Public Perception of the Effects of Stigmatization on Persons Living with HIV/AIDS (PLWHA) in Awka South Council Area of Anambra State, Nigeria

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Abstract

This work investigated the effects of stigmatizations on persons living with HIV/AIDS in using Awka South Council Area of Anambra State. The study employed survey research design in which 300 respondents constituted the study participants using multi-stage and accidental sampling techniques. The main source of data was questionnaire schedule and in-depth interview guide. However, secondary data were also gathered from textbooks, e-books and journals. The quantitative data from questionnaire was analyzed manually. Finding revealed that the socio-economic effects of stigmatization on persons living with HIV/AIDs include retrenchment and violation of human rights. It is therefore recommended, that government should monitor the implementation/intervention programmes and increase awareness campaign on modes of spread of HIV/AIDS.

Keywords: *Control, Disease, Epidemics, Rights, Stigmatization, Persons Living with HIV/AIDS*

Introduction

The effect of HIV- related stigma on control of HIV has shown to have a negative impact. Stigmatization has hampered every meaningful approach to control the spread of HIV/AIDS. One of the ways through which stigmatization have hampered the control of HIV/AIDS is the unwillingness of victims to disclose their status to others especially employers. Victims chose to remain silent because they may lose their job considering the social problem of employment. According to Banki, Moon, secretary general of United Nations (UN), (Washington times, 2008) noted that "stigma remains the ugliest aspect of being an HIV/AIDS patient. It is the main reason many are afraid of seeing a doctor to determine their status. It made AIDS a silent killer, because people fear the social disgrace attach to it. For this reasons, AIDS epidemic has continued to devastate societies around the world.

Stigmatization is meted to people living with HIV/AIDS falsely. Those who engage in stigmatization believe that the virus is highly contagious and they could easily become infected. Based on this, they see HIV-positive men and women as threats. Many become isolated in their homes, in public, at work places. They perceive people living with HIV/AIDS as lacking moral integrity, such as the believe that they are infected with HIV because they choose to take part in risky behaviour. According to Kaiser family foundation (2009), in a national survey noted, that one third of Americans believed that – HIV could be transmitted by sharing a drinking glass, touching a toilet seat or swimming in pool with someone with the virus. Nwangwu (2004) noted, stigmatization is a dynamic social process that arises from perception that an individual has undesirable attribute, thus, reducing him in the eyes of the society.

Again, stigmatization has manifested in form of discrimination in families religious settings, Educational institutions, Health care Centres and other places. According to Oxford Learner's Dictionary, seventh edition, discrimination has been defined as treating one person or group worse or better than other in an unfair manner. Victims of HIV/AIDS are based on their HIV-positive status. According to Guma (2008), discrimination occurs when people or institutions act upon stigma, and it entails unjust actions or inaction towards individuals. It arbitrarily distinguishes, restricts and excludes individuals, and leads to the denial of rights and services. Discrimination in itself is a breach of human rights. And the ramifications of discrimination in health facilities have serious and far reaching implications on health seeking behaviour and people experiences when they seek health.

Access to care is affected by stigmatization in various ways, which include barrier to the care of HIV positive individuals, reluctance of health care providers to treat individuals with HIV and stigmatization of ancillary or support services to people living with HIV/AIDS. UNAIDS Report (2008), on the status of the global AIDS epidemic noted that "Far too often, the health care system itself, - including doctor nurses and staff responsible for the care and treatment of people living with HIV are prime agents of HIV-related stigma and discrimination.

Stigma is perceived as a major limiting factor in primary and secondary HIV/AIDS prevention and care, and has interfered with voluntary testing and counseling and access to care and treatment

(Agweda & Dibua 2009). It is against the backdrop of foregoing problems that this study is position to evaluate the effects of stigmatization on victims on the control of HIV/AIDS in Awka South L.G.A. of Anambra State.

Objectives of the Study

The general objective of this research is to ascertain the public perception of the effects of stigmatization of victims of HIV/AIDS on the disease control programme in Anambra State and Awka South L.G.A. in particular. However, specific objectives are as follows:

1. To examine the socio-economic effects of stigmatization on victims of HIV/AIDS in Awka South Council / local government area

2. To ascertain the effectiveness of government's intervention programme on stigmatization on PLWHA in Awka South L.G.A.

3. To identify measures to reduce the effects of stigmatization of victims of HIV/AIDS in Awka South L.G.A.

Review of Related Literature on Stigmatization and Persons Living with HIV/AIDS (PLWHA)

Stigmatization is a major issue that societies and support organizations have to contend with in dealing with the problems of HIV/AIDS. Stigma can affect the prevention of Aids in the society. Stigma is a powerful and discrediting social label that radically and negatively affects the ways individuals view themselves and the ways others view the individuals as a person. Stigmatization is a dynamic social process that arises from the perception that an individual has an undesirable attributes, thus, reducing him in the eye of the society (Nwangwu 2004). Adeyemo and Oyinloye (2007) defines stigma as any characteristics that set an individual or group apart from majority of the population with the result that the individual or group is treated with suspicion or hostility. Bell, Devaraan and Gersbach (2003) suggested that certain people who have undesired "differentness" are stigmatized in that others regard them as tainted and discounted. People with discreditable attribute can decide to hide their attributes and avoid stigma or undertake formation management by controlling what they tell others. According to Bell, Devaraan and Gersbach (2003), the two strategies for the person with discreditable attribute are passing and withdrawal.

Passing is seeking to hide the discredible attributes and withdrawal is withdrawing from social contacts wherever possible. Banki-noon (2008) made distinction between enacted stigma and felt stigma. Enacted Stigma refers to Instance of`` discrimination against people with an undesirable attribute on the ground of their perceived unacceptability or Infirmity. Felt stigma refers principally to the fear of enacted stigma but also encompasses a feeling of shame associated with the unacceptable attributes. Stigmatization has caused anxiety and prejudice against the group most affected as well as those living with HIV/AIDs in the society

Stigmatization has affected societal reaction to people living with HIV/AIDS and the behavior and the attributes of such people. Oyediran, Oladipo and Anyati (2005) observe that stigma and discrimination remain in the Nigerian environment at family and community levels with misconceptions, misinformation and fear of getting HIV as underlying causes. Alubo et-al (2002) observe that among people living with HIV/AIDS in southern Benue state of Nigeria, the level of stigmatization is high and acceptance of people living with HIV/AIDS is low. HIV/AIDS related murders have been reported in as diverse as Brazil, Columbia, Ethiopia, India, Thailand and South Africa .For instance, in December 1988, Gugu Dhalamin was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking out openly on world AIDS day about her status. The associated press (1992) reported that the Australian Olympic federation had planned to boycott sport competition against the United State's basket ball team if magic Johnson who tested positive was allowed to participate. Stigmatization then reinforces tendencies for people living with HIV/AIDS to make themselves invincible and withdrawn from society. As Oyediran, Oladipo and Anyati (2005) contended, people living with or affected by HIV/AIDS are subjected to stigmatization and fear and this contributes to the culture of silence surrounding the disease and consequently its spread.

Globally HIV/AIDS victims are stigmatized. The stigma and it's consequential discrimination and prejudice are exhibited in diverse ways in different individual, groups, communities, institution (Baffoe 2013). In India, there is a report that patients with AIDS were been seen as nonentities by families and friends. They were quarantined, not given the opportunity to be seen by relatives and friends (Keba 2011). AIDS victims are therefore sometimes rejected, ostracized, avoided and tested without prior consent or confidentiality.

In Ghana the transmission of HIV is believed to have primarily originated from homosexual intercourse though, in some countries homosexual intercourse has been considered to be the Initial cause of the HIV/AIDS pandemic. Basically Ghanaian also considers HIV/AIDS as result of immoral behaviour, sexual Immorality, prostitution and other sexual promiscuity. The disease is therefore considered as divine punishment. Thus HIV/AIDS stigma may be viewed as resulting from cultural values (Keba 2011). Stigma is therefore as a result of misconceptions and dangers related to the disease due to societal, family and cultural norms and beliefs in relation to these deviant acts (Keba 2011).

These are a collective and mutual responsibility to family members in Ghana. Thus the offence, punishment and disgrace of family, members are indirectly linked to other family members or family as a whole. Hence there is collective responsibility system of praise and blame. Thus if a family member is infected or dies of HIV/AIDS the entire family becomes stigmatized. Family members are therefore encouraged through such blame-agenda by the community or society to hide their HIV/AIDS status in order to avoid societal rejection (Keba 2011).

According to (Keba 2011), the fear of getting HIV/AIDS when one associates with HIV/AIDS persons, itself, is risk factor to the permeation of the disease to a large section of the society. This is due to ignorance because aids is not contagious though infections. Both Africans and people of other parts of the globe have this ignorant believes. This may be due to the fact that people with the HIV/AIDS are often looked down upon. They may even lose their jobs. People refuse to eat, drink from same cup with them. Sometimes even comb and pomade are not shared with them. This ingrained fear also prevents people from shaking hands and eating from the same bowel with HIV/AIDS Victims. Sleeping with them maybe considered a great abomination. People ignorantly believe that engaging with such victims in any of these acts could lead to contraction of the disease (Keba 2011), noted that the fear of getting HIV/AIDS also prevents people from befriending, having sexual intercourse or marrying victims of the infection. Empirical literature has disproportionately testified to this assertion. Investigating into this attitude among, the youth could therefore help in removing some of the impediments to the prevention of transmission of the disease.

Apart from the health problems, HIV/AIDS stigmatization has far reaching social, political and economic consequence; according to United National Fact sheet (2001) HIV/AIDS is reducing the ratio of healthy workers to dependants, thereby reducing productivity. This trend has slowed the development of the private sector, a core element in the development strategies of many nations especially Nigeria. Indeed, the economic impact of HIV/AIDS on governance cannot be over emphasized. This is because the government and the private sectors are loosing highly valuable and very skilled employees to the epidemic: hence they are being confronted with mounting bills on health care, widow and orphan maintenance etc. This results to reduced revenue and lower return on investment. Social and political theory can help us to understand that stigmatization and discrimination are not isolated phenomena or the expression of individual attitudes, but are social processes used to create and maintain social control and to produce and reproduce social inequality.

Stigma is something that is "produced" and used to help to order society. For example, most societies achieve conformity by contrasting those who are "normal" with those who are "different" or "deviant". Cultures therefore produce "difference" in order to achieve social control. In many non Western societies, local knowledge systems may perform the same function at a more localized level (Geetz 1983). Similarly, concepts of symbolic violence and hegemony highlight the role of stigmatization in establishing social order and control, and identify stigmatization as part of social struggle for power. Symbolic violence is a process where words, images and practices promote the interest of dominant groups (Bourdieu 1977; Bourdieu and passeron 1977). And hegemony is achieved through the use of political, social and cultural forces to promote dominant meanings and values that legitimize unequal social structures (Focault 1978; Gramsci 1970; Williams 1982), so all cultural meanings and practices embody interests are used to enhance social distinctions between individuals, groups, and institutions.

Sociological analyses of discrimination are also useful because they emphasize the structural aspects of discrimination and "concentrate on patterns of dominance and oppression, viewed as expression of a struggle for power and privilege" (Marshall 1988).

HIV/AIDS-related stigma and discrimination take different forms and are manifested at different levels ---societal, community and individual –different contexts (UNAIDS 2000; Malcolm 1988). The following example highlights where HIV/AIDS-related stigma and discrimination have been most frequently documented and where there is the greatest potential for interventions to reduce or mitigate stigma and discrimination.

Such discriminatory practices as pre-employment screening, denial of employment to individuals who test positive, termination of employment of PLHA, and stigmatization of PLHA who are open about their serostatus (Gostin and Lazzarini 1997; Panos 1990; Barragan 1992) have been reported from developed and developing countries.There have been reports of workers refusing to work nest to those with HIV or AIDS or those perceived to be PLHA. Schemes providing medical assistance and pensions to employees have been under increasing pressure in countries seriously affected by HIV/AIDS, and some companies have used this as a reason to deny employment to PLHA (Williams and Ray 1993; Whiteside Ray 1993). Few companies have developed strategies to combat stigma and discrimination or defined their responsibilities toward employees with HIV/AIDS (Jackson and Pitts 1991; Bezmalinovic 1996).

There have been many reports from health care settings of HIV testing without consent, breaches of confidentiality, and denial of treatment and care (Parker &Aggleton 2002; Park, Faulkner & Schaller 2003). Failure to respect confidentiality, by clear identifying patients with HIV/AIDS, revealing to be problems in some health services (Panos 1990; Bharat et at 2010). Factors contributing to these stigmatization and discriminatory responses include lack of knowledge, moral attitudes, and perceptions that caring for people living with HIV/AIDS is pointless because HIV/AIDS is incurable (Priya & Sathyamala 2007).

In societies with cultural systems that place greater emphasis on individualism, HIV/AIDS may be perceived as the result of personal irresponsibility, and thus individuals are blamed for contracting the infection (Ogbu, 2006). In contrast, in societies where cultural systems place greater emphasis on collectivism, HIV/AIDS may be perceived as bringing shame on the family and community (Ogden & Nyblade 2005). The type of cultural system and where it fits along the continuum of individualism and collectivism will therefore influence the ways in which

communities respond to HIV/AIDS and the ways in which stigma and discrimination are manifested. Local cultural beliefs and explanations about disease and the causes of disease may also contribute to HIV/AIDS -related stigma and discrimination. For example, where illness is believed to be the result of "Immoral" or "Improper" behavior, HIV/AIDS may reinforce pre-existing stigma of those whose behavior is considered to be "deviant" (Thrasher, Earp, Gollin, & Zimmer, 2008). HIV/AIDS-related stigma and discrimination in families and communities is commonly manifested in the form of blame, scapegoating, and punishment. Communities often shun or gossip about those perceived to have HIV/AIDS. In more extreme cases, it has taken the form of violence (Orji 2006). For example, there have been reports from many countries of attacks on men who are assumed to be gay (Public media center 1995), of violence toward sex workers and street children in Brazil (De cook 2008), and of HIV/AIDS-related murders in Columbia, India, Ethiopia, South Africa, and Thailand (Panos 1990; AFAO 1997).

Theoretical Orientation: Labeling Theory

Labeling theory had its origin in suicide, a French Sociologist Emile Durkheim in 1887. He found that crime is not so much a violation of a penal code as it is an act that outrages society. He was the first to suggest that deviant labeling satisfy that function and satisfies societies need to control behavior. Labeling theory is the theory of how the self-identity and behaviour of individuals may be determine or influenced by the terms used to describe or classify them it is associated with concepts of self- fulfilling prophecy and stereotyping. Labeling theory holds that deviance is not inherent to an act, but instead focuses on the tendency of majorities to negatively label minorities or those seen as deviant from standard cultural norms. The theory was prominent during the 1960s and 1970s, and some modified versions of the theory have developed and still currently popular, unwanted description or categorizations – including terms related to deviance, disability or diagnosis of a mental disorder. Labeling theory concerns itself mostly not with the normal roles, that define our lives, but with those very special roles that society provides for deviant behaviour, called deviant roles, stigmatic roles or social stigma.

Victims of HIV/AIDs are labeled and stigmatized on the basis of deviating from the societal, norm, the society labeled them as moral bankrupt, According to Esu-Willians, Pulerwitz,Mgilane and

Stewart (2005) described stigma as a social process that marginalizes and label those who are different, and discrimination is defined as the negative practice that stem from stigma.

Study Area

Awka South Council or local government area is located in the southern part of Anambra State, at Latitute 6.6 N and 6.25N and longitude 7.0E and 7.15É (Aribodor, D. N., Njoku, O. O., Enanya, C. I. and Onyali I. O. 2013). Its capital Awka whichalso double as the capital of Anambra State. The Council was created in 1989. It is bounded on the north by Awka North L.G.A., on the east by Orji river L.G.A. of Enugu State, and on the west by Anaocha L.G.A. Strategically, Awka South is located midway between two major cities in the northern Igbo land, Onitsha and Enugu which has informed it's choice as an administrative Centre for the colonial authorities and today as a base for the Anambra State Government. Awka South is one of the oldest settlements in Igbo Land established at the Centre of the Nri Civilization which produced the earliest documented bronze works in sub-Saharan Africa around 800 AD and was the Cradle of Igbo civilization (Achebe, 2012). Their traditional ruler is known as Eze-uzu, it is blessed with tourist sites like the Awka shrine at Amoka, sacred water (Ezu-Ngene) at Nise. Awka South also celebrates New Yam festival among its cultural practices.

Awka South L.G.A is made-up of nine towns which include Awka (headquarters), Amawbia, Ezinato, Isiagu, Mbaukwu, Nibo, Nise, Okpuno and Umuawulu. According to National Population Census (2006), Awka South has a population of 189,049 with land area of 180 square kilometres. Awka South is famous in black smiting, farming and business, it is known basically as the seat of indigenous technology and craft, carving and iron works industry dominate the area. Nnamdi Azikiwe University is located on the eastern part of the local government.

Materials and Methods

The study employed survey research design. The sample size was 300 respondents. These individuals who constituted the study participants were selected using multi-stage, quota and accidental sampling techniques. The main source of data was questionnaire schedule and in-depth

interview guide. However, secondary data were also gathered from textbooks, e-books and journals. The quantitative data from questionnaire was analyzed manually.

Findings

Three hundred questionnaires were distributed with the help of research assistants. However, only 290 questionnaires were correctly filled and returned. Seven of these were lost in the field. Hence, the quantitative analysis for this study was done using 290 correctly filled and returned questionnaires. The findings of the study are presented below:

Table 1: Distribution of respondents by the socio demographic Data

	Variables	**Frequency**	**Percent**
Distribution of respondents by sex	Male	178	61.4
	Female	108	37.2
	No response	4	1.4
	Total	**290**	**100.0**
Distribution of Respondents by age	18-27	63	21.7
	28-37	71	24.5
	38-47	57	19.7
	48-57	39	13.4
	58-67	16	5.5
	68+	5	1.7
	No response	39	13.4
	Total	290	100.0
Distribution of respondents by marital status	Married	143	49.3
	Single	131	45.2
	Divorced	6	2.1
	Widowed	8	2.8
	Separated	2	.7
	Total	**290**	**100.0**
Distributions of Respondents by Religious Affiliation	Christianity	239	82.4
	Islam	20	6.9
	Traditional	8	2.8
	No response	23	7.9
	Total	**290**	**100.0**
	Civil Servant	53	18.3

Distribution of Respondents by socio-economy status	Farmer	60	20.7
	Trader	60	20.7
	Artisan	57	19.7
	Transportation Worker	60	20.7
	Total	**290**	**100.0**

The table above shows that 239 (82.4%) of the respondents are Christians, 20 (6.9%) of them are practitioners of Islamic religion while 8(2.8%) of them indicated they practice traditional religions 23(7.9%) of the respondents did not respond to the question. This implies that majority of the respondents are Christians. Finally table 1 reveals that 53(18.3%) of the respondents are civil servants, (60(20.7%) of them are farmers, 60(20.7%) of them indicated they are transport workers. It implies therefore that the occupation of majority of the respondents is farming, trading and transportation.

Table 2: Distribution of Respondents on their awareness of HIV/AIDS stigmatization.

Frequency	**Responses**	**Percentage**
260	Yes	89.7
20	No	6.7
10	No Response	3.4
290	**Total**	**100.0**

Tables 2 shows that 260 (89.7%) of the respondents are aware of HIV/AIDS stigmatization while 20 (6.7%) of them indicated they are not aware. 10 (3.4%) of the respondents did not respond to this question. This implies that majority of the respondents are aware of HIV/AIDS stigmatization. This finding corroborated with findings from in-depth interview. An IDI participant stated

I have not witnessed a case of stigmatization on victims of HIV/AIDS but, I got a lot of awareness through radio and television broadcast (Female, 35, Teacher, Married).

Table3: Respondents view on socio-economic effects of stigmatization on persons living with HIV/AIDS.

Responses	Frequency	Percentage
Job Retrenchment	171	29.5
Violation of human rights	153	26.4
Avoidance and Isolation	144	24.8
Poor Care within the health care sector	68	11.7
Loss of Reputation	40	6
None of the above	3	05
Total	**579**	**100.0**

The table above shows that 171(29.5%) of the respondents are of the opinion that the socio-economic effects of stigmatization is job retrenchment, 153(26.4%) indicated violation of human rights 144(24.8%) indicated avoidance and Isolation, 68(11.7%) indicated poor care within the health sector, 40(6.9%) indicated loss of reputation while 3(0.5%) indicated were none of the above. This shows that majority of the respondents identified job retrenchment as the socio-economic effects of stigmatization on victims of HIV/AIDS. This finding is in line with data from the in-depth interview.

An IDI Stated:

> *"Fear of being stigmatized makes victims of HIV/AIDS avoid and isolated themselves from business activities" (Male, 47, Married, Trader)*

Another IDI respondent posited:

> *"Stigmatization of victims of HIV/AIDS tends to stop people from their means of livelihood especially in private organization once they have knowledge of the HIV status of their employees" (Male, 47, Businessman).*

Table 4: Respondents view on their knowledge of anyone that has benefited from government intervention programmes.

Responses	Frequency	Percentage
Yes	42	14.5
No	178	61.5
Don't Know	4	1.4
No Response	66	22.7
Total	**290**	**100.0**

The table above shows that 42 (14.5%) of the respondents have knowledge of someone that have benefited from governments intervention programmes, 178 (61.5%) of them indicated they don't know while 66 (22.7%) of the respondents did not respond to the question. This shows that majority of the respondents indicated they don't know anyone that have benefited from government intervention programmes.

This finding is supported by data from qualitative instrument. An IDI respondent stated:

> *"How on earth will any government claim that it has created programmes to reduce the stigmatization of victims of HIV/AIDS? The end point is that the intervention did not reach majority of those that needed this services, especially people at the grassroots".*

Table 5: Respondents view on the measures to reduce the effects of stigmatization on PLWHA.

Response	Frequency	Percentage
Use of specific HIV/AIDS Sexual Reproductive education Programmes that emphasizes the rights of people living with HIV/AIDS	210	29.8
Adoption of human right approach to HIV/AIDS in the public Interest	170	24.1
Continuous awareness and understanding the mode of transmission of HIV/AIDS	244	34.7

Reform existing government Interventions with a view for proper implementation of the programme.	41	5.8
Introduction of measures that will reduce harmful gender and traditional norms	39	5.5
Total	704	100.0

The table above shows that 210(29.8%) of the respondents identified uses of specific HIV/AIDS sexual reproductive education programme that emphasizes the rights of people living with HIV/AIDS as the measure to be employed living the HIV/AIDS as the measure to be employed in reducing the effects of stigmatization on HIV/AIDS victims, 170(24.1%) identified adoption of human rights approach to HIV/AIDS on the public interest, 244(34.7%) Identified continuous awareness and advocacy campaign and understanding the mode of transmission of HIV/AIDS, 41(5.8%) indicated reform of existing government Intervention with a view for proper implementation of the programmes while 39(3.3%) of the respondents identified introduction of measures that will reduce harmful gender and traditional norms. This shows that majority of the respondents are of the opinion that continuous awareness and advocacy campaign and understanding the mode of transmission of HIV/AIDS is the measure that should be employed in reducing the effects of stigmatization on HIV/AIDS victims. This finding is in line with data from the in-depth interview.

An IDI participant stated:

> *"Indeed there is a number of things that can be done to reduce the effects of HIV/AIDS stigmatization. People should be adequately taught how the virus is transmitted and that they should not keep away from talking to people that are carriers of the virus".*

Another IDI participant stated:

> *"I believe sexual education should be introduced in schools and laws against stigmatizations of people living with HIV/AIDS should be further strengthened"*

Summary and Conclusion

In summary, the study observed that the socio-economic effects stigmatization on PLWHA in Awka South Local Government of Anambra State is enormous. These socio economic effects

include job retrenchment, violation of human rights, avoidance and isolation, poor health within the heath section and loss of reputation. This is in line with the findings of Monjok, Essien and Smesmy (2009) WHO identified loneliness and rejection as the effects of HIV/AIDS stigmatization. Labelling in its own can result to a number of negative effects and consequences on the victims. The Study also found that the government intervention programmes in curbing stigmatization of the victims on the control of HIV/AIDS in Awka South Local Government Area has not been effective over the period. The level of effectiveness is not reasonable enough.

The study identified measures to curb the effects of HIV/AIDS in Awka Local Government Area of Anambra State. These measures include use of specific HIV/AIDS sexual reproductive education programmes that emphasize the right of people living with HIV/AIDS, Adoption of human rights approach to HIV/AIDS in the public interest, continuous awareness and advocacy campaign and understanding the mode of transmission of HIV/AIDS. Such activities, designed to empower marginalized group should complement ongoing efforts to change individual attitudes toward PLWHA and those affected by the epidemics through for example, media campaigns promoting tolerance and compassion. Useful lesson could be learned from effort to address stigma and discrimination associated with other issues, such as mental health and leprosy. In Scotland, for example, providing the community with information and encouraging day-to-day contact with people with mental illness helped to reduce stigmatization of mental illness (Brunton 1977), and a national campaign in the UK to educate the public about mental illness resulted in more positive attitudes and greater willingness to seek treatment from health professionals (Smith, Brandy, Carter, Fernandes & Lamore 2011). In Tanzania, a health education campaign designed to reduce the stigma of leprosy improved community attitude in term of, for example, greater willingness to share food or shake hands with a person with leprosy (Talha khan & Burki 2011). Reform of existing government interventions with a view for proper implementation of the programme and introduction of measures will reduce harmful gender and traditional norms. This finding is supported by that of Ogden and Nyblade (2005) who noted that tackling values, norms and moral issues can reduce the rate of stigmatization against HIV/AIDS. It's no doubt that the stigmatizations of PLWHA precipitated retrenchment, violation of human rights and have contributed to silent death of some of them in Awka South Local Government Area.

Recommendations

Based on the findings, the following recommendations are put forward:

1. Advocacy campaign should be stepped-up with a multifaceted approach to stigma and discrimination. A national response which employs a range of approaches will have the great impact e.g "Know your rights" campaigns, social change communications, social mobilizations, participatory education, interaction between people living with HIV and audiences, celebrity champions and media, campaign and legal support.

2. The society should reform and strengthen the existing laws that cater for the rights of HIV/AIDS victims within the work place.

3. Government should promote and facilitate programme valuation and operational research. Measurement helps evaluate effectiveness and the identification of programmes to scale up and can be built into programmes during design and implementation.

4. Government should monitor through its agencies i.e NACA: the implementation of palliatives/Intervention programmes to reduce the effect of stigmatization on control of HIV/AIDS.

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