indicate that younger persons aged 20 – 29 years predominated in the sample constituting 53% and resulting in a mean age of 29.4 years. During the survey, research assistants (RA) reported that most adults were not met at home during the day. This could have been responsible for the overrepresentation of the youth in the sample. The next dominant age group represents those between 30 and 39 years (24%). Over three-fifths of the respondents were single while one-third was married. The divorced, separated and widowed respondents were very few. The predominance of young people is also reflected in their marital status. Forty-seven percent had either acquired tertiary education or were still in higher institutions and forty-five percent had secondary education (table 1). It could be said that the sample was moderately literate. Here again the dominance of youth in the sample is appreciated. Employment status of the respondents demonstrates that 39 (2.4%) of the respondents did not respond to the question. Among those who reacted to the question, more than one-half of the respondents were employed (representing 30% of self–employed and 29% in paid employment) while 38% of respondents were unemployed. The finding indicates the general level of unemployment in Nigeria. The official rate of unemployment in Nigeria is 54.4% (Soyombo, 2007). The predominance of unemployed could be attributed to the over representation of youth aged 18-29 years who could still be schooling. Almost two-thirds of the sample earned less than N20,000 per month. Disaggregating this proportion, one-half of the respondents earned less than N10,000. This includes the unemployed respondents who had no income. It indicates that majority of the respondents belonged to the low income bracket and corresponds with the employment status. About 15% received between N10,001 and N20,000 per month. Nineteen percent declined to respond to the question. This is one of the problems encountered in Nigerian researches. People are

reluctant and skeptical about revealing their salaries to researchers. They fear tax, rent increase and the like.

Out of the 1,611 respondents, 46% lived in single or two rooms known as room and parlour (face-me-I-face-you); 26% lived in 2 or 3 bedroom flats (table 1 below). The finding supports the economic status of the respondents. Just about two-thirds of the total respondents were served with pipe borne water. Out of these, 41% had pipe borne water connections in their houses while the other 24% used public taps. It is worthy to mention here that Lagos Mainland LGA is one of the old settlement areas in Lagos State which are well served with pipe borne water network. More respondents (16%) used water from boreholes than wells (0.8%) whereas 7% bought from vendors. Eighty-one percent (1,306) had water closets in their houses while eighteen percent used pit/bucket latrines, defecated into the lagoon or in the bush/field or riverside. It is surprising that pit latrines still exist in Lagos metropolis in this 21st century.

Table 1: Socio-demographic characteristics of general population respondents

Characteristics	Total N=1611
Gender	
Male	873 (54.2)
Female	738 (45.8)
Marital status	
1. Never married	1016 (63.1)
2. Married	531 (33.0)
3. Divorced/separated	39 (2.4)
4. Widowed	23 (1.4)
No response	2 (0.1)
Age groups	
1. 15-19	141 (9.0)
2. 20-29	830 (52.8)
3. 30-39	373 (23.7)
4. 40-49	145 (9.2)
5. 50-59	58 (3.7)
6. 60-100	24 (1.5)
No response	40 (2.5)
Level of education	
0 None	24 (1.5)
1. Primary	96 (6.0)
2. Secondary	726 (45.1)
3. Tertiary	759 (47.1)
No response	6 (0.4)
Employment status	
1. Not employed	611(37.9)
2. Self- employed	487 (30.2)
3. Paid employment	474(29.4)
No response	39 (2.4)
Monthly total income	
1. Less than N10,000	804(49.9)
2. N10,001 – N20,000	241 (15.0)
3. N20,001 – N30,000	90 (5.6)
4. N30,001 – N40,000	53 (3.3)
5. N40,001+	120(7.4)
No response	303 (18.8)

Table 1 Continued

Types of dwellings	Total
1 Single room	397(24.6)
2 Room and parlour	341(21.2)
3 Mini flat	191(11.9)
4 2 – 3 bedroom flat	419(26.0)
5 Duplex	85(5.3)
6 Single family house	170(10.6)
No response	8(0.5)
Main sources of drinking water	
1. Pipe borne water	654 (40.6)
2. Public tap	388 (24.1)
3. Well in the house	38 (2.4)
4. Public well	13 (0.8)
5. Bore hole	259 (16.1)
6. water vendors/ tankers	117 (7.3)
7. Bottled water	76 (4.7)
8. Others sachet/rain/streamwater	60 (3.8)
No response	5(0.3)
Types of toilets	
1 Bucket latrine/bush/riverside	26(1.6)
2 Pit toilet/latrine	266(16.5)
3 Water closet	1306(81.1)
No response	13(0.8)
Religion	
1. Traditional/ No religion	20 (1.2)
2. Christianity	1249 (77.5)
3. Islam	339 (21.0)
No response	3(0.2)
Ethnic groups	
Hausa/Birrom	30 (1.9)
Igbo	378 (23.5)
Yoruba	948 (58.8)
Others including Togolese/Ghanaian	230(14.3)
No response	25(1.6)

Source: Fieldwork, 2006

Over three quarters were Christians while twenty-one percent were Muslims (see table 1 above). The demographic structure of Lagos Mainland LGA reflects a preponderance of people of the Christian faith and this, more likely than not, accounts for the high representation of Christians. The dominant ethnic group in the sample is Yoruba (60%). This could be as a result of the predominance of Ijebus, a Yoruba sub-ethnic group, in Epe. Out of the remaining 40%, Igbos represented 24% and the rest were Edo/Esan, Ibibio/Efik/Ogoja/Obudu, Hausa/Birrom, Igala/Benue/Tiv/Idoma, Ijaw, Itsekiri, Urhobo and Togolese, Egun and Ghanaian as immigrants. The finding reflects the heterogeneous ethnic configuration in Lagos state.

CONCEPTION OF HIV/AIDS BY RESPONDENTS

Respondents' conception of HIV/AIDS will affect how they react and behave towards PLWHA. Therefore they were asked to state their understanding of HIV/AIDS. Astoundingly, more than one-half of the respondents perceived HIV/AIDS to be a deadly or killer or dangerous disease and to 15% it is an incurable or terminal disease. Some of their descriptions of AIDS were succinctly captured thus: *"Disease with no cure; It's a killer disease; Disease that shrinks people; disease that shortens life"*. Their conception may be premised on the early AIDS metaphors and stereotypes. However, 19% described it as a viral sexually transmitted infection (STI). A few of the respondents described it as a disease that sucks blood. *'Sickness that drains people', it is a disease that dries the blood'*. Among the category "others" are those who still deny the existence of HIV infection. For instance, one respondent said: *"I don't believe it exists, it is all lies"*. A 30 year old man said: *"I don't know much about it"*. Some of the respondents labeled it a disease of others by asserting that *"it is meant for the promiscuous ones; it is a disease contracted through risky behaviour"*.

For lay diagnosis, the respondents were asked to describe three physical signs and symptoms that would make them identify and diagnose AIDS. Diarrhoea, excessive weight loss, skin rashes, persistent sickness and fever, cough, hair loss and skin lesions ran through their responses. These mentioned signs and symptoms are consistent with clinical descriptions of AIDS but may not confirm diagnosis without HIV tests. As judged in lay terms, people may be diagnosed as having AIDS if they manifest any of these: '*tinted hair, paleness, peeled skin, getting thin, skeleton body; unnecessary sickness every time; stooling, headache, white tongue, high fever, continuous sickness and death; rashes on the body, stomach problem and boils'*

Cultural perceptions and meanings of HIV/AIDS by respondents' ethnic groups

Here are the various local terminologies of HIV/AIDS and their interpretations in various languages of Nigeria. **Benue state -** *'Ogbeiku' i.e. waiting for death'* i.e. incurable disease that eventually ends in death.

Edo - *'Ukiagbe'* means 'you cannot kill it i.e. an incurable disease. *'Ugedgbe Ikumewun'* -sickness from dog without cure.

Ghana –*'Edo Atike mele ewuo'* meaning incurable disease.

Hausa – '*Kanjamau'*. The concept describes the clinical manifestations of AIDS. When an AIDS patient manifests any of the signs such as diarrhoea, excessive weight loss, prolonged fever, cough and skin rashes, the person is said *to be suffering from AIDS i.e. kanjamau.* It also connotes "*something that doesn't listen to drugs; the final bus stop*" i.e. stubborn and incurable disease. Another meaning of AIDS in Hausa is '*Lahira salama alekum'. 'Heaven I'm on my way'; 'I'm coming'*. One is knocking on the door of heaven. All these expressions in Hausa indicate that once one is afflicted with HIV infection all hope is lost. The destination is death only.

Igbo – AIDS is *'Obiri na ja ocha"*- 'ends in the red earth or a disease that ends in the grave" i.e. incurable and death is certain. Also Igbos call it *'oya mminwu'*. This is the popular concept used by the media and it is described as a disease that dries the body i.e. extreme wastage describing one of the physical characteristics. *'Echi Eteka'* tomorrow is too far i.e. instant death.

Yoruba – The **Yoruba** have various names for it **–** *'Arun ko gbo ogun'* or *'arun tio gbo ogun'* or *'aisan ko gbo ogun' or 'aisan tio gbo ogun'* – All the expressions mean the same thing - ill-health that defies all medication. It connotes no cure. Other names in Yoruba include *'Kokoro ti nje ara'* disease that consumes or dries up the body. Again the physical manifestation is described. *'Arun meje meje*' – a disease that sucks blood i.e. a blood sucker. *'Olorun Esan* – God's revenge for sexual pervasion. It could also connote God's punishment. 'Ibinu Olorun' - God's anger. Some misconstrue it as gonorrhoea and call it *'Atosi'*. From the afore-stated, AIDS was characterized as a terminal disease, an inevitable death, loss of weight, blood disease and God's punishment.

KNOWLEDGE OF HIV INFECTION

Questions were asked on the mode of HIV transmission and prevention. The response categories were four: (1) Spontaneous yes (2) Prompted yes (3) No and (4) Don't know. In total, 1,427 respondents (90% of the total) acknowledged that HIV was transmitted through sex as against 149 (9%) who were prompted to know that sexual intercourse was a means of HIV transmission while 14 (0.9%) were totally ignorant of sexual transmission of HIV infection. Worrisome proportions believed HIV could be contracted through kissing infected PLWHA (37%), insect bites (24%), using public toilets with PLWHA (19%), sharing eating utensils with PLWHA (17%), swimming in the same pool with PLWHA (7%), hugging and shaking hands with an infected person (5%). The issue of kissing as a mode of transmission of HIV infection has been very controversial since HIV epidemic. Some argue that deep and rigorous kissing with a sore in the mouth could lead to HIV infection while others submit that the

quantity of the virus in saliva is so negligible as to cause an HIV infection. FGD respondents believed that AIDS could be transmitted by mosquito bites, through social contacts like sharing food or eating utensils, using a common toilet, or from a cough or sneeze and from contaminated food and water. This was expressed by all the female participants of the FGD, *"It can be gotten from food and water that we eat and drink if the food is not properly prepared and covered and if flies are allowed to perch on it, anything can happen".* All these expressions show a high level of misperceptions about transmission of HIV infection.

For prevention modes, use of condoms, avoiding injections with unsterilized needles and avoiding sharing contaminated sharp objects and having no other sexual partners were popularly mentioned. Others include avoiding blood transfusion of unscreened blood and blood products. About 43% mentioned abstinence; 83% opposed patronizing commercial sex work; delay of sexual debut (60%); avoiding kissing infected persons (46%). An interesting and astounding finding is the submission that people should pray to God (62%) and seek protection from traditional doctor to avoid contracting HIV infection (10%). This is very dangerous because praying to God and still display some risky and unprotected sexual behaviours will not prevent HIV transmission rather it exposes one to the infection. A high proportion of respondents (93%) knew that a healthy looking person could be a PLWHA. However, a significance proportion of the respondents did not believe that healthy looking people could be carrying the virus. Twelve percent of the respondents asserted that AIDS had cure. They listed drugs like Abalaka's medicine.

RESPONDENTS' FEELINGS, ATTITUDES AND BEHAVIOURS TOWARDS PLWHA

Respondents' feelings, attitudes and behaviours towards the PLWHA in the families and communities were examined. On the whole, 15% felt angry at the PLWHA (table 2 below). Their feelings towards the PLWHA are related to the perceived life style of the individual PLWHA as demonstrated by the FGD participants: Mrs. B, one of the FGD participants said:

> *"If I know the person is someone who was never promiscuous but somebody who went about life carefully I normally feel pity but if it was somebody that is known to be wayward, please why should I feel pity for such a fellow".*

In confirming that perceived life style is associated with social discrimination, here is another view from a female FGD participant in Lagos Mainland where a PLWHA was perceived to be a "nice girl" and that earned her sympathy from people:

> *"I pity them because I used to know a girl on the Island that had this disease, she was a nice girl, nobody can imagine how she came about this disease and everybody used to pity her she just died recently after having for like ten years, although she had a child who died earlier".*

This suggests that those PLWHA perceived to be promiscuous or immoral will be more vulnerable to social discrimination than others.

About 32% were scared of PLWHA. These findings suggest that the respondents are likely to discriminate against PLWHA. Over one-quarter of the respondents subscribed that PLWHA should be quarantined or isolated from other members of the communities for fear of contagion. These findings are corroborated by the findings of the FGDs. For instance, all female Lagos Mainland discussants agreed that the PLWHA should be separated from the public in order to protect the population.

> *If government can separate them from us it will be better because some people are wicked and can do anything. I heard once that a boy tested positive and he was a student in a higher institution. When he found out he was positive, he vowed to spread it. So you can imagine the evil such a person would do. That kind of person should not be allowed in public because if it's on ground already that once somebody tested positive, he or she would not go home but go to where the government has prepared for them, such a person would not be able to perpetrate such an evil act,* said one of them.

In supporting her statement another woman added:

> *You see, there was a time that when a person had measles or chicken pox, that person would be sent to a hospital and detained there until he recovered from the disease, that kind of thing is good. Once someone tests positive, government should have a hospital for them where they would remain until they are cured or until a cure is found for the disease*.

Also in table 2 below, 25% desired that PLWHA's movements be restricted to certain areas in their communities. Forty-three percent would not share toilets; cutlery (61%); or rooms with the PLWHA (30%). Almost two-fifths of the respondents would not purchase goods from neighbours who were known to be living with HIV/AIDS. The possible explanations for these findings lie in the misconceptions of HIV/AIDS and misperception of its transmission. This study had earlier revealed that the respondents thought that HIV could be contracted from toilet seats and from the mouth. There is no distinction between the responses of the interviewed respondents and the FGD respondents. For example, while some of the male participants from Lagos Mainland would buy nonperishable items from the PLWHA others would not patronize them irrespective of the type of items sold. One of the discussants said: *"I can't buy anything from the person because the person has HIV"*. Female discussants had a resolute negative response no matter what the PLWHA were selling. One participant exclaimed: *"WHAT? I won't go near the person no matter what he's selling"; 'even if they are selling "omo" (children)*. Results of Herek et al are supported by these findings. The proportion of the respondents who opposed this view (61%) would not mind purchasing from the PLWHA. They

reasoned that they would patronize the PLWHA just to show love and secondly that HIV infection is contracted only through blood contact. Moreover, the PLWHA need financial assistance.

Table 2: General population respondents' feelings and attitudes to PLWHA

Angry at PLWHA	**Total**
Yes	234(14.6)
No	1365 (85.4)
Total	1599 (100.0)
Afraid of PLWHA	
Yes	515(32.2)
No	1085 (67.8)
Total	1600 (100.0)
PLWHA should be separated	
Yes	445(27.9)
No	1151(72.1)
Total	1596 (100.0)
PLWHA's movement should be restricted	
Yes	390 (24.8)
No	1184 (75.2)
Total	1574 (100.0)
Willing to share same toilets with PLWHA	
Yes	909 (57.0)
No	686 (43.0)
Total	1595 (100.0)
Willing to share eating utensils with PLWHA	
Yes	626 (39.3)
No	968 (60.7)
Total	1594 (100.0)
Willing to share a room with PLWHA	
Yes	1111 (69.6)
No	485 (30.4)
Total	1596 (100.0)
Continue to buy from PLWHA	
Yes	963 (61.1)
No	614 (38.9)
Total	1577 (100.0)

ASSOCIATION BETWEEN THE HIV-RELATED KNOWLEDGE AND DISCRIMINATION

Many questions in the interview schedule measured social discrimination and its predictors but for the purpose of this paper unwillingness to share same toilets is adopted as dependent variable because the virus does not survive outside the body and toilets cannot constitute a medium for the spread of HIV infection not even in the case of any other STIs. Anyone who refuses to use the same toilets with a PLWHA is highly discriminatory. As earlier discussed, knowledge of HIV transmission was measured by asking questions on modes of transmission, mode of prevention, respondents' conception of HIV, knowing whether a healthy-looking person could be living with HIV/AIDS. The discrimination question was 'would you be willing to share the same toilets with PLWHA? There were two categories of responses: 'Yes' denotes willingness or non-discriminatory attitude or behaviour while 'no' is

unwillingness or discrimination. The predictive power of knowledge of HIV transmission was further subjected to multivariate logistic regression analysis. Other socio-demographic characteristics of the respondents were included in the analysis. Such variables are: gender, age, education, marital status, religion and place of residence.

The table 3 below indicates that 47% of women compared with 40% of men were disinclined to share the same toilets with PLWHA. Therefore, women are more likely than men to exclude PLWHA from using the same toilets. Among the 161 respondents from Epe LGA, 104 or 65% respondents said they would not use the same toilets with any PLWHA (see table 3 below). This proportion is greater than the proportion of respondents (41%) from the highly urbanized Lagos Mainland that held the same view. It can therefore be said that respondents from relatively rural Epe LGA are more likely than the respondents from Lagos Mainland LGA to isolate PLWHA. There is no significant difference between the responses of respondents aged 18 – 29 and those aged between 30 – 49 years. The older respondents aged 50 years and above (49%) are more likely than younger ones to avoid PLWHA. This may be attributed to level of education of younger generation.

Three-fifths of the never-married respondents would share toilets with PLWHA while divorced and separated respondents (54%) were found to be most discriminatory (see table 3 below). Therefore marital status may have a correlation with discrimination. Never married respondents are less likely to discriminate against PLWHA. Out of 23 respondents with no formal education, 16 (70%) were disinclined to share toilets with PLWHA (table 3 below). This level of discrimination declined to 59% with the respondents who had acquired primary education. It declined further to 50% and 35% among secondary school and tertiary education respondents respectively. Even the least percentage i.e. 35% is perturbing. There is a high level of discrimination despite the high level of education among the respondents. The findings show a steady and gradual decline of discrimination as the level of education increases. The findings therefore, suggest that there is an inverse relationship between education and this form of social discrimination.

Table 3: Distribution of respondents' characteristics including knowledge of HIV transmission by (un)willing to share same toilets with PLWHA

Characteristics of general population	Willing to share same toilets with PLWHA		
Gender	**Willingness**	**Unwillingness**	**Total**
Male	520(60.0)	346(40.0)	866
Female	389(53.4)	340(46.6)	729
Place of residence			
Epe	57(35.4)	104(64.6)	161
Lagos Mainland	852(59.4)	582(40.6)	1434
Age			
15-29	552(57.5)	408(42.5)	960
30-49	292(56.7)	223(43.3)	515
50-100	41(50.6)	40(49.4)	81
Marital status			
single/cohabiting	600(59.7)	405(40.3)	1005
Married	277(52.7)	249(47.3)	526
Divorced/separated	18(46.2)	21(53.8)	39
Widowed	12(52.2)	11(47.8)	23
Level of education			
None	7(30.4)	16(69.6)	23
Primary	39(41.1)	56(58.9)	95
Secondary	369(51.0)	354(49.0)	723
Tertiary	488(65.2)	260(34.8)	748
Religion			
Traditional/no religion	11(55.0)	9(45.0)	20
Christianity	726(58.7)	511(41.30	1237
Islam	169(50.4)	166(49.6)	335
Respondents' conception of HIV			
viral/acquired immune deficiency disease	183(64.7)	100(35.3)	283
fatal/incurable disease	610(55.3)	493(44.7)	1103
blood disease	31(58.5)	22(41.5)	53
others/don't know	43(55.1)	35(44.9)	78
Sexual intercourse			
Spontaneous yes	825(58.0)	599(42.0)	1427
Prompted yes	72(48.3)	77(51.7)	149
no/don't know	6(42.9)	8(57.1)	14
Use of condoms			
Spontaneous yes	656(58.5)	465(41.5)	1121
Prompted yes	156(52.7)	140(47.3)	296
No	77(58.3)	55(41.7)	132
Healthy looking person can be carrying HIV			
True	849(58.5)	603(41.5)	1452
False	36(43.4)	47(56.6)	83
Don't know	9(27.3)	24(72.7)	33

Source: Fieldwork 2006

Among religious groups, Muslim respondents were most discriminatory (50%). Christians (41%) were inclined to share same toilets with PLWHA than the respondents of no religion. The study reported that Muslims, particularly in Epe which is dominated by Muslims, refused to discuss HIV/AIDS which they claimed was forbidden during Ramadan fasting period. This is discriminatory and coupled with the fact that it has also been found that Epe rural respondents were more discriminatory than urban respondents. This may have explained the association found between Muslims and discrimination.

There is no discernible pattern of association found between respondents' conception of HIV infection and unwillingness to use common toilets with PLWHA. Those who denied the existence of HIV/AIDS/those who were ignorant and those who classified HIV/AIDS as fatal and incurable disease (45% each) were discriminatory compared with those respondents (42%) who perceived HIV/AIDS as a blood disease (table 3 above). Those who correctly defined HIV were found to be the least discriminatory. Forty-two percent of those who acknowledged that HIV was transmitted through sexual intercourse compared to 52% of those who were prompted in answering the question and 57% of the those who gave a negative answer and those who did not have any idea that HIV could be transmitted through this medium, would discriminate against PLWHA by excluding them from the use of toilets. By contrast, 58% of those who had the full knowledge of HIV transmission, 48% of those who were prompted to know that HIV could be transmitted through sex and 43% of the ignorant group would be favourably disposed to share toilets with PLWHA. These findings suggest a possible inverse correlation between knowledge of the transmission and unwillingness to use the same toilets with PLWHA (social discrimination) although the proportion that fully knew about HIV transmission and still did not want to share toilets with PLWHA is quite high and therefore worrisome. It suggests that the people have not fully comprehended the HIV pandemic. Similarly, for the use of condoms as protective device against HIV infection, those who were prompted (47%) as against 42% of those who knew spontaneously that condoms prevented HIV and 42% of ignorant ones were not favourably disposed to share toilets with PLWHA. On the contrary, Knowing that a healthy person could be a carrier has an inverse relationship with discrimination. The result shows that the ignorant respondents are most likely to isolate PLWHA (73%) compared to 57% of those who did not believe and 42% of those who were aware that a healthy looking person could be living with HIV infection.

LOGISTIC REGRESSION MODELS PREDICTING THE LIKELIHOOD OF DISCRIMINATING AGAINST PLWHA

Table 3 suggests that there is an inverse relationship between knowledge of HIV infection (knowing that a healthy-looking person may be living with the virus) and discrimination. This finding was confirmed by the logistic regression analysis. The ORs of (0.27) and 0.32 of those who knew and those who did not believe that a healthy looking person could be a PLWHA have negative regression coefficients of -1.33 and -1.13 respectively (see table 4 below). These indicate that those who were aware and those who did not believe that a healthy-looking person could be a PLWHA were less likely than those who were totally ignorant to discriminate against PLWHA. Table 3 also suggests that there is an inverse relationship between education and this form of social discrimination. This finding is supported by the logistic regression analysis in table 4 below although illiteracy is not a predictive variable. Table 4 below shows that primary education is a significant factor of discrimination (OR of 2.12$p<0.01$). The OR of 2.12 for primary education declined to 1.67 ($p<0.001$) for secondary education. Respondents with primary education are twice likely to avoid PLWHA than those with tertiary education which is held constant as reference category (RC). Similarly, those with secondary education are more likely to isolate PLWHA than higher educated people. In conclusion therefore, the higher the level of education the lower the level of discrimination against PLWHA. This is probably because educated people are more likely to be enlightened.

It has been observed in the cross tabulation analysis that respondents from relatively rural Epe LGA are more likely than the respondents from Lagos Mainland LGA to isolate PLWHA. In table 4 below, logistic regression with OR of 2.06 and an SE (0.72) was highly significant ($p<0.001$) for Epe respondents. Therefore place of residence has a significant predictive power on social discrimination against PLWHA. Epe respondents are twice likely than respondents from Lagos Mainland LGA to exclude PLWHA from the use of same toilets. This may be attributed to literacy level which is likely to be higher in the urban centres than in rural areas. Secondly, there could be more enlightened population and more publicity about the awareness of HIV/AIDS in urban centres than in rural areas. Another variable found to influence discrimination is gender. The negative regression coefficient of (-0.33) for the men signifies an inverse relationship i.e. women are more likely than men to deny PLWHA the use of toilets. This confirms the findings of the cross tabulation. Therefore gender and discrimination are related.

Table 4: Logistic regression models predicting the likelihood of discriminating against PLWHA

	Regression coefficient	Standard error (SE)	Odds ratio (Exp(B)	95.0% confidence interval (CI) for EXP(B)	
				Lower	Upper
Gender					
Male	-0.325**	.115	0.722**	0.577	0.905
Female (reference category, RC)					
Age					
15-29	-0.081	0.313	0.922	0.499	1.704
30-49	-0.226	0.286	0.798	0.456	1.398
50-100 (RC)					
Marital status					
single/cohabiting	0.144	0.510	1.154	0.425	3.136
Married	0.340	0.491	1.405	0.537	3.675
divorced/separated	0.477	0.593	1.611	0.504	5.152
Widowed (RC)					
Level of education					
None	0.906	0.497	2.476	0.935	6.552
Primary	0.751**	0.253	2.119**	1.290	3.481
Secondary	0.512***	0.117	1.669***	1.327	2.100
Tertiary (RC)					
Religion					
traditional/no religion	-0.302	0.509	0.739	0.272	2.006
Christianity	-0.181	0.139	0.834	0.636	1.095
Islam (RC)					
Place of residence					
Epe	0.722***	0.192	2.060***	1.413	3.002
Lagos Mainland (RC)					
Respondents' conception of HIV					
viral/acquired immune deficiency disease	-0.137	0.292	0.872	0.492	1.546
fatal/incurable disease	0.186	0.266	1.205	0.715	2.030
blood disease	0.031	0.394	1.032	0.477	2.233
others/don't know (RC)					
Sexual intercourse					
Spontaneous yes	1.021	0.679	2.775	0.734	10.491
Prompted yes	1.159	0.700	3.185	0.808	12.561
no/don't know (RC)					
Use of condoms					
Spontaneous yes	-0.011	0.209	0.989	0.656	1.491
Prompted yes	0.140	0.238	1.150	0.722	1.834
No (RC)					
Healthy looking person can be carrying HIV					
True	-1.330*	0.483	0.265**	0.103	0.682
False	-1.129*	0.540	0.323*	0.112	0.932
Don't know (RC)					
Constant	-.289	1.016	.749		
-2 Log likelihood	1837.023(a)				
Selected cases	1417				

a Estimation terminated at iteration number 4 because parameter estimates changed by less than .001.
*p< 0.05; **p<0.01; ***p<0.001

DISCUSSION

The study found out that knowing that a healthy person could be living with HIV infection is a significant factor of discrimination by both cross tab and is confirmed by the logistic analysis. An inverse relationship was found between this variable and discrimination. The study revealed that there was a high level of myths and misperception of the mode of transmission of HIV infection. The respondents are therefore likely to isolate PLWHA. Also found, is denial of HIV/AIDS existence. Despite all the enlightenment campaigns, denial of existence of HIV/AIDS still persists. This is worrisome because this particular group of people will not go for voluntary testing and will not protect themselves from contracting it and therefore are highly vulnerable although they may not constitute a problem to discrimination. Studies on social capital have shown that people who deny HIV infection are particularly vulnerable to the epidemic (Barnett and Whiteside, 2002; Desclaux, 2003).

Women were found to be more discriminatory. This may be attributed to their negative attitudes towards buying from PLWHA. It was revealed in this study that women vehemently refused to purchase from PLWHA. This is contrary to the men's submission. Furthermore, many female respondents among the Lagos Mainland discussants maintained that PLWHA should be segregated from the society for fear of contagion. They also opined the HIV could be contracted from contaminated food and water so such people are more likely to be discriminatory.

The study also revealed that respondents from Epe are more discriminatory than the respondents from Lagos Mainland LGA. Studies have shown that discrimination is pervasive in rural communities. There have been concerted efforts to disseminate appropriate and factual information about HIV/AIDS to rural people but whether these get to them is another issue. With constant epileptic power supply, it will be difficult getting information to the people.

Education of the general population was inversely related to discrimination. Educated people are more enlightened, have more access to correct information about HIV/AIDS and more likely to reside in urban centres than lower educated and illiterate people. Therefore, they may be more tolerant of PLWHA.

The results also showed that respondents wanted PLWHA's movements to be restricted. This contravenes the principle of free movement which is provided in the 1999 Constitution of the Federal Republic of Nigeria.

CONCLUSION AND RECOMMENDATIONS

The research focused on the correlation between HIV infection and discrimination against PLWHA. Specifically it set out to identify the relationship between knowledge of HIV transmission through sexual intercourse, HIV prevention- condom use, people's conception of HIV, and knowing that a healthy- looking person could be infected on the one hand and HIV-related discrimination on the other. Desclaux's cultural theory that associated HIV-related discrimination with myths, misconceptions and misperceptions of HIV/AIDS was found relevant to the study. The study therefore hypothesizes that knowledge of HIV infection influences the likelihood to discriminate against the PLWHA. The study further depicted that women, those with low education and relatively rural dwellers, were likely to discriminate against PLWHA. It was also revealed that HIV/AIDS was grossly misinterpreted and labeled a lethal disease caused by promiscuity, immorality, witchcraft, filthy environment, sharing of common or public toilets and divine punishment and that conduced to social discrimination. The findings highlighted further, widespread discrimination against PLWHA within the families and the communities. Therefore, based on these findings the following are recommended:

- Although there is increased awareness and positive response to PLWHA with the intensification of HIV/AIDS education, this needs to be matched by an equally increasing level of knowledge about the critical factors in transmission for there to be an effective strategy to combat the ignorance that causes people to discriminate against the PLHWA. Many people still do not know that they can live with a PLWHA without getting infected, that they can shake hands and share many things together. This is important because many people are not showing love to PLWHA and do not treat them with dignity. The level of discrimination is still high. The fear and prejudice that lie at the core of HIV/AIDS-discrimination need to be tackled at both community and national levels. Therefore, all stakeholders, that is, government at all levels, international organizations, national NGOs, CBOs and CSOs should take effective steps to provide enlightenment, information and education to the general public.
- Furthermore, the paper is advocating making formal education available and free at least to secondary school level since education has an inverse correlation with HIV-related discrimination. HIV/AIDS and family life education (FLE) should be introduced in schools at all levels with appropriate and culturally acceptable programmes.
- Discrimination results in abuses and violation of human rights of PLWHA. Many PLWHA lack knowledge of their rights in society. Therefore, there is need to educate them so that they can challenge the discrimination and denial they meet in society.

- The right not to be subjected to discrimination is enshrined in 1999 Constitution of the Federal Government of Nigeria and many international legal instruments. It is also contained in the 2003 HIV policy. The international legal instruments include the African Charter on Human and People's Rights; the Convention on Elimination of All Forms of Discrimination against Women; the Convention on the Rights of the Child; the International Convention on Elimination of All Forms of Racial Discrimination; the International Covenant on Economic, Social, and Cultural Rights; and the International Covenant on Civil and Political Rights. Most of these laws have not been domesticated. Only the African Charter and the Convention on the Rights of the Child have been incorporated into the domestic law of Nigeria. Nigeria is also a signatory to the Universal Declaration of Human Rights. These laws can provide powerful means of mitigating the worst effects of discrimination and stigma. Therefore this paper is calling for the domestication and enforcement of these legal instruments.

Conclusion and recommendations:

Although the study found an inverse correlation between knowledge of HIV and discrimination, there is still a discrepancy. Myths and misperceptions of HIV abound culminating into unimaginable phobia of contagion and consequently to social discrimination of PLWHA. People still shun PLWHA despite high level of awareness about HIV/AIDS. Therefore, a comprehensive HIV education is required to eradicate discrimination completely. All the stakeholders should re-embark on massive HIV education particularly in rural areas. Discrimination results in violation of the principle of natural justice that should apply to all individuals irrespective of their status. Therefore, the above mentioned legal instruments should be domesticated and enforced to protect the rights of PLWHA.

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