



Community Engagement and Social Mobilization as Strategies in Hiv/Aids Stigma Reduction Among Adults Using Ghain Supported Sites in Anambra State

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Article Info

Received: September 25, 2023

Accepted: October 18, 2023

Published: October 25, 2023

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Citation: Chinedu-Eleonu PO and Nsonwu Magnus. (2023) "Community Engagement and Social Mobilization as Strategies in Hiv/Aids Stigma Reduction Among Adults Using Ghain Supported Sites in Anambra State.", *Clinical Case Reports and Clinical Study*, 9(5); DOI: 10.61148/2766-8614/JCCRCS/157.

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Abstract:

The main purpose of the study was to determine community engagement and social mobilization as strategies in HIV/AIDS stigma reduction among adults using GHAIN supported comprehensive sites in Anambra state as at 2009. The research adopted descriptive survey research design. A total of 330 adults was respondents used to source data. The instrument used for data collection for this study was self-developed structured questionnaire. Validity and reliability of the instrument were ensured. Descriptive statistics of percentage (%) and inferential statistics or chi square (%?) were used to answer research questions and test hypotheses respectively. The result of the findings revealed that the community engagement can help in reducing stigma among HIV/AIDS adult patients using community leaders, religious leaders, various kings of organizations, using healthy infected individuals to organize interactive sections talking about the infection, and by involving health professionals to create awareness about the infection. Again, using social mobilization as strategies to reduce HIV stigma, it was found that formation of support groups among people living with the virus will go a long way in reducing the stigma: Other ways includes, using radio jingles to inform people about the infection, enacting laws against stigmatizing people living with the virus, not requesting for HIV status of individuals before marriage, not using separate equipment for HIV infected individuals during sugary or delivery. The results equally showed that stigmatization could lead to some health implications like stress, loneliness, aggressiveness, depression, frustration, withdrawer and bitterness. There are some community practices that encourages stigma, things like ear piecing, female circumcision. Finally the results proved that using strategies like educating the people about the infection, not discriminating them in employment, changing the attitude of health workers towards them, allowing them all the benefits and privileges accorded others and making the disease seem like other disease will help PLWHA cope with the infection. Recommendations were also made pertinent among which are health educators to carry out enlightenment campaign in communities on the need to engage them in ways to reduce stigma like using religious leaders and community leaders to educate other about the infection. Both the federal, state and local governments should endeavor to use some of the strategies like enacting laws against stigma, using radio jingles to tell people about the infection and using NGO to teach about it so as to reduce stigma. Religious leaders should stop requesting for HIV status of individuals during marriage. HIV mode of transmission should be incorporated into school curriculum for people to learn it and stop being afraid of being infected by ordinary body contact. Government should encourage the formation of support groups in all comprehensive hospitals and communities where PLWHA meet to discourse issues about themselves to reduce self stigma. Health care workers should be re-oriented on the dangers of stigmatizing their patients.

Introduction:

HIV/AIDS-related stigma affects self-esteem, mental health, access to care, providers' willingness to treat people with HIV, violence, and HIV incidence. Interventions to reduce stigma are therefore crucial for improving care, quality of life, and emotional health for people living with HIV and AIDS. HIV/AIDS-related stigma has been specifically identified as a domestic policy challenge that must be addressed to reduce the number of new HIV infections, and eliminating stigma is a crucial element of global efforts (Institute of Medicine, 2001; Joint United Nations Programme on HIV/AIDS [UNAIDS] [1]

The radical behavioral change that is needed to reduce HIV transmission requires radical commitment. Prevention strategies will never work if they are not implemented completely, with appropriate resources and benchmarks, and with a view toward sustainability. The fundamentals of HIV prevention need to be agreed upon, funded, implemented, measured, and achieved. That, presently, is not the case [2].

Community-level action or social mobilization—much of it initiated by persons infected or affected by HIV - has always played a major role in the global response to AIDS. In many countries, community response and or social mobilization came before the official national response. It has proved essential to many components of a successful national response—most notably awareness, prevention, policy and legal changes, impact alleviation, advocacy, and family or community care and support [3].

HIV-related stigma refers to all unfavorable attitudes, beliefs, and policies directed toward people perceived to have HIV/AIDS as well as toward their significant others and loved ones, close associates, social groups, and communities. Patterns of prejudice, which include devaluing, discounting, discrediting, and discriminating against these groups of people, play into and strengthen existing social inequalities—especially those of gender, sexuality, and race—that are at the root of HIV-related stigma [4].-

Stigmatization is conceptualizing and creating a framework for the study of stigma. stigma is "**an attribute that is deeply discrediting within a particular social interaction**". stigma focuses on the public's attitude toward a person who possesses an attribute that falls short of societal expectations. The person with the attribute is "reduced in our minds from a whole and usual person to a tainted, discounted one". Stigma falls into three categories including; (i). *Abominations of the body*-various physical deformities, (ii) *Blemishes of individual character*-weak will, domineering or unnatural passions, treacherous and rigid beliefs, or dishonesty. Blemishes of character are inferred from, for example, mental disorder, imprisonment, addiction, alcoholism, homosexuality, unemployment, suicidal attempts, or radical political behavior. (iii) *Tribal stigma of race, nation, and religion*-beliefs that are transmitted through lineages and equally contaminate all members of a family [5]

Although stigma is considered a major barrier to effective responses to the HIV/AIDS epidemic, stigma reduction efforts are

relegated to the bottom of AIDS programme priorities. The complexity of HIV/AIDS-related stigma is often cited as a primary reason for the limited response to this pervasive phenomenon [6]

HIV-related stigma may negatively impact the health, quality of life, social support and well-being of people living with HIV (PLHIV). Previous studies have used diverse samples and a multitude of measurement instruments to examine demographic and health correlates of HIV-related stigma, highlighting the importance of synthesizing findings across different studies to gain a better understanding of these associations [7].

Engaging the community by mobilizing them socially can go a long way in reducing the stigma and discrimination among people living with the HIV virus. UNAIDS defined a community as a group of people who have

something in common and will act together in their common interest. A community's ability to act together may have existed for centuries, or it may be triggered in a very short time by some urgent problem. Many people belong to a number of different communities - examples include the place they live, the people they work with, religious group, or people of like manner that have one thing in common and come together to discourse their issues with the aim of finding solution to it [8].

Until people identify themselves as a community and share some sense of mutual belongings, there is no real community, While the concept of community has been widened the need to design culturally and epidemiologically specific responses (i.e. to help specific group of people) has created a corresponding need to define individual communities more closely. Such a definition includes the objective work of counting people, identifying their socio- economic status, then those that tested positive will grade themselves together to form what is called Support group with the soul aim of assisting one another and in some cases, organize some trainings for member in various trades so as to empower them so on [9].

These support groups usually organize their meetings in hospitals that offer HIV and AIDS comprehensive activities and their major aim is to assist newly positive individuals to come out of stigma and discrimination. In the same vain, people that wish to assist them (individuals, companies, or co-operate organizations/ non governmental organizations) either financially or otherwise can easily do so through this group. Some times, members of these groups do organize home visits to members so as to encourage one another. For the purpose, of this study, these groups of people are regarded as community and social immobilizers based on the definition of the UNAIDS. in all the comprehensive sites supported by Global HIV/AIDS Initiative Nigeria (GRAIN) in Anambra state, this support groups are in existence and very active and functional. These support groups are .made up of men and women of various age groups and they are of different religious denominations and of different academic qualifications [10]

Starting a community effort is generally much easier than sustaining it. Many community organizations or social mobilization and programmes have been at work for years, and

continue today with the same energy. Others have withered and lost energy; some have disappeared. For responses to be effective, existing community initiatives must be reinforced and new must be nurtured as they establish themselves. This will require flexible partnership arrangements with governments and other forces in the campaign against HIV/AIDS, particularly in developing countries. In the past, community mobilization has usually meant initiatives at a neighborhood, village or local district level. Today, however, the AIDS pandemic and modern communications technology have challenged traditional ideas of community. National and even global communities have emerged with shared concerns to prevent the spread of the virus, to care for those affected by HIV and AIDS, and to advocate for health and human rights[11].

While the concept of community has been widened, the need to design culturally and epidemiologically specific responses (i.e. to help specific group of people) has created a corresponding need to define individual communities more closely. Such a definition includes the objective work of counting people, identify their socio-economic status, and so on.

Nurturing and sustaining community mobilization. A community or social organization becomes mobilized when a particular group of people becomes aware of a shared concern or common need, and decides together to take action in order to create shared benefits. This action may be helped by the participation of an external facilitator-either a person or another organization. However, momentum for continued mobilization must come from within the concerned group or it will not be sustained over time.

It is against the background of healthy living and wellness that the researcher was motivated towards ascertain community engagement and social mobilization as strategies in HIV/AIDS stigma reduction among adults using GHAIN sites in Anambra state in 2009 [12].

Stigma is a persistent influence on HIV/AIDS, inflicting substantial personal, social and economic costs on individuals, friends and families, as well as communities and nations. It was opined that Stigma and discrimination are widely recognized as factors that height the HIV/AIDS epidemic. Low-Beer (2008), stated that Uganda's success in combating HIV/AIDS has been attributed to a number of factors, including, political, religious and societal engagement and openness - actors that combat stigma and assist prevention efforts. Elevated by deeply-felt responses including fear of infection, moral outrage, and shame, those living with HIV/AIDS may be shunned, denied care and support, or avoid life-saving medical care out of fear of rejection.. Moreover, HIV/AIDS-related stigma and resulting discriminatory acts create circumstances that height the spread of HIV. Population-level HIV declines and behavioral risk avoidance in Uganda[13].

Based on these information, the researcher came up with the idea that community engagement and social mobilization could be one of the strategies HIV/AIDS stigma could be reduced among adults using GHAIN supported comprehensive sites in Anambra state as case study.

Materials and Method:

Research design:

Descriptive survey research design was employed for the study.

Description of the study area:

This study was conducted in three HIV and AIDS comprehensive hospitals supported by GRAIN in Anambra state as at 2009. These hospitals include General hospital Awka, St. Charles hospital Borromeo Onitsha and General hospital Onitsha using HIV positive adults of ages of twenty one and above (male and female) that registered with the hospitals. General hospital Awka is located in Awka south L.G.A which is the southern part of the state, shares boundary with Enugu and it houses the state capital. It is bounded in the North by Mgbakwu and Isu-Aniocha towns in the South by Nise town, in the West by Nawfia town and in the East by Amansi town. It is the administrative town of the state. In the olden days, Awka is known for their expertise in goldsmith especially in making local guns and for their annual festival called IMO-AWKA which usually comes around June every year.

The two other facilities that were used in this study General hospital Onitsha and St Charles Borromeo hospital are located within the same local government area of Onitsha North. Onitsha is the biggest commercial city in West Africa and is situated within the East of the Niger Bridge and ^ordering Anambra state with Delta state. GH Onitsha is at the southern part of the local government while Borromeo is situated within the popular junction in the state called All Hallows or Nnamdi Azikiwe house/junction which is at the Eastern part of the local government. The general hospital is a state hospital, while Borromeo is owned by Catholic mission. The copulation of Onitsha city according to 2006 census was 5.7 million.

The Study Population:

The target population for the study consisted of all the male and female adults above twenty-one years that are HIV positive that registered for care and treatment in these three hospitals that are resident or non- resident within the two local Governments Areas that houses the three hospitals. The accessible population for the study consisted of three hundred and thirty ;30) HIV positive adult patients that assess care within these three hospitals from 2007 to 2009.

Sample and Sample Technique:

The sample for this study comprised three hundred and thirty 330 adults (198females and 132males) drawn from the three GHAIN supported sites (hospitals)as at 2009 in Anambra state. The sampling technique used in this study was multistage sampling procedure.

Stage one: Clustering the HIV/AIDS activities in Anambra State into five based on the comprehensive sites. Simple random sampling technique by balloting with replacement was used to draw three comprehensive sites.

Stage two: Non-probability (chance selection) was used in choosing the first 20 clients who visited the chosen hospitals in each clinic days.

Stage three: Alternate selection was used to select the first three Tuesdays and Thursdays of the first three weeks in the month of June and the last three weeks of July 2010 as days of sample collections, making a total of six days from each of the selected sites.

Instrument for Data collection:

The main instrument for data collection was self-developed structured questionnaire. It consisted of six sections. Section A contained three (3) questions on background information of the respondents. Section B contained six (6) questions on strategies for community engagement in HIV/AIDS stigma reduction. Section C consisted of six (6) questions on strategies for social mobilization in HIV/AIDS stigma reduction. Section D contained eight (8) questions on health implications of HIV/AIDS. Section E contained nine (9) questions on practices that encourage HIV/AIDS stigma. While section F contained six (6) questions on strategies for coping with HIV/AIDS stigma. All the questions were patterned into four- points scale of strongly Agree, (4) Agree (3), Disagree (2), and strongly disagree. *i* Appendix B)

Validity of the instrument:

The self structured questionnaire was approved by the project supervisor and validated by a jury of experts in public health from Nigerian Universities. The validators were requested to examine the objectives of the study alongside the instrument to confirm the adequacy in eliciting required Information for the study. Modifications were done based on the validators comments.

Method of Data Collection:

A total of one hundred and fifteen copies of the questionnaire were sent to each of the three hospitals (General Hospital Awka, General Hospital Dnitsha and St Charles Borromeo Hospital Onitsha). In GH Awka and SCBH Onitsha, it was given to the triage nurse at the ART clinic, but in GH Onitsha, it was given to the laboratory scientist in the ART Lab and they were instructed on how to administer it to the people living with HIV PLWHA). A triage nurse is one that checks the vital signs of these clients record them in their folders and send the folders to the doctors for further investigations. A small had paper card was prepared with numbers one to thirty and as the patients arrive in the morning every clinic day; the cards were given to them as they enter until it gets to the thirtieth person. Later on, they will share the questionnaire to the first twenty persons and if they discover that any of them has collected before she gives to the next person. The person in charge of the questionnaire in the hospital (either the nurse or the Lab scientist) will then educates them on the important of the questionnaire and how to fill it. For those that could not write, the nurse / lab. Scientist or the researcher (where available) will go further to read the questions and assist them in filling them based on their responses.

All the filled copies of the questionnaire are collected same day or within the week from the hospitals for analysis.

Method of Data Analysis:

The data were collated and analysis done with SPSS version 17.0. Research questions were answered using percentages while the null hypotheses were tested using inferential statistics of chi-square (X^2). The level of significance was set at 0.05. Appropriate degrees of freedom were worked out.

Results:

| RESPONDENT | NO. ADM | NO. RETURNED | NO. REJECTED | Freq uenc y of used instr ument | % GOOD |
|------------|---------|--------------|--------------|---------------------------------|--------|
| GH ONITSHA | 115 | 111 | 1 | 110 | 95.65 |
| SCBH OSHA | 115 | 113 | 1 | 112 | 97.39 |
| GH AWKA | 115 | 111 | 3 | 108 | 93.91 |
| | | | | | |
| TOTAL | 345 | 335 | 5 | 330 | 95.65% |
| | | | | | |

Table 1: Percentage (%) response to the questionnaire by the Hospitals.

Of the one hundred and fifteen copies of the questionnaire administered to each of these three hospital sites, one hundred and eleven (111) were returned from G H Onitsha, out of which one (1) was not properly filled, one hundred and thirteen (113) were returned from SCBH Onitsha out of which one (1) was not properly filled, and in GH Awka we had one hundred and eleven (111) returned but three (3) were not properly filled. In all a total of three hundred and thirty five questionnaires were returned (98.53%) out of which five was discarded as a result of improper filling, and a total of three hundred and thirty were correctly filled representing (95.65%).

| Gender | F | % |
|--------|-----|------|
| Male | 93 | 28.2 |
| Female | 237 | 7.8 |
| Total | 330 | 100 |

Table 2: represents frequency distribution of respondents' gender. It shows that 93 (28%) are males, while 237 (71%) are females.

| Age brackets | f | % |
|--------------|-----|------|
| 22-30 yrs | 106 | 32.1 |
| 31-39 yrs | 120 | 36.4 |

| | | | |
|-----------------|-----|------|---|
| 40 - 48 yrs | 72 | 21.8 | – |
| 49yrs and above | 32 | 9.7 | |
| Total | 330 | 100 | |

Table 3: Frequency distribution of respondents' ages.

Table 3 shows frequency distribution of respondent ages. It reveals that 106 (32.1%) are within the age of 22 - 30years, 120 (36.4%) are within 31 - 39 years, 72 (21.8%) are within 40 - 48 years, while 32 (9.7%) are 49 years and above.

| Level of education | f | % |
|----------------------|-----|-------|
| Non-formal education | 11 | 3.3 |
| Primary education | 108 | 32.7 |
| Secondary education | 153 | 46.4 |
| Tertiary education | 58 | 17.6 |
| Total | 330 | 100.0 |

Table 4: Frequency distribution of respondents' levels of education.

Table 4 shows frequency distribution of respondents' levels of education. It reveals that 11(3.3%) of the respondents had non-formal education, 108 (32.7%) had primary education, 153 (46.4%) had secondary education while 58 (17.6%) had tertiary education.

Section B: Strategies for Community engagement in HIV/AIDS stigma reduction.

Research question 1:
What are the strategies for community engagement in HIV/AIDS stigma reduction in adults using GHAIN supported comprehensive sites in Anambra state?

Responses.

| Strategies Agreed | Disagreed | | | | Total |
|---|-----------|--------|------|--------|-------|
| | f | % | f | % | |
| I sing community leaders | 284 | (86) | 46 | (14) | 330 |
| Using religious leaders for health talk | 295 | (89.4) | 35 | (10.6) | 330. |
| Using organizations to talk about it | 293 | (88.8) | 37 | (11.2) | 330 |
| "sing healthy infected ones to talk | 261 | (78.1) | 69 | (20.9) | 330 |
| Organizing interactive sessions | 291 | (88.2) | 39 | (11.9) | 330 |
| Jsing health professionals to talk | 314 | (95.5) | 16 | (4.8) | 330 |
| Total | 1738 | (526) | 242 | (73.4) | 1980. |
| Average | 289.7 | 87.7 | 40.3 | 12.3 | 330 |

Table 5: Frequency distribution of strategies for community engagement as a means « HIV /AIDS stigma reduction.

Table 5 shows frequency distribution of strategies for community engagement in HIV/AIDS stigma reduction among adults using GHAIN supported comprehensive sites in Anambra state. It shows that 284 (86%) of the total number of respondents used for this study agreed that using community leaders to educate people about the virus will reduce stigma, while 46 (14%) disagreed. Two hundred and ninety-five (89.4%) of the respondents agreed that using religious leaders to inform people about the infection and its mode of transmission will reduce the stigma, while 35 (10.6%) disagreed. Furthermore, 293 (88.8%) agreed that using various kinds of organizations to talk about the infection can reduce stigma, while 37 (11.2%) of the respondents disagreed to this. Two hundred and sixty-one (78.1%) were in agreement that using healthy HIV infected people to talk to the community at the village squares during festivals while 69 (20.9%) disagreed. Two hundred and ninety-one (88.2%) agreed that organizing interactive sessions between HIV positive individuals and others to talk about the infection will reduce stigma, while 39 (11.9%) disagreed. Three hundred and fourteen (95.5%) of the respondents agreed to the fact that inviting health professionals once in a while to create awareness about the infection in the communities will go a long way in reducing stigma while 16 (4.8%) disagreed.

Section C: Strategies for social mobilization in HIV/AIDS stigma reduction.

Research question 2:

What are the strategies for social mobilization in HIV/AIDS stigma reduction among adults using GHAIN comprehensive sites in Anambra state in 2009?

Responses

| Strategies | Agreed | | Disagreed | | Total |
|--------------------------------------|--------|-------|-----------|------|-------|
| | f | % | f | % | |
| Forming support groups for them | 309 | 93.7 | 21 | 6.3 | 330 |
| Using radio jingles to inform people | 295 | 89.4 | 35 | 10.6 | 330 |
| Using infected ones to talk about it | 285 | 86.3 | 45 | 13.7 | 330 |
| Enacting Law against HIV stigma | 265 | 80.3 | 65 | 19.7 | 330 |
| Using NGOs to educate about HIV | 301 | 91.2 | 29 | 8.8 | 330 |
| Not requesting for HIV test b/4 job. | 293 | 88.8 | 37 | 11.3 | 330 |
| Total | 1748 | 529.7 | 232 | 70.4 | 1980 |
| Average | 291.3 | 88.3 | 38.7 | 11.7 | 330 |

Table 6: Frequency distribution of strategies for social mobilization as a means of stigma reduction.

Table 6, shows the frequency distribution of strategies for social mobilization in HIV/AIDS stigma reduction among adults using GHAIN supported comprehensive sites in Anambra state using the mentioned methods. From the population of the study, 309 (93.7%) of the people agreed that formation of support groups among people living with HIV virus will reduce the stigma among the people, while 21 (6.3%) of the people disagreed. Two hundred and ninety-five (89.4%) of the population agreed that using Radio jingles to inform people about the infection will reduce stigma among people living with the virus, while 35 (10.6%) disagreed to it. Two hundred and eighty-five (86.3%) were in agreement that using HIV infected individuals to talk to others through TV programs will reduce stigma among the people while 35 (10.6%) of the population disagreed to this as means of reducing stigma. Two hundred and sixty-five (80.3%) of the people agreed to the fact that enacting laws against stigmatizing people living with HIV will reduce the stigma, while 65 (19.7%) disagreed to this.

Three hundred and one (91.2%) of the study respondent agreed that using NGOs to educate people about the infection during social gatherings will go a long way in reducing HIV/AIDS stigma while 29 (8.8%) of the respondent disagreed. Two hundred and ninety-three (88.8%) of the respondents agreed that not requesting for HIV status of individuals before employment will reduce the stigma, while 37 (11.3%) of them disagreed to the statement.

Section D: Assessment of knowledge about health implications of AIDS stigmatization.

Research question 3:

What is the level of knowledge of adults in Anambra state about the implications of stigmatization on HIV/AIDS patients in their community?

| Strategies Implications of stigma | Responses | | | | | | Total |
|--------------------------------------|-----------|--------|----------|--------|-----|------|-------|
| | High | % | Moderate | % | Low | % | |
| leads to stress | 118 | (35.8) | 190 | (57.6) | 22 | 6.6 | 330 |
| Loneliness | 127 | (38.5) | 180 | 54.5 | 23 | 6.9 | 330 |
| Aggressiveness | 108 | (32.7) | 189 | 57.3 | 33 | 10.0 | 330 |
| Depression | 115 | (34.8) | 183 | 55.5 | 32 | 9.7 | 330 |
| Frustration | 121 | (36.7) | 191 | 57.9 | 18 | 5.4 | 330 |
| Low self esteem | 130 | (39.4) | 185 | 56.1 | 15 | 4.5 | 330 |
| withdrawal | 110 | (33.3) | 200 | 60.6 | 20 | 6.0 | 330 |
| Bitterness | 100 | (30.3) | 211 | 63.9 | 19 | 5.7 | 330 |
| Total | 929 | | 1529 | | 182 | | 2640 |
| Average | 35.2 | | 57.8 | | 6.9 | | 330 |

Table 7: Frequency distribution of respondents' level of knowledge of implications of stigmatization on HIV/AIDS patients in their community.

Table 7, shows the frequency distribution of respondents' level of knowledge of health implications of HIV/AIDS stigmatization among positive adults in Anambra state. From the population of the study, 118

(35.8%) of the respondent possessed high level of knowledge that stigmatizing people living with HIV/AIDS in Anambra state leads to stress, 190 (57.6%) possessed moderate level of knowledge, while 22(6.6%) possessed low level of knowledge on the same issue. Regarding loneliness as a health implication of stigmatization, 127 (38.5%) of the respondents possessed high level of knowledge, 180 (54.5%) possessed moderate level of knowledge, while 23 (6.9%) possessed low level knowledge on the same issue. Again, 108 (32.7%) of the respondents possessed high level of knowledge that aggressiveness is part of the health implications of HIV stigmatization, 189 (57.3%) of the respondents possessed moderate level knowledge of this while 33 (10.0%) of the respondent had low level of knowledge of this. One hundred and fifteen (34.8%) of the respondents possessed high level of knowledge that HIV stigma can lead to depression, 183 (55.5%) of the people possessed moderate level of knowledge while 32 (9.7%) possessed low level of knowledge of this. On the same issue, frustration as one of the health implications that could result form stigmatizing people living with HIV/AIDS and 121 (36.7%) of the respondents possessed high level knowledge of this, 191 (57.9) of the people possessed moderate level of knowledge of this while 18 (5.4%) of the respondents possessed low level of knowledge of this. One hundred and thirty (39.4%) of the respondent possessed high level of knowledge that stigmatizing people living with HIV could lead to low self esteem, 185 (56.1%) of the people possessed moderate level of knowledge of this while 15 (4.5%) of the respondents possessed low level of knowledge of this. One hundred and ten (33.3%) of the respondents possessed high level of knowledge that HIV/AIDS stigma can lead to self withdrawal, 200 (60.6%) of the respondents possessed moderate level of knowledge of this, while 20 (6.0%) of them possessed low level of knowledge of this. Bitterness is another health implication of HIV/AIDS stigmatization and 100 (30.3%) of the respondents possessed high level of knowledge of this, 211 (63.9%) of the respondents possessed moderate knowledge of this while 19 (5.7%) of the respondent possessed low level of knowledge of this.

Section E: Practices that encourage HIV/AIDS stigmatization.

Research question 4:

What are some of the community practices that encourage HIV/AIDS stigmatization among adults in Anambra state?

| Strategies | Responses | | | | |
|-----------------------------------|-----------|------|-----------|------|-------|
| | Agreed | % | Disagreed | % | Total |
| Community practices | | | | | |
| Cultural practice of ear piercing | 271 | 82.1 | 59 | 17.9 | 330 |
| Not touching infected person | | | | | |
| because of fear of infection | 262 | 79.4 | 68 | 20.6 | 330 |
| Cultural practices (tribal marks) | 259 | 78.5 | 71 | 21.5 | 330 |
| Cultural | 233 | 70.6 | 97 | 29.4 | 330 |

| | | | | | |
|---------------------------------|--------|-------|------|-------|------|
| practices (circumcision) | | | | | |
| HIV test before marriage | 252 | 76.3 | 78 | 23.7 | 330 |
| Documented HIV test b/4 wed. | 274 | 83.0 | 56 | 17.0 | 330 |
| Separate equip, for surgery | 284 | 86.1 | 46 | 14.0 | 330 |
| Special h/glove during delivery | 303 | 91.9 | 27 | 8.2 | 330 |
| Total | 2, 138 | 647.9 | 502 | 152.3 | 2640 |
| Average | 267.3 | 81.0 | 62.8 | 19.0 | 330 |

Table 8: Responses to some of the community practices that encourages HIV stigmatization among adults in Anambra state.

Table 8, shows the responses on community practices that encourage HIV/AIDS stigmatization among positive adults that uses CHAIN supported comprehensive site in Anambra state. From the population of the study, it was discovered that 271 (82.1%) of the people agreed that cultural practices like ear piecing encourage HIV infected ones being stigmatized, while 59 (17.9%) disagreed to this statement. Two hundred and sixty-two (79.4%) agreed that not touching HIV/AIDS infected persons due to fear of being infected encourages stigmatization while 68 (20.6%) of the population disagreed to this. Two hundred and fifty-nine (78.5%) of the study population agreed that cultural practices like inscribing tribal marks encourages HIV stigmatization while 71 (21.5%) of the people were in total disagreement to that. Two hundred and thirty three (70.6%) of the people were in agreement that some cultural practices like circumcision encourages HIV/AIDS stigma in adults while 97 (29.4%) disagreed to this. Two hundred and fifty-two (76.3%) of the people agreed that requesting for HIV status result of individuals before traditional marriage encourages its stigmatization but 78 (23.7%) of the population did not agree to this idea. Two hundred and seventy-four (83.0%) of the population were of the opinion that religious belief of producing documented HIV status before church weeding encourages stigmatization while 56 (17.0%) were in disagreement to this. Two hundred and eighty-four (86.1%) of the population were of the opinion that having separate equipment for people living with HIV virus during surgery encourages stigmatization while 46 (14.0%) pf the population were in disagreement with this. Three hundred and three (91.9%) agreed that using separate/ special hand gloves for HIV positive pregnant women during delivery encourages stigmatization.

Section F: Strategies for coping with HIV/AIDS stigma.

Research question 5:

What are the strategies for coping with HIV/AIDS stigma among adults in Anambra state?

| | | | |
|-----------|------------|------------|-----------|
| Gender | Mae | Female | Total |
| Agreed | 112(33.9%) | 174(52.7%) | 286 |
| Disagreed | 24(7.3%) | 44 | 20(6.06%) |
| Total | 198(60%) | 330 | 132(40%) |

| Strategies | | responses | | |
|--------------------------------------|-------|-----------|-------|-------|
| Agreed | % | Disagreed | % | Total |
| f | | f | | |
| Educating people about HIV 300 | 90.9 | 30 | 9.1 | 330 |
| Making the infection like others 293 | 88.8 | 37 | 11.2 | 330 |
| Forming social groups 269 | 81.5 | 61 | 18.5 | 330 |
| Allowing same benefit as others 272 | 82.4 | 58 | 17.6 | 330 |
| Change altitude of H/workers 265 | 80.3 | 65 | 19.7 | 330 |
| Equal employment opportunity 319 | 96.7 | 11 | 3.3 | 330 |
| Total 1718 | 520.6 | 262 | 161.3 | 1980 |
| Average 286 | 86.8 | 44 | 26.9 | 330 |

Table 9: Responses on strategies that could help HIV/AIDS adult patients in Anambra state cope with the stigma.

Table 9, shows responses on strategies that could help HIV/AIDS individuals using GHAIN supported comprehensive sites in Anambra state cope with the stigma. From the table, it was observed that Three hundred (90.9%) of the study population agreement that educating people about HIV/AIDS infection will help positive people cope with stigmatization, while 30 (9.1%) disagree to that. Two hundred and ninety-three (88.8%) of the population agreed that making the disease seem like any other disease (not making it special) could help them cope with stigma, while 37(11.2%) disagree to this. Two hundred and sixty-nine (81.5%) agreed that forming social groups can help them cope with stigmatization, while 61 (18.5%) disagree to this. Two hundred and seventy-two (82.4%) agreed that allowing them all the benefits and privileges accorded other persons could help them cope with stigma while 58 (17.6%) disagree to this. Two hundred and sixty-five (80.3%) agreed that changing the attitude of health workers towards HIV/AIDS patients will help them to cope with stigma, while 65 (19.7%) of the respondents disagree to this statement. Three hundred and nineteen (96.7%) agreed that not discriminating against them in employment will help them cope with HIV stigma, while 11 (3.3%) disagreed.

Strategies for coping with HIV/AIDS

Table 10: Relationship between male and female adults in Anambra state in their strategies for coping with HIV and AIDS stigma
Cal X² value = 0.03, %² 0.05 = 3.84. df =3; P <.05

Cal X2 value = 0.03, %2 0.05 = 3.84. df =3; P <.05

Table 10 shows relationship between male and female adults in Anambra state in their strategies for coping with HIV/AIDS stigma. It reveals that out of the 132(40%) males, 112 (33.9%) agreed to the strategies that there is no significant relationship between male and female adults in Anambra state in their strategies for coping with HIV/AIDS stigma, while 20 (6.06%) disagreed to the strategies. Also, out of the 198(60%) females; 174 (52.7%) agreed to the strategies while an appreciable respondents of 24 (7.3%) disagreed. Based on this finding, it was discovered that female respondents agreed more with 87.8% than the males that have 84.8%. When the data were exposed to chi-square statistics to test the hypothesis, the null hypothesis which stated that there is no significant relationship between male and female adults using CHAIN comprehensive sites in Anambra state in their strategies for coping with the HIV/AIDS stigma based on their gender, was accepted. The result revealed that since the calculated chi-square of 0.03 is less than \$ table value of 3.84 at degree of freedom 1 and at 0.05 level of significance relationship between male and female adult in their level of knowledge of coping with HIV stigma reduction is therefore accepted. Conclusion was that there is no significant relationship between male and female adults using CHAIN comprehensive sites in Anambra state in their strategies for coping with HIV/AIDS stigma.

| | | | | | |
|-----------|------------|------------|-----------|----------|-----|
| Agreed | 73(12.1%) | 89(27%) | 54(16.4%) | 21(6.4%) | 237 |
| Disagreed | 33(10%) | 31(9.4%) | 18(5.5%) | 11(3.3%) | 93 |
| Total | 106(32.1%) | 120(36.4%) | 72(21.8%) | 32(9.7%) | 330 |

Cal χ^2 value =9.0, £ 0.05 = 7.82. df =3; P <.05

Table 11: Relationship among respondents of various ages in Anambra state in their

Table 11 shows relationship between adults of various ages in Anambra state in their strategies for coping with HIV stigma. It reveals that out of 106 (32.1%) of the total respondent that is within the ages of 22-50years, 73 (12.1%) agreed to the strategies that there is no significant relationship among adults of various ages in Anambra state in their strategies for coping with HIV/AIDS stigma, while 33 (10%) disagreed to the strategies. Again, among the respondents between the ages of 31-39years that is totaling 120 (36.4%) in number, 89 (27%) agreed to the strategies that there is no significant relationship among adults of various ages in Anambra state in their strategies for coping with HIV/AIDS stigma, while 31 (9.4%) disagreed to the strategies. Furthermore, among the respondents of ages 40-48years totaling 72 (21.8%), 54 (16.4%) of them were in agreement with the strategies that there is no significant relationship among adults of various ages in Anambra state in their strategies for coping with HIV/AIDS stigma, while 18 (5.5%) of this group disagreed to the strategies. Finally within adults of ages 49years and above, totaling 32 (9.7%), 21 (6.4%) of them agreed to this strategies while 11 (3.3%) of the respondents disagreed that there is no significant relationship

among adults of various ages in Anambra state in their strategies for coping with HIV/AIDS stigma. When the data were exposed to chi-square statistics to test the hypothesis that there is no significant relationship among adults of various ages in Anambra state in their strategies for coping with HIV/AIDS stigma, the result revealed that since calculated %² value of 9.0 is greater than the %² table value of 7.82 at df of 3 and at 0.05 of level of significant. The null hypothesis that there is no significant relationship among adults of various ages in their level of coping with HIV stigma is therefore rejected. Conclusion drawn was that there is significant relationship among adults of various ages in their level of coping with HIV stigma. Respondents with the age bracket of 40-48 years agreed most to the strategies while those within the ages of 49 years and above disagreed most.

Levels of Education

| Strategies | Non-formal | primary | secondary | tertiary | Total |
|------------|------------|------------|-------------|------------|-------|
| Agreed | 7(2.1%) | 85(25.8%) | 122(37%) | 41(12.4%) | 255 |
| Disagreed | 4(1.2%) | 23 (7%) | 31(9.4%) | 17(5.6%) | 75 |
| Total | 11(3.3%) | 108(32.7%) | 153 (46.4%) | 58 (17.6%) | 330 |

Table 12: Relationship among respondents of various levels of educations in Anambra state in their strategies for coping with HIV/AIDS stigma.

Calculated \$ value = 12.05, %² 0.05 = 7.82, d£=3; P < .05

Table 12 shows relationship among respondents of various level of education in Anambra state in their strategies for coping with HIV/AIDS stigma. It reveals that among those that have non-formal education totaling 11 (3.3%), 7 (2.1%) of them agreed to the strategies that there is no significant relationship among adults of various levels of education in Anambra state in their HIV stigma reduction, while 4 (1.2%) disagreed to the strategies. Again, among those that ended in primary education totaling 108 (32.7%), 85 (25.8%) agreed to the strategies of no significant relationship among adults of various level of education in Anambra state in their strategies for coping with HIV/AIDS stigma while 23 (7%) of the population disagreed to the strategies. In addition, among those that attended secondary school level of education totaling 153 (46.4%), 122 (37%) agreed to this strategies while 23 (9.4%) disagreed to the strategies. Finally, out of those that attended tertiary education totaling 58 (17.6%), 41 (12.4%) agreed to the strategies of no significant relationship among adults of various levels of educations in Anambra state in their strategies for coping with HIV/AIDS stigma, while appreciable respondents of 17 (5.6%) disagreed to the strategies. When the data were exposed to chi-square statistics to test the hypothesis that there is no significant relationship among adults of various levels of education in Anambra state in their strategies for coping with HIV/AIDS stigma, the result reveals that since the calculated %² value of 12.05 is greater than the \$ table of 7.82 at df 3 and at 0.05 level of significant. The null hypothesis that there is no significant relationship among adult of various levels of education in Anambra state in their HIV stigma reduction is rejected. Conclusion was that there is significant Relationship among adults of various level of

education in Anambra state in their HIV stigma reduction. Respondents with secondary education agreed most while those with non-formal education disagreed most.

Discussion:

This particular section is specifically denoted to re-examine the various findings against the objectives of the study, with a view to ascertaining the data and other information obtained through review of related literature. Research question 1

This sought to find out the strategies for community engagement in HIV/AIDS stigma reduction in adults using CHAIN supported comprehensive sites in Anambra state?

Table 5 showed that the use of health professionals to educate the community about the infection came strongest among the respondents with 314 (95.5%) while 16 (4.8%) disagreed to this. This was followed by using religious leaders to educate the communities with 295 (89.4% in agreement and 35 (10.6%) were in disagreement. This conform with the related literature which revealed that the New York state Targeted provider Education Demonstration program, funded by HRSA/HAB, builds capacity in minority organizations for education and training of health and human services providers helps in reducing stigma within the communities. (HRSA & George, 2003). Never the less, other strategies like using other organizations to talk to the people about the infection, came up strongly with 295 (88.8%), organizing interactive sections within the communities, had 291 (88.2%), using religious leaders 284 (86.0%), and using healthy infected ones to talk about the infection came up with 261 (78.1%), all indicated that educating the people about the infection is a welcome strategy in HIV/AIDS stigma reduction. This was in agreement with [14] that states that some of the strategies that can be use effectively to reduce HIV stigma is to use various organizations in the communities and religious bodies to talk about the disease. Using healthy infected individuals to talk to the community came last in this series, indicating that many of the respondents will not agree to disclose their status in the public, telling others about the infection and the reason could be fear of being stigmatized. In view of this, I suggest that for further studies on this that this last method should not be considered since it could not give a strong positive result.

Table 6 revealed that 309 (93.7%) of the respondent indicated that forming support group among PLWHA contrary to 21 (6.3%) who disagreed to it. This was in conformity with the research that was carried out in 1997 where Magic Johnson announced that he was HIV positive, two waves random-digit-dialing national telephone surveys were conducted. Johnson's disclosure took place three weeks before Wave 11. Results showed that respondents who were highly influenced by Johnson disclosure became less intent on avoiding people living with HIV/AIDS (PLWHS). The study also found that direct contact with PL WHS was associated. Three hundred and one (91.2%) agreed to the use of NGOs like GHAIN to tell people about then infection will go a long way in reducing stigma, while 29 (8.8%) disagreed to it. As a staff with GHAIN, I can state that this is a practical experience of what I have seen happening in the field and that it is very real. Two hundred and

ninety-five (89.4%) agreed that using radio jingle to inform the people about the infection will be of great importance while 35 (10.6%) were in disagreement. Two hundred and ninety -three (88.8%) agreed that not requesting for HIV test before employment is a way of reducing stigma while 37 (11.3%) disagreed to it. This is in conformity with the literature review statement that, people living with HIV, as well as people who are merely believed to be HIV positive, have been fired from their jobs, evicted from their homes, and denied services [15].Two hundred and sixty-five (80.3%) were in agreement that enacting law against HIV stigma is a way to reduce stigma while 65 (19.7%) of the respondent refused to this. This is in agreement with [16] which stated that Law and Legal protections are essential components of the social response to stigma and discrimination. Furthermore, Burris, stated that the recognition of the negative consequences of HIV/AIDS stigma, for individuals as well as for the public health, led to the enactment of statutory protections for people living with HIV disease. The confidentiality of HIV-related information, particularly HIV test results, enjoys considerable protection under state laws and the U.S Constitution. [17]

Table 7 revealed that 315 (95.5%) of the respondent agreed that low self esteem is the strongest effect, followed by frustration 312(94.6%), bitterness 311 (94.2%), withdrawer 310 (93.9%), stress 308 (93.4%), loneliness 307. 93,0%), depression 298 (90.3%), and aggressiveness 297 (90.0%). This is :n agreement with (Brown, eto, 2001) conclusion about consequences of HIV stigma which he stated as, deterioration of interpersonal relations, negative emotions, rejection of the HTV antibody test, stress related to the .-iding of the condition, anxiety, depression, guilt, loss of support, isolation, emotional or physical violence.

Data on table 8 showed that 303 (91.9%) of the respondent agreed that using special/separate hand gloves during delivery is a major challenge, while 27

(8.2%) disagreed to it. Two hundred and eighty-four (86.0%) agreed that using separate equipment for them during surgery is another challenge while 46 (14.0%) disagreed to this. Two hundred and seventy-four (83.0%) agreed that the request of documented HIV result before wedding is a major challenge, while 56 (17.0%) disagree to this. Two hundred and seventy-one (82.1%) agreed that poor knowledge of how one can get infected brings about stigma while 59 (17.9%) of the people were in disagreement to this. Two hundred and sixty- two (79.4%) agreed that having good knowledge -about the infection could lead to stigma while 68 (20.6%) disagreed to this.

Two hundred and fifty-nine (78.5%) of the respondents agreed that fear of being infected brings about HIV patients being stigmatized, while 71 (21.5%) of the people disagreed to this. Two hundred and fifty two (76.3%) of the people agreed that requesting HIV status of individuals before traditional marriage causes stigma while 78 (23.7%) of the people disagreed that this can lead to stigma. Two hundred and thirty three (70.6%) were in agreement with the fact that some cultural practices could lead to HIV stigma while 97 (29.4%) did not agree to this. This is in agreement with Joint United National Program on HIV/AIDS (UNAIDS) and World Health Organization (WHO), AIDS Epidemic Update. This stated that, in United State and around the world, many communities punish

people for simply revealing their HIV status. An HIV diagnosis can cause family members, neighbors, and even medical providers to shun the HIV-infected person [18].

From table 9 of this study it shows that 319 (96.7%) of the respondent were in agreement with the statement that giving adult PLWHA in Anambra state equal employment opportunity will help them cope with stigma, while 11 (3.3%) of the people disagreed to this. Three hundred (90.9%) of the respondent agreed that educating the people about HIV infection will help them to cope with the stigma while 30 (9.1%) disagreed. Two hundred and ninety three (88.8%) agreed that making the infection like other infection disease will help them cope with stigma but 37 (11.2%) disagreed to it. Two hundred and seventy two (82.4%) of the respondent agreed that allowing them the same opportunities like other people will help them cope with HIV stigma while 58 (17.6%) of the people were in disagreement to it. Two hundred and sixty-nine (81.5%) of the people agreed that forming social groups among them will help them cope with stigma, while 61 (18.5%) disagreed to it. Two hundred and sixty-five (80.5%) of the people agreed that reorientation of attitude of health workers about them will help them cope with the stigmatization, while 65 (19.5%) of the respondents disagreed to this. This is inconformity with Herek research devoted to stigma and access to care in which he mentioned that reluctance to health care providers to treat people living HIV as one of the leading cause of stigma among the people [19]. In another development, It was stated that HTV related stigma can negatively affect self-esteem and mental health while increasing the risk of discrimination and violence. These factors can foster a reluctance to seek care. He went further to state that HIV/AIDS related stigma also fuels new HIV infection because it can deter people from getting tested for the disease, making them less likely to acknowledge their risk of infection, and discourage those who are HIV-positive from discussing their HIV status with their sexual and needle-sharing partners [20]

Table 10 shows the relationship between male and female adults in Anambra state in their strategies for coping with HIV/AIDS stigma. Based on the report, out of 132 (40%) males that participated in the program, 112 (33%) of them were in agreement that there is no relationship between male and female adults in Anambra state in their strategies for coping with HIV stigma while 20 (6%) of them disagreed to this. Furthermore, out of 198 (60%) females that participated in the program, 174 (52.7%) were in agreement with the fact that there is no significant relationship between male and female adults in Anambra state in their strategies for coping with HIV stigma, while 24(7.3%) of them were in disagreement to this. Having been in the field, working with an NGO (Global HIV/AIDS Initiative Nigeria GHAIN) which its ultimate aim and objectives is geared toward improving life of people living with HIV/AIDS and preventing others from getting infected the researcher observed that with his field experience, he is in total support of this finding. My field experience confirmed that there is no significant relationship between male and female adults in their strategies for coping with HIV/AIDS stigma. Based on this, the hypothesis is rejected. This may be because both male and female genders are exposed to infection and stigmatization. Table 11 shows strategies for coping with HIV/AIDS stigma among adults in Anambra state based on their ages. From the study,

those that are between the ages of 22-30years that participated in the study were 106 (32.1%) and out of this number, 73 (12.1%) of the respondent were in agreement that there is no significant relationship between adults of various ages in Anambra state in their strategies for coping with HIV stigma, while 33 (10%) of the respondent disagreed to it. Those that are within the ages of 31-39years were 120 (36.4%) in number, and out of this, 89 (27%) of them were in agreement that there is no relationship between adults of various ages in Anambra state in their strategies for coping with HIV stigma, while 31 (9.45%) disagreed to this. Those between the ages of 40-48years were 72 (21.8%) and out of this, 54 (16.4%) were in agreement while 18 (5.5%) disagreed to this. Other adults that are within the ages of 49 and above that participated in this program were 32 (9.7%) and out of this, 21 (6.4%) agreed to the concept that there is no significant relationship between adults of various ages in Anambra state in their strategies for coping with HIV stigma, while 11 (3.3%) disagreed to it.

Table 12 shows the attitudes of adults towards persons living with HIV/AIDS that amount to stigmatization based on their levels of education. From the respondents, out of 11 (3.3%) persons that had non-formal education, 7 (2.1%) was in agreement that there are some attitudes of adults in Anambra state towards persons living with HIV/AIDS that amount to stigmatization while 4 (1.2%) disagreed to it. Those that ended in primary education were 108 (32.7%) out of this number, 85 (25.8%) were in agreement while 23 (7%) disagreed to it. Those whose level of education ended in secondary education were 153 (46.4%) out of this number, 122 (37%) were in agreement that there are some attitudes of adults in Anambra state towards persons living with HIV/AIDS that amount to stigmatization hence accepting the hypothesis that states that there is no significant relationship among adults of various level of education in Anambra state in their strategies for coping with HIV/AIDS, while 31 (9.4%) of the this group disagreed to this. Among those that attended tertiary level of education, which are 58 (17.6%) in number, 41 (12.4%) were in agreement to the above statement while 17 (5.6%) of them disagreed to this statement. This is in conformity with the statement of Taiwo O which states that, the major drivers of the HIV epidemic in Nigeria includes: Poverty, and not lack of education. [21]

Conclusion:

The findings from research questions one and two indicates that there is neither community engaged nor social mobilization in HIV/AIDS stigma reduction among adults using GHAIN supported comprehensive sites in Anambra state in 2009. The implication of the finding is that a lot of the PLWHA dies faster as a result of stigma associated illness like (stress, loneliness, depression, frustration, low self esteem and such like) than the actual viral attack.

Again, because religious leaders and employers of labors in Anambra state demand for the HIV status of individuals before marriage or employment, positive individuals stand the chance of not getting married/being married or getting employment. This means that such person should either result into begging or stealing or die of hunger.

In addition, some of the adults living with the virus use GHAIN supported comprehensive sites are treated as outcasts by their people because of fear of being infected by shaking hands with them (poor knowledge of the infection). The implication is that at a stage, some people will give false information about their status so that they will not be stigmatized or isolated by the community, and many more will refuse to go to Heart to Heart centers to find out their status hence increasing the spread of the virus.

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