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Societal Beliefs and Reactions About People Living with HIV/AIDS

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1. Introduction

Although the overall growth of the global AIDS epidemic appears to have stabilized, still, Sub-Saharan Africa has the majority of new infections with 1.8 million (1.6 million- 2.0 million) people becoming infected in 2009 (UNAIDS, 2010). Sub-Saharan Africa remains the region most heavily affected by HIV/AIDS, accounting for 68% of all people living with HIV/AIDS (PLWHA) and for 72% of AIDS related deaths in 2009 (UNAIDS, 2010). In West Africa, Nigeria has the largest epidemic in absolute numbers (UNAIDS, 2008) with 2.98 million people living with HIV and 192,000 adults and child deaths from AIDS in 2009 (UNAIDS, 2010). The HIV/AIDS prevalence rate in Nigeria remains uneven across different states (Utulu & Lawoyin, 2007; UNAIDS, 2010). A retrospective study carried out between 2000 and 2004 among 10,032 pregnant women attending the antenatal clinic at the Braithwaite Memorial Hospital, Port Harcourt Nigeria showed that 5.93% of the women were HIV- positive patients (Obi et al., 2007). Another study carried out in the university teaching hospital at Port Harcourt Nigeria between 1999 and 2004 showed a paediatric prevalence rate of 25.8% (Alikor & Erhabor, 2005). More recently, HIV prevalence among pregnant women attending antenatal clinic in Rivers State is 7.3% in 2008 (UNAIDS, 2010) making Rivers state one of the states with high HIVprevalence among pregnant women in Nigeria.

One of the many challenges associated with HIV/AIDS is stigma. Stigma is generally recognized as an 'attribute that is deeply discrediting' that reduces the bearer 'from a whole and usual person to a tainted, discounted one' (Goffman, 1974). Herek (2002) describes stigma as an enduring condition, status, or attribute that is negatively valued by a society and whose possession consequently discredits and disadvantages an individual (Herek, 2002). Steward and colleagues noted further that stigma is very much about the socially constructed meanings associated with the attribute or characteristic (Steward et al., 2008). Because AIDS or HIV infection is an enduring condition or characteristic that is negatively valued (Herek, 2002), AIDS-related stigma continues to be a barrier to caring for, and supporting, people whose HIV status is known in society (Campbell et al., 2007).

Stigma arises and stigmatization takes shape in specific contexts of culture and power (Parker & Aggleton, 2003). Stigma is especially significant in many developing countries, such as those in Africa, where social networks and, therefore, societal values, are relatively

strong (Greeff et al., 2008). The family and the community constitute vital aspects of the social structure that normally offers strength and support during times of need and crisis (Ajuwon et al., 1998; Hilhorst et al., 2006; Kipp et al., 2007). In this communal and social network, contact with someone afflicted with a disease regarded as a mysterious threat, inevitably, feels like trespassing or, worse, as violation of a taboo (Sontag, 1989).

Stigma influences all phases in prevention, detection and care for PLWHA. It decreases turn-up for facilities for voluntary counselling and testing in hospitals (Weiser et al., 2006). Anticipated stigmatizing societal reactions may also decrease the tendency to disclose sero-status to the immediate social environment and, more importantly, to sexual partners. Specifically, a study carried out in Port Harcourt, Nigeria, showed that 77% of PLWHA had disclosed their HIV sero-status to one or more others, of which 22.3% disclosed their condition to their parents, 9.7% to their siblings, 27.8% to pastors, 6.3% to friends, 10.4% to their family members and 23.6% to their sexual partners (Akani & Erhabor, 2006). Other studies has also documented selective disclosure patterns among PLWHA. (Gari et al., 2010; Anglewicz, et al., 2011; Stutterheim et al., 2011).

In a previous study, we reviewed behavioral problems of PLWHA in Sub-Saharan Africa in seeking care, and argued that this is partly due to stigmatizing responses to PLWHA from health care professionals and society at large (Mbonu, Van den Borne, & De Vries, 2009). Given the negative impact of stigma on care seeking and the selective disclosure of a positive HIV-sero-status to close and trusted people, it is important to understand why HIV/AIDS attracts such a degree of negative reaction in society. In the present study, we focus further on a description and analysis of public beliefs and reactions towards PLWHA in a multi-street study located in Port Harcourt Nigeria, to understand why and what makes society stigmatize PLWHA. The paper concludes with recommendations that may help reduce the negative reaction towards PLWHA.

2. Methodology

A descriptive qualitative research design, using a convenient multi-venue street-intercept interview technique was used to explore public beliefs and reactions towards PLWHA. The street-intercept methodology provides access to segments of the urban population that are hard to reach and has a high degree of validity and reliability (Green, 1995; Miller et al., 1997; Baseman et al., 1999; Rotheram-Borus et al., 2001; Fortenberry et al., 2007). It is also used frequently in studies of sensitive topics, such as drug use and sexual behavior (Hidaka et al., 2008). In our study, due to the sensitivity of the topic, and in order to get remarks about PLWHA, we talked not only about individual processes but also at a meta-level about social processes. Furthermore, participants sometimes gave examples of processes or perceptions based on hearsay while in other parts they talked about themselves and their own experiences, perceptions and thoughts.

Participants were recruited between January and April 2006. Eligibility requirements included being an adult older than 18 years and residence or employment in Port Harcourt. Streets were selected from the Obio Akpor local government area of Port Harcourt. We recruited 40 participants for the interviews. Self-reported PLWHA were excluded. Port-Harcourt city is located in the Southern part of Nigeria specifically in the Eastern Niger Delta. The area is particularly rich in crude oil. Families have a median of 5 persons per household (Akpogomeh & Atemie, 2002).

2.1 Recruitment and consent of participants

A convenience sample was used in this study. Interviewees were approached at the recruitment venues and interviews were held in workplaces, offices, restaurants, shops or on the street. An introductory sentence informed participants that the interviews were covering stigma towards PLWHA. Verbal consent was obtained from participants and total anonymity was guaranteed. Forty-one persons were approached, of whom 40 agreed to participate in the interviews (See Table 1). The one person who refused was too busy to grant an interview. No compensation was offered to participants. Interviews were conducted throughout the week. Interviews were conducted in the English language and were face to face. The interviews lasted between an hour and one and half hour. Basic demographic data about participants were gathered before the interviews. Interviews continued until no new information emerged. All interviews were audio-taped and transcribed verbatim.

2.2 Data analysis

Nvivo (QRS release 2.0), a computer-assisted qualitative data analysis system, was used to aid analysis and reporting. The analysis of the interviews enabled us to identify causal relationships and, therefore, come up with a causal structure. Field notes and information from the literature review were also used during the analysis. Emerging issues were examined to identify related concepts. Different factors were formed from the emerging themes. A model was built to explore important relationships between concepts. Attributes were formed to include important characteristics such as gender and work category, which were subsequently imported into Nvivo.

2.3 Validity

An independent researcher coded a random selection of data to look for new concepts. The independent researcher compared emerging themes with the coding by the authors. New meanings and discrepancies were checked by re-reading the transcripts and fine-tuning interpretations until unambiguous categories and themes were agreed. No important discrepancies were found.

3. Results

Demographic characteristics are presented in Table 1. Twenty four persons were female and 21 persons were married. An explanatory model was organized in a causal structure based on the combined responses of the interviewees (Figure 1). The model shows stigma by society as being affected by 10 different determining factors, all of which relate to processes and conditions that allow a manifestation of the stigma. These determining factors are degree of knowledge, association with promiscuity, blame, societal reaction to care givers, media, poverty, fear, religion, gender, and government role. Blame functions both as a determining factor that creates stigma, as well as manifestations of stigma. Other manifestations of stigma are abandonment, isolation, and harassment.

The views of both men and women are combined. The described findings and interpretations offer a general insight, illustrated with verbatim excerpts. In the following sections, the various determining factors are presented. Subsequently, we describe different manifestations of stigma. Thirdly, the conditions of care will be described, and finally, we discuss how these processes and condition interrelate in the explanatory model.

Participant	Gender	Marital Status	Types Of Work	Tribe
1	Female	Single	Company Worker	Efik
2	Male	Married	Police Officer	Kalabari
3	Female	Married	Legal Practitioner	Efik
4	Female	Married	Legal Practitioner	Ibo
5	Female	Married	Sales Woman	Ibo
6	Female	Married	Teacher	Yoruba
7	Female	Married	Teacher	Ibo
8	Male	Single	Company Worker	Yoruba
9	Female	Single	Motor Company	Ibo
10	Male	Married	Manager	Yoruba
11	Female	Single	Manager	Efik
12	Male	Married	Supervisor	Ibo
13	Male	Single	Manager	Efik
14	Female	Single	Office Secretary	Ibo
15	Female	Single	Hair Dresser	Ibo
16	Male	Single	Company Worker	Efik
17	Female	Single	Company Worker	Efik
18	Female	Single	Company Worker	Ibo
19	Female	Single	Company Worker	Ibo
20	Male	Single	Company Worker	Ibo
21	Female	Married	Company Worker	Ibo
22	Male	Married	Police Officer	Efik
23	Female	Married	Legal Practitioner	Efik
24	Female	Married	Manager	Yoruba
25	Female	Married	Teacher	Ibibio
26	Male	Married	Businessman	Ibo
27	Male	Married	Manager	Yoruba
28	Female	Single	Computer Analyst	Yoruba
29	Female	Married	Shop Owner	Ibo
30	Male	Married	Government Worker	Ibo
31	Male	Married	Company Worker	Efik
32	Male	Single	Restaurant Worker	Efik
33	Male	Single	Company Worker	Ibo
34	Female	Married	Insurance Worker	Ibo
35	Female	Married	Motor Company Worker	Ibo
36	Female	Single	Student	Ibo
37	Female	Single	Student	Efik
38	Male	Single	Student	Efik
39	Male	Single	Student	Ibo
40	Female	Married	Surveyor	Yoruba

Table 1. shows the information about the participants

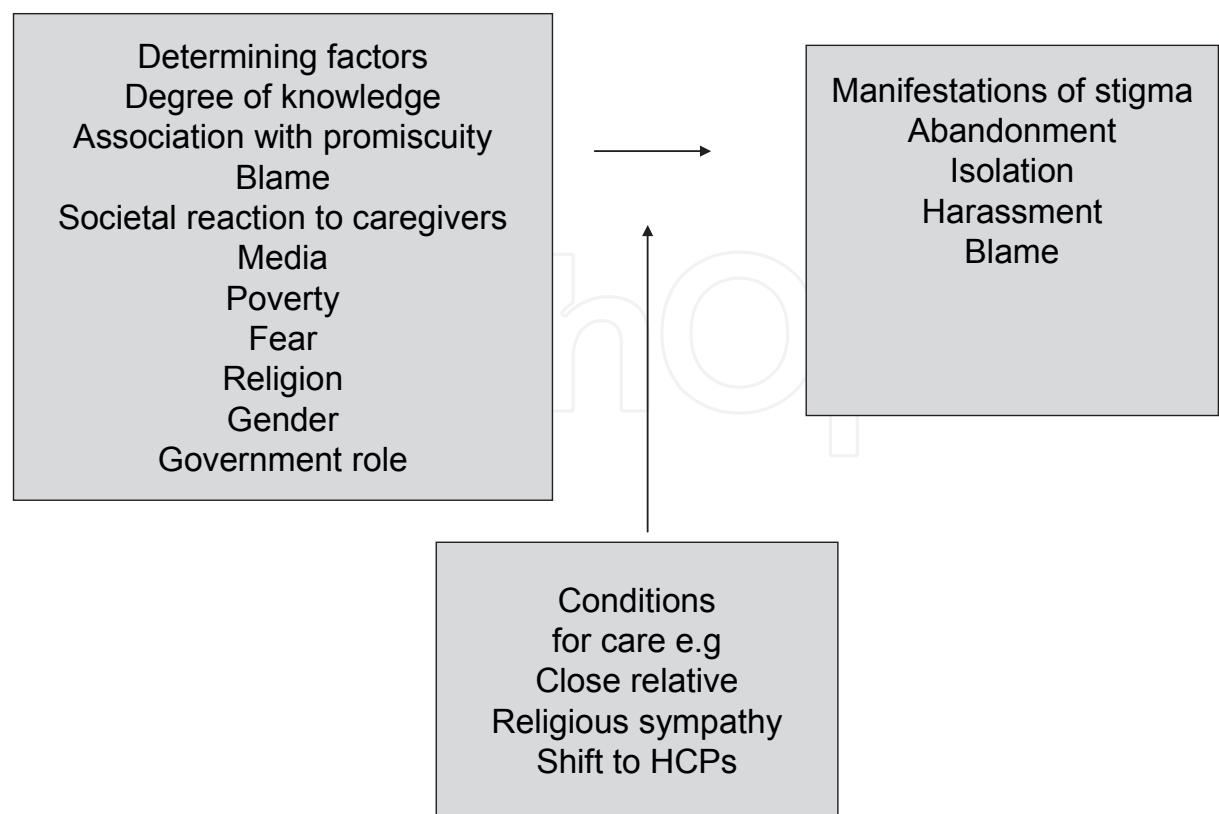


Fig. 1. shows determining factors, conditions of care And manifestations of stigma

3.1 Determining factors

We distinguished many factors, such as degree of knowledge, association with promiscuity, blame, reactions to care givers, media, poverty, fear, religion, gender, and government role.

3.1.1 Degree of knowledge

We found that inadequate knowledge about transmission and about HIV/AIDS can influence how people react to PLWHA. Although information on different ways of transmission of HIV may be increasing, still many people are not aware of accurate means of transmission of HIV virus. To some of the participants, people’s lack of knowledge about HIV/AIDS infection and the routes of transmission contributes to reluctance to care for PLWHA, as the following quote illustrates:

‘Reaction depends on the education of the person involved, the mentality. Many people think if they touch the HIV person they will get it.’ (Male, single)

PLWHA are especially ostracized when they show signs and symptoms of AIDS. Many participants based a judgment about HIV status on appearance, rather than on information, and a person’s looks may determine how negative the reaction he or she receives. For instance, if a person with HIV is heavy weighted, people around may not believe that the person has HIV. When the person has an appearance widely associated with HIV, people begin to react negatively to the person, even if they are wrong about the diagnosis. Participants in our study described the appearance of a HIV-positive person as slim with skin rashes. They frequently mentioned loss of weight and being sick for a long time, as elaborated on in the following quote:

'The hair of people with HIV starts falling out with boils all over the skin and they are slim.' (Female, single)

People felt confirmed in this judgment strategy, and looked for outward HIV/AIDS features. Some participants, without knowing the exact illness of a person, assume the HIV status of that person and feel they are right if they see prototypical HIV/AIDS features. For instance, in the words of one interviewee:

'I know someone has HIV when someone is real lean and before you know it the person is sick. When they take the person to the hospital the doctor will examine and find out that the person is HIV positive.' (Male, single)

3.1.2 Association with promiscuity

According to the participants, people associate HIV/AIDS with promiscuity and perceive this as a barrier to caring for PLWHA. Many of them reported that HIV/AIDS is contracted from unprotected sexual intercourse. The general impression among our participants is that HIV/AIDS is acquired when the person has had much sexual activity with different persons. It was common for the participants in this study to depersonalize themselves from the belief of associating promiscuity with HIV/AIDS by shifting the belief to other people, for instance:

'Most people believe HIV is contracted through sexual transmission so immediately they see someone with HIV they automatically believe the person is promiscuous and goes around sleeping around but it can be got from different ways like blood transfusion.' (Male, married)

3.1.3 Blame

According to our respondents, a person with HIV/AIDS in society is frequently an object of blame. When people blame PLWHA for contracting the illness, it makes them stigmatize those people. Many of the participants said that society expects people to stick to their steady or wedded partners, as that is the way of avoiding contracting HIV/AIDS; infected people deserved to be blamed, in their view for instance:

'I think people blame HIV persons. Some people feel HIV persons get HIV because they are prostitutes or go about having sexual intercourse with men or flirting about. So if people find out someone has HIV, people will see the person as somebody who is not responsible. The society feels if the person has not been going from person to person sexually, why should they come in contact with such illness?' (Male, single)

Another participant put it this way:

'If you are married to somebody, you are not supposed to go to another woman. You should stick to your wife. Then the single person has to be careful with their movement. People with HIV/AIDS should be blamed because they met someone; that is why they got HIV/AIDS.' (Male, single)

3.1.4 Societal reaction to caregivers

There was a consensus among participants that the reactions to people who care for PLWHA originate from their immediate environment, such as communal reactions, neighbors' influence and spousal reactions or from healthcare professionals. A participant expressed the idea that people care for one another with the expectation of reciprocity, that is, that they themselves may have a need for the care of another person in the future. Unfortunately, caring for a person with HIV/AIDS may not fit into this method of care because they are regarded as people who will die soon. Many of the participants were also

concerned about the way other people will react to them when caring for a person with HIV/AIDS. A female participant described what happened when she went to hospital to learn the result of a HIV/AIDS test of a relative visiting her, which turned out to be positive. She received this response in the hospital:

Laboratory worker: 'Oh madam, how long has this HIV person been staying with you in your house?

Woman: She has been staying for three months

Laboratory worker: You have to bring all your children for a HIV test. No, No, infact any help you want to give her let it be from a distance. She should be sent packing [sic] (sent away) from your house.' (Female, married)

This exchange indicates the extent of stigmatizing reactions even from health care professionals. In some cases, people fear that neighbors might spread the word that a family is caring for a person with HIV/AIDS, thereby affecting the possibilities of family marriage. One of the common procedures in marriage is that the family of the groom asks around for information about a potential bride before going into marriage. This implies that neighbors' judgments can be significant. Some participants felt that their desire for marriage and to have children overrides caring for a person with HIV/AIDS. This concern was shown vividly in the following comment:

'Of course, caring for a person with HIV matters to me, because people around me can know about it or how else do people get husbands? They (potential suitors) can ask questions around about me where I live. I will not care for a person with HIV/AIDS even if she is my twin sister. Do you want me to get AIDS? I do mind as long as it is HIV/AIDS or do you want me to die young. You know it is a very serious disease that has no cure. You can see I am not married. I am a single girl. I do not want anything that will stain my image.' (Female, single)

3.1.5 Media

According to some participants, the media have created an image that HIV/AIDS is contracted by people who have sex with multiple partners, or who visit sex workers. One participant had the following to say:

'People react to a person with HIV in the same way, no matter how you get it. The reason why it is like that is that the first awareness of HIV publicity said HIV was for people sleeping around. The media always said stick to one partner, use a condom. This made people feel that once people stick to one partner, they will not get HIV, not realizing that it is possible the one partner already has HIV.' (Female, married)

Participants said that the information people get from radio and television is that HIV/AIDS can be guarded against. This helps in fuelling the negative public reaction people give to PLWHA by shifting the responsibility to the individual. The next participant was concerned by the way media send HIV/AIDS messages to the public using words as for instance "obirinajocha" (means you end up in the white sand underground), which can contribute to how people respond to HIV/AIDS:

'What is being chumed out in the media is also an issue. One begins to wonder whether they are out to create an undesired effect because we hear all over the media that this is an incurable disease and people should better not attempt by any means to pick it up. The media create an atmosphere of helplessness for HIV positive people, as well as their care givers'. (Male, married)

3.1.6 Poverty

Poverty is seen as an underlying factor in preventing care for people suffering from HIV/AIDS. Poor people are often looked down upon in the society. Thus, HIV/AIDS only

contributes further to stigmatization of such people. Economic difficulties complicate the situation for persons with HIV or for people who may be willing to care for them. Sometimes, even when relatives provide PLWHA with money for drugs, people caring for the person with HIV/AIDS can divert the money for personal use or for burial because they feel the person is dying anyway, in addition to trying to avoid caring for the person. They regard it as a waste of scarce resources, as one interviewee noted:

'...when the HIV person was sick, his elder brother was given money by people to take care of the person with HIV for drugs but he spent the money on him self. He believed his brother was going to die so there was no need of giving him that money for care.' (Female, single)

3.1.7 Fear

Many of the participants had a fear of HIV/AIDS infection, and felt they could make mistakes when caring for such a person. People feel that PLWHA are close to death and since people are afraid of death, they try to avoid anything that reminds them of their own mortality, for instance:

'People who know someone with HIV, the relationship with the person will change somehow because people are scared. Nobody wants to die. When we see someone (HIV person) like that we need to know how to deal with them.' (Male, single)

3.1.8 Religion

Our data revealed that religion may play both a detrimental and a supportive role. It is an important factor in the stigma of PLWHA with some of the participants placing religion above the medical treatment, causing much conflict in caring for PLWHA. Some of the participants believed it was possible to heal HIV/AIDS because there is nothing God cannot do. This merely reflects the notion that, if they contract HIV/AIDS, they may likely seek care in faith healing houses. This affects care-seeking behavior and, especially may cause treatment delay. This participant was convinced that, in her church, HIV/AIDS can be cured:

'Many people with HIV/AIDS will fear to tell their pastor that they have AIDS so it is a problem because I know in my church they heal HIV/AIDS.' (Female, married)

However, another participant felt that the way the church goes about HIV/AIDS is wrong. In the church, where people look up to pastors and hope to get comfort, clergy may misuse the power they have over people, as demonstrated by the following comment:

'There is segregation in the church. The church counselors give a paper to new couples to go for compulsory HIV screening and when the results turn positive, they give them back seats in the church. The church committee gossip around and people who have heard are not comfortable with the persons with HIV so they feel segregated.' (Female, married)

Giving them back seats is possible because they are able to use their power to give them whichever seat position they wish. Information about who has HIV also travels very fast in the church, as one participant noted:

'I heard about the HIV couple in the church I attend. I did not know until people found out and started telling others. It was the pastor who found out through spiritual means and called them out. He asked them whether they are HIV positive and they said yes.' (Female, single)

Openly asking for persons with HIV/AIDS to come out in public has added implications because the whole church will become aware of the HIV status of those involved.

3.1.9 Gender

Our data show that women living with HIV experience more problems because their position is often marginal and inferior. Many of the participants expressed the concern that women encounter more problems because they are largely dependent on their husbands in almost every aspect: financially, emotionally, and in decision-making. Many of the participants said some women may be willing to care for a person with HIV/AIDS, but they need the approval of their husbands before they can go ahead. Chastity are also expected from women so when they contract HIV/AIDS, they are blamed to a larger extent, which may affect the willingness to care for them. The following illustrates a classic example of gender difference in blame:

'The person I know living with HIV is a girl. It will be different for a man because people will not think immediately of sex as a cause of the HIV. They will think he got it from barbing salon.' (Female, single)

When a woman is infected with HIV, she is easily labeled a prostitute, as one participant observed:

'Women seem to suffer in everything. You find out that when a lady is HIV positive, nobody wants to hear anything apart from the fact that she has been fornicating and moving from place to place. They say she deserves what happened to her.....but if it is a male it is different.' (Female, single)

This male participant showed concern that women have a possibility of spreading HIV/AIDS more purposively than men, as the following illustrates:

'It is better to tell government to take away a person with HIV especially females because if one does not take care she can spread it to other male people. Some of them know they will die one day so they start flirting about.' (Male, single)

3.1.10 Government role

Many of the participants felt that government has a major role in providing care for PLWHA and increasing the knowledge of people about HIV/AIDS. Take the following quote, for example:

'Government should continue with public information. People are still not educated very well. Some people think that if you share toilet with a HIV person you will get HIV.' (Female, married)

Participants also felt government should be involved in the care of persons with HIV, as shown by the following quotes:

'Government should make antiretroviral therapy within the limit of individuals. Some should be helped if they cannot afford it because I read in the newspapers that ART is very expensive.' (Female, married)

3.2 Manifestations of stigma

As a result of these factors, there are changes in the relationship between the general public and PLWHA. The various manifestations of external stigmas, such as abandonment, isolation, harassment and blame will be discussed.

3.2.1 Abandonment

Participants in this study reported knowing PLWHA that are abandoned or would advocate abandoning PLWHA. People are suspicious that people with HIV/AIDS can purposely share household sharp objects or start flirting because they know they will die. Because of that, some participants wanted the government to restrict the movement of PLWHA. Other people felt that persons with HIV/AIDS have to accept their fate and need to learn to live

with the fact that people will stigmatize them. Another participant preferred to shift the responsibility of care to health care professionals:

'Why must a HIV person come to the house? They should stay back in the hospital.' (Female, married)

3.2.2 Isolation

Participants described how their relationship will change upon realizing that a person with HIV/AIDS, or a caregiver of such a person, is around. People avoid people with HIV/AIDS. This explains why PLWHA are reluctant and selective in disclosure as a way of coping with HIV/AIDS stigma. People also feared that, once they care for someone with HIV/AIDS, word will spread around and from there on, people will isolate them. This participant talks about her experience of how PLWHA are cared for:

'Sometimes people with HIV/AIDS are locked up in the room and the care givers pass a hole through which they give them food so that the caregivers do not come in contact with the person. Sometimes the caregivers do not even give the person food so that the person can die.' (Female, single)

A participant shared what happened when a person with HIV/AIDS living close to her came back home from hospital:

'They try to isolate the woman who is caring for her daughter. When she was discharged and came home to their house, people started peeping at them through the window. People will not want to go to the kitchen when she is cooking and they will not want to go near the bathroom until they finish using the bathroom. Everybody wants to keep away. People look at the care giver as someone who is not reasonable anymore.' (Female, single)

3.2.3 Harassment

We also found that harassment can be a manifestation of stigmatisation and can be shown in any form of unwelcome behavior. According to this participant, who tried to describe what will happen to someone caring for a person with HIV/AIDS:

'The care givers of HIV persons will have a problem because it will be the talk of the area. People will say there is a person with HIV/AIDS in that area. Some will not be relating to them because they are afraid.' (Male, single)

In addition, people gossip in the community. This participant gave an account of a person she knows and has HIV/AIDS:

'People were running away, they always say they don't want to be involved, wherever she passes people will point at her and say look at that person with HIV. Nobody wants to visit her. The ones that go just want to gossip.' (Female, single)

3.2.4 Blame

Our findings indicate that the society frequently assigns blame to PLWHA. Blame is another way used by the people to stigmatize persons with HIV, for example:

'People blame them because they feel a responsible person is supposed to live a rightful life so they cannot contact the disease.' (Male, married)

Consider also the following point:

'You know, here in Nigeria, if you have such sickness, people will start blaming the person with HIV. They will tell her all sorts of things. They do not care how she got it. They will say the person got it from sexual intercourse.' (Female, single)

Despite these various effect factors manifesting as stigma, some participants set conditions for care, which will be discussed in the next section.

3.3 Conditions for care

The extent to which a person with HIV is discriminated against can, sometimes, depend on the closeness of the person who is rendering the care. Some of our participants felt that they will only care for a close person with HIV, as in the following instance:

'Caring for a HIV person depends on how close the person is. If it is my brother or sister I can manage but if it is my house help I will be afraid.' (Female, single)

Due to sympathy on religious grounds, some participants felt some people will still care for persons with HIV/AIDS when they have no other option:

'People will run away though it may not be everybody. Some people because of fear of God, will like to encourage that HIV person because there is no other way to do it. One cannot poison a person with HIV to die. One will prefer to take care of the person until God wants him or her.' (Male, single)

The way people discriminate home caretakers of a person with HIV/AIDS can be different from the way they react to healthcare professionals. Many of the participants in our study mentioned that the public may not react to healthcare professionals in the way they react to home care givers, because they feel they may have a need for a healthcare professional themselves. They are generally expected to be doing their work and their duty, which includes caring for PLWHA in a protective way. One participant, when asked whether healthcare professionals caring for PLWHA will be stigmatized like home caregivers, responded by saying that their profession makes them different from home care givers:

'Look at the name you called them, professionals. Healthcare professionals know how to take care of themselves.' (Female, single)

The various factors, conditions and processes that give rise to external stigma, and the way they relate, will be discussed below.

4. Discussion

This study offers a description and exploration of the various factors, conditions and processes that allows stigma to manifest in Port Harcourt Nigeria. Our study indicates that people are still not very knowledgeable about HIV/AIDS, its mode of transmission and treatment possibilities. People react negatively towards PLWHA because they know little about the disease. Hence, they cannot handle PLWHA even when it is a close relative (Hilhorst et al., 2006). Lear (1998) argued that the problem of behavioural change is compounded by the persistence of myths concerning HIV/AIDS. Furthermore, as long as diseases such as HIV/AIDS are not well understood in an era in which medicine's central premise is that all diseases can be cured (Sontag, 1989), it will continue to evoke reactions from the society. Apart from our present data which show that society has negative reactions towards PLWHA, other studies in Sub-Saharan Africa, (Hilhorst et al., 2006; Campbell et al., 2007; Greeff et al., 2008; Demmer, 2011; Singh et al., 2011) have also shown that those who care for PLWHA receive negative reactions, putting the entire family at risk, making HIV/AIDS a societal problem. Moreover, 2010 UNAIDS report also shows that PLWHA have experienced different stigmatization reactions ranging from verbal abuse, physical harassment to denial of health care (UNAIDS, 2010).

Our data show that not only that people stigmatize people diagnosed with HIV/AIDS, they also preoccupy themselves with the health diagnosis of other people through creating ideas about special features and body structures associated with certain illnesses such as HIV/AIDS. People not only live in a society that is structured by communal interaction (Wood & Lambert, 2008) but is also intertwined with gossip and rumors. HIV/AIDS

inspires much gossip, rumor and speculation. The images and the ideas associated with PLWHA are an expression of their concern for social order and of a sense of dissatisfaction from within society (Sontag, 1989). This has significant implications for PLWHA. It increases self-stigmatization, in addition to the stigmatization from society when they have body features that are widely believed to indicate HIV/AIDS. It is perhaps not surprising that our study shows that PLWHA who are heavy weighted may be exonerated because people do not believe they can be heavy weighted and at the same time have HIV/AIDS, especially when they are on antiretroviral therapy (ART) and have less need for frequent hospitalization. This aspect of body politics was also reported by Greeff and colleagues (Greeff et al., 2008).

Our data emphasize that people link HIV/AIDS to promiscuity, which makes people stigmatize PLWHA because they are regarded as people who have gone against the societal values by having indiscriminate sex. Society has strong morals and values that guide it (Campbell et al., 2007) and sex is considered a highly private issue not to be discussed in the open (Ajuwon et al., 1998; Stewart & Richter, 1998). HIV/AIDS is also seen as a disease that flushes out an identity of a certain "risk group", a community of pariahs that might have remained hidden from neighbours, colleagues, family and friends because HIV/AIDS is considered as a calamity brought about by oneself (Sontag, 1989). Our data shows that the association with promiscuity is what causes blame because of the assumed bad behavior. The linking of blame to immoral behaviour was also similarly reported in a multi-country study of Zimbabwe, South Africa, Tanzania and Thailand, in which participants from Tanzania and Zimbabwe felt that PLWHA deserved what they got in terms of being punished for their reckless behavior (Maman et al., 2009). In our study, participants often assigned blame to PLWHA without bothering to find out the cause of infection with HIV/AIDS of the person. It is noteworthy that our findings show that blame is both a cause of stigma and a manifestation of stigma. First, society acts as a social watchdog for people by linking moral judgments to people's assumed behavior. Secondly, the judgment meted to PLWHA affects the willingness to give care; society is not ready to help someone whose illness arose from wilful social misbehavior thereby stigmatizing PLWHA. Moreover, due to societal judgment, PLWHA and the family care givers may find it difficult to justify for any financial help since many people do not have health insurance. This finding, taken together with another study carried out in Nigeria, confirms the likelihood of people needing financial help in Nigeria (Hilhorst et al., 2006). The probability of being helped is worsened by the principle of reciprocity in society, which is of particular concern. Hilhorst and colleagues (2006) went on to say that social capital implies reciprocity that has to be built and maintained requiring investments and resources which PLWHA may not be able to meet with such obligations. Furthermore, society is a death-denying one, where the prospect of no future or the loss of independence is an abomination (Chateauvert, 1993). Our data show that, while some people may be willing to assist PLWHA because they feel they can end up in the same situation in the future, others stigmatize PLWHA by expecting government to take them away or keeping them back at the hospital. Those who choose to care for PLWHA often prefer to keep that a secret so that the stigma does not spread to the rest of the family. This is particularly significant in Nigeria, because when people find out someone close to them is HIV-positive, it can jeopardize the chance of marriage because of the high value of marriage and pregnancy (Ajuwon & Shokunbi, 1998).

Findings from our study have shown that the churches do help PLWHA, but sometimes they make their situation very difficult. People are often obedient to the pastors and in the

church, and the pastors were very influential, making their actions very crucial. Aholou and colleagues further noted that the churches have strengths, credibility and are well grounded in communities (Aholou et al., 2009). Many PLWHA regard church as one of the places of protection from negative reaction from society, but they end up being stigmatized by their fellow worshippers. Our data show that a positive HIV test result from premarital HIV screening means that the information may leak to other members of the church and the continuity of the marriage maybe jeopardized since there is no standard guideline regarding the privacy and confidentiality of people. Premarital HIV screening is also quickly becoming a prerequisite for marriage to be contracted in many churches (Uneke, Alo & Ogbu, 2007) and since marriage is very important in society, many people end up knowing their status by necessity while ill prepared for the negative reactions from the society. Sontag (1989) argues that any disease that is considered a mystery and acutely enough to be feared will be felt to be morally, if not literally, contagious, in addition to the notion that cleanliness is next to godliness; thus, stigmatization is not unexpected for PLWHA even in the church. Lear (1998) shows that some Roman Catholic churches in Kenya and Uganda have used words such as "Love faithfully to avoid AIDS" to discourage usage of condoms. Other recent studies (e.g., Iwelunmor et al., 2006; Campbell et al., 2007; Neville & Rubin, 2007) also reported both supportive and detrimental roles. The belief in faith healing and miracles was also found in our study, which means that many who know of their status may choose faith healing as a first choice of care, or combine it with care from a health institution.

With all these negative reactions towards PLWHA in general, our study also shows that societal reactions can be different depending on the person's gender. Society is constructed in such a way that it is a man's world because decisions and actions are often dependent on men (Ajuwon & Shokunbi, 1998). Society exonerates men with multiple partners (Ankra, 1994; Ajuwon et al., 1998; Hartwig et al., 2006; Utulu & Lawoyin, 2007) as it reflect male virility. The sexual norm in Nigeria promotes sexual liberty for men and sexual purity for women (Ajuwon & Shokunbi, 1998). Yet, our study shows that, when a man contracts HIV/AIDS, he may be regarded a victim and attracts more sympathy. This is in keeping with studies carried out in Nigeria, which show that male PLWHA are more accepted than female ones (Hilhorst et al., 2006; Babalola et al., 2009). A man is also often able to hide his HIV-positive status if he chooses, and may end up spreading the infection because he is the breadwinner and may have money to care for himself. A woman, on the other hand, is mostly, financially dependent (Ajuwon et al., 1998; Hilhorst et al., 2006; Strebel et al., 2006), often finding it difficult to hide her status. Their maginal position also means they will not be able to seek appropriate care since they are mostly embarrassed if seen in a sexually transmitted infection (STI) clinic, making them resort to traditional healers or patent medicine dealers (Ajuwon & Shokunbi).

Our data point out that, even when money is given for the care of PLWHA, family members may decide not to use it, since the person is regarded as dying and they may want to save it for the burial. This finding, taken together with other studies carried out in Sub-Saharan Africa (Plummer et al., 2006; Campbell et al., 2007; Amuri et al., 2011) shows that poverty creates an additional burden to PLWHA and their carers. Corpses are valued and cost money to be buried, with people more willing to offer help during funerals than during the period of actual illness (Hilhorst et al., 2006).

Our study also shows that the media contributed to stigmatization because of the way they portrayed information about HIV/AIDS earlier in the epidemic. For example, in a Nigerian

news paper in October 19, 1987, HIV/AIDS was typified as “a self-inflicted scourge caused by reckless sexual extravaganza, and the person must be prepared to bear the consequence of their lustful discretion” (Lear, 1998). Such images in the media flourish and take time to be reversed.

5. Limitations of the study

A major weakness of this study is that the data cannot be generalized. We can also conclude that these results are not representative of Port Harcourt city or the community, but the study aims to gather a broad perspective on stigma and societal reactions to PLWHA. The study was carried out in the city where people from different tribes live and reflects only the ideas or culture of the people interviewed.

Another weakness of the present study relied on verbal reports of participants. It was difficult for participants to admit to stigmatizing HIV persons because of social desirability, but when indirectly asked about others or spontaneously describing other's reactions, many of them expressed the view that stigmatization is still strong in society. Despite these limitations, this study illustrates the importance of not only knowing that stigma is still very much present, but also calls for more research in this area.

6. Conclusion and recommendations

The findings of our study may be valuable for developing interventions on stigma. The societal image of PLWHA can fuel the spread of HIV/AIDS because people continue to have unprotected sex based on their personal judgment on physical features associated with HIV/AIDS, because they believe a person with HIV/AIDS is supposed to be emaciated, without knowing that a well-cared-for person with HIV/AIDS can have a normal weight. Sometimes, the long-term nature of illness of someone can fuel suspicion from people, especially when the person is moved from one hospital to another or from the hospital in the city to the village. Participants placed great emphasis on faith-healing power when the pastor prays, which may influence the way they care for PLWHA. At the same time, some other participants felt the church should use their position to teach people how to care for sufferers of HIV/AIDS. The church should also use their position to protect the rights of PLWHA. Almost all the participants were of the opinion that care givers of people with HIV/AIDS should continue to care for them, mainly because they felt that they may find themselves in that position, as can anyone. Government should play a more active role in supporting PLWHA financially especially the vulnerable ones, such as women and children, to help cover the basic needs and accessing HIV/AIDS programmes. When people are knowledgeable about HIV/AIDS they know the steps they may take to protect themselves. Government should also create policies that protect PLWHA in important areas, such as the workplace. HIV/AIDS is likely to stay for many years, and so society may benefit from learning to live with it and not discriminating against PLWHA. Emphasis on the proactive role by media and faith-based institutions should be encouraged by government.

Problems associated with HIV/AIDS are very real in society. The government needs to educate the entire population through radio, television, markets, churches and everywhere there is a possibility of people listening. Continuous education of people about HIV/AIDS, modes of transmission, and how people can protect themselves when caring for HIV/AIDS is important. People should fully be aware that caring for a person with HIV/AIDS can be

done without necessarily running a risk of contracting HIV/AIDS. A significant proportion of people in society have heard about HIV/AIDS and the kind of aggression with which the media initially provided information on HIV/AIDS, which enhanced discrimination, should now be turned towards giving HIV/AIDS a human face.

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8. References

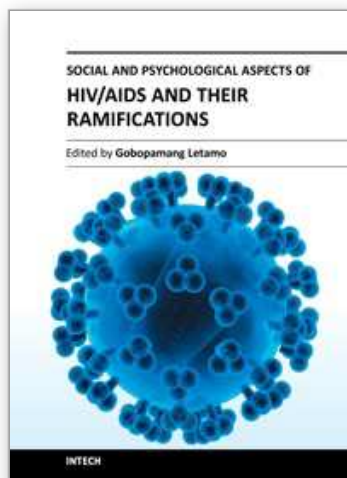
- Aholou, T.M., Gale, J.E., & Slater, L.M. (2009). African American clergy share perspectives on addressing sexual health and HIV prevention in premarital counseling: A pilot study. *Journal of Religion and health*, PMID: 19495984.
- Ajuwon, A.J., Oladepo, O., Adeniyi, J.D., & Brieger, W.R. (1998). Sexual practices that may favor the transmission of HIV in a rural community in Nigeria, In D. Buchanan and G Cernada (eds), *Progress in preventing AIDS? Dogma, Dissent and Innovation*, Global perspectives (pp21-33), Amityville, New York: Baywood publishing Company, Inc.
- Ajuwon, A.J., & Shokunbi, W. (1998). Women and the risk of HIV infection in Nigeria: Implications for control programs, In D. Buchanan and G Cernada (eds) (pp21-33), *Progress in preventing AIDS? Dogma, Dissent and Innovation*, Global perspectives, Amityville, New York: Baywood publishing Company, Inc.
- Akani, C.I., & Erhabor, O. (2006). Rate, pattern and barriers of HIV serostatus disclosure in a resource limited setting in the Niger delta of Nigeria. *Tropical Doctor*, 36 (2), 87-89.
- Akpogomeh, O.S., & Atemie, J.D. (2002). Population profile in: The land and people of Rivers State, Eastern Niger Delta. Edited by Alagoa and Derefaka, A.A. Onyoma Research Publications, PortHarcourt, Nigeria.
- Alikor, D.E., & Erhabor, N.O. (2006). Trend of HIV- seropositivity among children in a tertiary health institution in the Niger Delta region of Nigeria. *African Journal of Health Sciences*, 13 (1-2), 80-85.
- Amuri, M., Mitchell, S., Cockcroft, A., & Anderson, N (2011). Socio-economic status and HIV/AIDS stigma in Tanzania. *AIDS Care*, 23 (3): 378-382.
- Anglewicz, P & Chintsanya, J (2011). Disclosure of HIV status between spouses in rural Malawi, *AIDS Care*, 9, 1-8.
- Ankrah, E. M., & Henry, K. (1994). Empowering women may retard HIV. *Network* 15, 20-21.
- Babalola, S., Fatusi, A., & Anyanti, J. (2009). Media saturation, communication exposure and HIV stigma in Nigeria, *Social Science and Medicine*, 68 (8), 1513-1520.
- Baseman, J., Ross, M., & Williams, M. (1999). Sale of sex for drugs and drugs for sex: An economic context of sexual risk behaviour for STDs. *Sexually Transmitted Diseases*, 26 (8), 444-449.
- Campbell, C., Nair, Y., Maimane, S., & Nicholson, J. (2007). Dying twice: a multi-level model of the roots of AIDS stigma in two South African communities. *Journal of Health Psychology*, 12 (3), 403-416.

- Chateauvert, M. (1993). AIDS related stress in Canadian healthcare workers. In H. Van Dis and E Van Dongen, *Burnout in HIV/AIDS Health Care and Support: Impact for professional and Volunteers*, Amsterdam: University Press, Amsterdam.
- Demmer, C (2011). Experiences of families caring for an HIV-infected child in KwaZulu-Natal, South Africa: an exploratory study, *AIDS Care*, PMID: 21400305
- Epidemiological fact sheet (2008). Retrieved 5 May 2009 from WHO website: [www://apps.who.int/globalatlas/predefinedreports/efs2008/full/efs2008_ngpdf](http://apps.who.int/globalatlas/predefinedreports/efs2008/full/efs2008_ngpdf).
- Fortenberry, J.D., Mcfarlane, M.M., Hennessy, M., Bull, S.S., Grimley, D.M., Lawrence, J, St Lawrence, Stone, B.P., & Van Devanter, N. (2007). Relation of health literacy to gonorrhea related care. *Sexually Transmitted Infection online*, DOI: 10.1136/STI.77.3.206.
- Gari, T., Habte, D., Markos, E (2010). HIV positive status disclosure among women attending ART clinic at Hawassa university referral hospital, South Ethiopia, *East African Journal of Public Health*, 7 (1), 87-91.
- Goffman, E. (1974). *Stigma: Notes on the Management of Spoiled Identity*. New York: Jason Aronson.
- Greeff, M., Phetlhu, R., Makoe, L.N., Dlamini, P.S., Holzemer, W.L., Naidoo, J.R., Kohl, T.W, Uys, L.R., & Chirwa, M.L. (2008). Disclosure of HIV status: experiences and perceptions of persons living with HIV/AIDS and nurses involved in their care in Africa. *Qualitative Health Research*, 18 (3), 311-324.
- Green, G. (1995). Attitudes towards people with HIV: Are they as stigmatizing as people with HIV perceive them to be? *Social Science and Medicine*, 41 (4), 557.
- Hartwig, K.A., Kissioki, S., & Hartwig, C.D. (2006). Church leaders comfort HIV/AIDS and stigma: A case study from Tanzania. *Journal of Community and Applied Social Psychology*, 16, 492-497.
- Herek, G. M. (2002). Thinking about AIDS and stigma: a psychologist's perspective. *Journal of Law, Medicine and Ethics*, 30(4), 594-607.
- Hidaka, Y., Operario, D., Takenaka, M., Omori, S., Ichikawa, S., & Shirasaka, T. (2008). Attempted suicide and associated risk factors among youth in urban Japan. *Social Psychiatry and Psychiatric Epidemiology*, 43 (9), 752-757.
- Hilhorst, T., Van Liere, M.J., Ode, A.V., & de Koning, K. (2006). Impact of AIDS on rural livelihoods in Benue state, Nigeria. *Journal of Social Aspect of HIV/AIDS Research Alliance (SAHARA)*, 3(1), 382-393.
- Iwelunmor, J., Airhihenbuwa, C.O., Okoror, T, A., Brown, D.C., & Belue, R. (2006). Family systems and HIV/AIDS in South Africa. *International Quarterly of Community Health Education*, 27 (4), 321-325.
- Kipp, W., Tindyebwa D., Rubaale, T., Karamagi, E., & Bajenja E. (2007). Family caregivers in rural Uganda: the hidden reality. *Health Care for Women International*, 28 (10), 856-71.
- Lear, D. (1998). AIDS in the African press. In D. Buchanan and G Cernada (eds) (pp. 215-226). *Progress in preventing AIDS? Dogma, Dissent and Innovation*, Global perspectives, Amityville, New York: Baywood publishing Company, Inc.
- Maman, S., Abler, L., Parker, L., Lane, T., Chirowodza, A, Ntogwisangu, J., Srirak, N., Modiba, P., Murima, O., & Fritz, K. (2009). A comparison of HIV stigma and discrimination in five international sites: The influence of care and treatment resources in high prevalence settings, *Social Science and Medicine*, DOI: 10.1016/J.socscimed.2009.04.002.

- Mbonu, N.C., Van Den Borne, B., & De Vries, N.K. (2009). A model for understanding the relationship between stigma and health care-seeking behaviour among people living with HIV/AIDS in Sub-Saharan Africa. *African Journal of AIDS Research (AJAR)*, 8 (2), 201-212.
- Miller, K.W., Wilder, L.B., Stillman, F.A., & Becker, D.M. (1997). The feasibility of a street intercept survey method in an African-American community. *American Journal of Public Health*, 87 (4), 655-658.
- Neville, M.A., & Rubin, D.L. (2007). Factors leading to self-disclosure of a positive HIV diagnosis in Nairobi, Kenya: people living with HIV/AIDS in the Sub-Sahara. *Qualitative Health Research*, 17 (5), 586-98.
- Obi, R.K., Iroagba, I.I., & Orjiakor, O.A. (2007). Prevalence of human immunodeficiency virus (HIV) infection among pregnant women in an antenatal clinic in Port Harcourt, Nigeria. *African Journal of Biotechnology*, 6 (3), 263-266.
- Parker, R., & Aggleton, P. (2003). HIV and AIDS-related stigma and discrimination: a conceptual framework and implications for action. *Social Science and Medicine*, 57 (1), 13-24.
- Plummer, M.L., Mshana, G., Wamoyi, J., Shigongo, Z.S., Hayes, R.J., Ross, D.A., & Wright, D. (2006). 'The man who believed he had AIDS was cured': AIDS and sexually transmitted infection treatment-seeking behaviour in rural Mwanza, Tanzania. *AIDS Care*, 18(5), 460-466.
- Rotheram-Borus, M.J., Mann, T., Newman, P.A., Grusky, O., Frerichs, R.R., Wight, R.G., & Kuklinski, M. (2001). A street intercept survey to assess HIV- testing attitudes and behaviors. *Aids Education and Prevention*, 13 (3), 229-238.
- Singh D., Chandoir, S.R., Escobar, M.C., Kalichman, S. (2011). Stigma, burden, social support and willingness to care among caregivers of PLWHA in home-based care in South Africa, PMID: 21400316.
- Sontag, S. (1989). *Illness as metaphor and AIDS and its metaphors*. New York: Doubleday publishers.
- Steward, W.T., Herek, G.M., Ramakrishna, J., Bharat, S., Chandry, S., Wrubel, J., & Ekstrand, M.L. (2008). HIV-related stigma: adapting a theoretical framework for use in India. *Social Science and Medicine*, 68 (8), 1225-1235.
- Stewart, T.J. & Richter, D.L. (1998). Perceived barriers to HIV prevention among University students in Sierra Leone, West Africa. In D. Buchanan and G Cernada (eds) (pp 35-46), *Progress in preventing AIDS? Dogma, Dissent and Innovation*, Global perspectives, Amityville, New York: Baywood publishing Company, Inc.
- Strebel, A., Crawford, M., Shefer, T., Cloete, A., Henda, N., Kaufman, M., Simbayi, L., Magome, K., & Kalichman, S. (2006). Social construction of gender roles, gender based violence and HIV/AIDS in two communities of the Western Cape, South Africa. *Journal of Social Aspects of HIV/AIDS Research Alliance (SAHARA)*, 3 (3), 516-528.
- Stutterheim, S.E., Shiripinda, I., Bos, A.E., Pryor, J.B., De Bruin, M., Nellen, J.F., Kok, G., Prins, J.M., Schaalma, H.P (2011). HIV status disclosure among HIV-positive African and Afro Caribbean people in the Netherlands. *AIDS Care*, 23 (2), 195-205.
- The Joint United Nations Programme on HIV/AIDS (UNAIDS) (2008). Retrieved 5 May 2009 from UNAIDS website:

- [www://data.unaids.org/pub/report/2008/jc1526_epibriefs_subsaranafrica_en.pdf](http://data.unaids.org/pub/report/2008/jc1526_epibriefs_subsaranafrica_en.pdf).
- The Joint United Nations Programme on HIV/AIDS (UNAIDS) (2010). The Global Report. Retrieved 10 March 2011 from UNAIDS website:
http://www.unaids.org/globalreport/documents/20101123_GlobalReport_full_en.pdf.
- The Joint United Nations Programme on HIV/AIDS (UNAIDS), 2010 country progress report. Retrieved 17 March 2011 from UNAIDS website:
http://www.unaids.org/en/dataanalysis/monitoringcountryprogress/2010progressreportsubmittedbycountries/nigeria_2010_country_progress_report_en.pdf.
- Uneke, C.J., Alo, M., & Ogbu, O. (2007). Mandatory premarital HIV testing in Nigeria: The public health and social implications. *AIDS Care*, 19 (1), 116-121.
- Utulu, S.N., & Lawoyin, T.O. (2007). Epidemiological features of HIV infection among pregnant women in makurdi, Benue state, Nigeria. *Journal of Biosocial Science*, 39 (3), 397-408.
- Weiser, S.D., Heisler, M., Leiter, K., Percy-de Korte, F., Tlou, S., De Monner, S., Phaladze, N., Bangsberg, D.R., & Lacopino, V. (2006). Routine HIV testing in Botswana: a population-based study on attitudes, practices and human rights concerns. *PLoS Medicine*, 3 (7), e261.
- Wood, K., & Lambert, H. (2008). Coded talk, scripted omissions: the micropolitics of AIDS talk in an affected community in South Africa. *Medical Anthropology Quarterly*, 22, 213-233.

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This book has assembled an array of chapters on the social and psychosocial aspects of HIV/AIDS and their impact on HIV/AIDS and related behaviours. The book addresses key areas of HIV and AIDS, including, but not in any way limited to, care-seeking behaviour, adherence, access, psychosocial needs and support services, discrimination and the impact the epidemic has on various sectors of the economy. The book has seventeen chapters; seven chapters deal with social aspects of HIV/AIDS, four with psychosocial aspects of HIV/AIDS, and the remaining six chapters with the impact of social and psychosocial factors on HIV/AIDS and related behaviours. The book is an essential reading for academics, students and other people interested in the field of HIV and AIDS.

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