

Full Length Research Paper

HIV/AIDS-related stigmatization and discrimination and coping strategies among people living with HIV/AIDS (PLHIV) at the anti-retroviral (ARV) Clinic, University College Hospital Ibadan, Nigeria

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The aim of this study was to determine the magnitude of HIV/AIDS related stigmatization, discrimination and coping strategies among people living with HIV/AIDS (PLHIV) at University College Hospital Ibadan. The study adopted a descriptive cross-sectional study design carried out among 700 PLHIV selected using a systematic random sampling technique from May to June 2010. A validated pretested questionnaire was used to collect the data which was analysed using SPSS version 16. The mean age of the respondents was 40.0 ± 9.40 years and more were females (474, 67.70%). About 212 (30.30%) have experienced stigmatization with verbal insult (138, 65.10%), subjection to ridicule (134, 63.20%) and avoidance by friends (89, 42.0%) being the most reported forms of induced stigmatization/discrimination. In addition, there was no significant relationship of experiencing stigmatization/discrimination by gender ($P=0.097$). However, more females experienced physical assault than male. Strategies adopted by respondents in coping with stigmatization and discrimination were unmoved 376 (53.70%), prayer 321 (45.90%) and ignoring the person 281 (40.10%). The study reported prevalence of various forms of stigmatization and discrimination against PLHIV. Therefore, there is need for more awareness campaign in communities on the dangers of HIV-related stigmatization and discrimination on the health of PLHIV.

Key words: Social discrimination, perception, stigmatization, social support, HIV/AIDS.

INTRODUCTION

The Human Immunodeficiency Virus (HIV) infection and the Acquired Immune Deficiency Syndrome (AIDS)

remain a disease of public health concern in Nigeria. This is because Nigeria is the most populous country in sub-

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Saharan Africa and is one of the countries highly affected by the HIV/AIDS scourge (UNAIDS, 2014; Dahlui et al., 2015). The estimated number of people living with HIV (PLHIV) as at 2015 is 3.4 million people giving a prevalence of 3.2% among the adult population (UNAIDS, 2015). Since the first case of AIDS in Nigeria was reported in 1986, Nigeria adopted antenatal care sentinel surveillance as the system for monitoring the epidemic, in line with WHO guidelines (UNAIDS, 2015). The first sentinel survey gave a prevalence of 1.80%; thereafter, it increased to 5.4% in 1999 and peaked at 5.8% in 2001. The prevalence declined to 4.4% in 2005, 4.1% in 2010 and 3.0% in 2014 (UNAIDS, 2015). Furthermore, in Oyo State, the prevalence of HIV, based on the result of the national sero-surveillance studies conducted in 1992 and 2004, were 0.1 and 4.2%, respectively (FMOH, 2005). It was also reported that there was no town or village that had not reported cases of HIV and AIDS and about 85% of the infections were reported to have been contracted through unprotected heterosexual intercourse (FMOH, 2005). The international community embraced the goal of universal access to HIV prevention, treatment, care and support in 2005. This has led to universal access to diagnosis, treatment and care for PLHIV (Monjok et al., 2009; UNGASS, 2005; World Health Organization, 2006).

The three documented phase of the AIDS epidemic in most countries include “epidemic of HIV infection”, “epidemic of AIDS” and stigmatisation. The third phase is very challenging as it is characterized by discrimination, blame and denial (Mann, 1987). Nigeria appears to be in between the full AIDS epidemic phase and the stigma and discrimination phase. Experiencing the weight of AIDS epidemic and also seeing a lot of discrimination of PLHIV. HIV and AIDS-related stigma and discriminatory conduct provide opportunities for the spread of the infection (FMOH, 2002). This is because to avoid the unpleasing consequences of revealing their status, stigmatized persons may conceal their sero-positivity from others most especially their sexual partners thereby leading to the spread of the infection (Tsai et al., 2013; Pennebaker, 1989; Katz et al., 2013). This practice undermines prevention efforts and support and also increases the impact of the infection on individuals, families, communities and nations (Population Council Horizons, 2002). Furthermore, the stigma and discrimination attached to being diagnosed with HIV/AIDS is far bigger and considerably different from being diagnosed with more prevalent non-communicable diseases like diabetes, cancer and hypertension. This may be due to the fact that HIV is primarily transmitted through sexual intercourse and people sometimes erroneously link HIV infection with sexual promiscuity. Self-stigmatisation which can manifest as self-blaming and shame can lead to psychological consequences such as depression, withdrawal and feelings of worthlessness (UNAIDS, 2002). The effect of stigmatizing PLHIV and

self-stigmatization by PLHIV all lead to social exclusion. This study therefore focuses on exploration of stigma and discrimination from the perspective of the stigmatized and their coping strategies among PLHIV at Anti-Retroviral Viral clinic, University College Hospital Ibadan, Nigeria.

MATERIALS AND METHODS

Study design

The study was a descriptive cross sectional study of persons living with HIV and AIDS at the President Emergency Plan for AIDS Relief (PEPFAR), University College Hospital (UCH).

Study area

University College Hospital Ibadan is one of the 15 Federal University Teaching Hospitals in Nigeria. The hospital is located in Ibadan, the largest city in West Africa. It is established to serve as a teaching hospital for medical and allied professionals. The hospital consists of various clinics, including PEPFAR; the PEPFAR clinic UCH is jointly managed by the Government of the United State of America, the Nigerian government in collaboration with UCH, Ibadan and Harvard School of Public Health.

Study population

Adult persons attending PEPFAR clinic constituted the study population. They were persons living with HIV and AIDS. The clinic as at the time of the study had approximately 11000 patients of different socio-demographic characteristic; approximately 35 new patients were admitted per day.

Sample size determination

The formula for single proportion was used in calculating the sample size with 50% used as the proportion and 99% as the confidence interval.

$$N = z^2 \times p (1 - p) / d^2$$

$$N = 2.578^2 \times 0.5 (1 - 0.5) / 0.05^2 = 665$$

The calculated sample size of 665 was increased to 700 so as to address possible cases of attrition or incomplete responses. Thus, the study recruited 700 participants out of 11,000 in the PEPFAR register as at September, 2009.

Sampling procedure

A sampling interval of 16 was calculated, thus the first respondent was randomly selected; thereafter, every 16th patient on the PEPFAR register was selected for the study. Peradventure any of the 16th person decline to participate, then the 17th person was selected. Thus, 420 females and 280 males were selected for the study in all HIV/AIDS clinic days between the month of May and June 2010.

Instruments for data collection

The instrument for data collection was a semi-structured validated



Figure 1. HIV status of respondents' sexual partners.

questionnaire divided into five sections (sections A to E). Section A focused on respondents' demographic characteristics; section B was on experiences relating to HIV-related stigma and discrimination. Section C was used to assess respondents' attitude, consequences/effects of HIV-related stigma and discrimination; while section D explored respondents' past and prevailing coping strategies to HIV-related stigma and discrimination experiences.

Method of data collection

On each day of data collection, the questionnaire was administered to the respondent after adequate explanation of the purpose of the study. The interview was either interviewer-administered or self-administered depending on the respondents' level of education. The questionnaires were retrieved back from each respondent immediately after completion and reviewed for incompleteness and necessary correction.

Validity and reliability

The questionnaire was reviewed in-house among experts in health promotion and education, medical sociologists, and a medical statistician for face, construct and content validity. Similarly, to improve the reliability of the instrument, the questionnaire was pre-tested among 70 PLHIV receiving care at Saint Mary Catholic Hospital Eleta, Ibadan. The Cronbach Alpha Correlation Co-efficient was used to determine the reliability of the instrument.

Data analysis

Administered questionnaires were edited and coded with the use of a coding guide. The data in each questionnaire were entered into a computer and was analysed using the Statistical Package for Social Sciences (SPSS Version 16, IBM Corp., Chicago, USA). In addition, descriptive statistics, Chi square and t-test were used to test for variables of interest at $P < 0.05$.

Ethical consideration

The study proposal was submitted to the UI/UCH Ethical Review

Committee for evaluation and approval. Official permission and approval was also obtained from the management of Saint Mary Catholic Hospital, Eleta Ibadan where the pre-test was carried out and from the PEPFAR authority where the actual study was conducted.

RESULTS

Socio-demographic characteristics

The ages of respondents ranged from 14 to 79 years with a mean age of 40.0 ± 9.4 years. A large proportion of the respondents 474 (67.7%) were females. Respondents' occupations include the following: trading 330 (47.2%), retired civil servants 128 (18.3%), artisan 76 (10.9%) and 35 (5.0%) were unemployed. Majority of the respondents were married 483 (69.0%) and 498 (71.1%) had secondary education and above Table 1).

According to Table 2, majority of the respondents (508, 72.50%) were screened for HIV because they were sick while less than two third (448, 64.0%) and 178 (25.40%) of facilities where the respondents were screened was owned by the Federal Government and individuals, respectively. In addition, majority of the respondents (666, 95.10%) had sexual partners, of which 582 (87.30%) and 55 (12.40%) sexual partners were their spouse and boyfriend/girlfriend, respectively. Furthermore, more than two third of the respondents 508 (72.60%) were aware of their partners HIV status and only less than one third 212 (30.30%) affirmed that they had ever experienced stigmatization or discrimination as a result of their HIV status.

According to Figure 1, 36.90% of the respondents' sexual partners were HIV positive, while 39.0% were HIV negative and 24.10% do not know the HIV status of their sexual partners.

Table 1. Socio-demographic characteristics of respondents

Characteristic	Frequency (N=700)	Percentage
Sex		
Male	226	32.3
Female	474	67.7
Age group*		
<30	94	13.4
30 - 39	256	36.6
40 - 49	243	34.7
≥50	107	15.3
Occupation		
Trading	330	47.2
Retired civil servant	128	18.3
Artisan	76	10.9
Teaching	52	7.4
Unemployed	35	5.0
Driver	35	5.0
Student	29	4.2
Civil servant	10	1.4
Clergy	3	0.4
Traditional ruler(King)	1	0.1
Politician	1	0.1
Marital status		
Married	483	69.0
Single	85	12.1
Widow	73	10.4
Separated	37	5.3
Divorced	19	2.7
Cohabitation	3	0.4
Education status		
No formal education	67	9.6
Primary education	135	19.3
Secondary education	245	35.0
**Tertiary education	253	36.1

*Mean age = 40.0 ± 9.4; age: ≤ 19 years= 0.6%; 20-24 years= 2.7%; 25-29 years = 10.1%.

**National Certificate Examination=10.3%, Technical school=9.1%, Ordinary National Diploma=10.0%, Higher National Diploma=3.7%, Bachelor degree=2.3%, Postgraduate=0.7%.

The HIV/AIDS induced stigma and discrimination ever perpetrated against PLHIV were manifested in several forms including the following: physical assault 51 (24.1%), verbal abuse/insult 138 (65.1%), subjection to ridicule 134 (63.2%), avoidance by friends 89 (42.0%) and not treated humanely like other patients 55 (25.9%). Experiences of induced stigma within the three months preceding the study also includes physical assault 7 (13.7%), denial of job opportunity 7 (15.2%), sacked from job 5 (14.7%) and refusal of medical care in a health care facility 5 (20.0%) (Table 3).

The forms of self-stigmatization ever experienced included: fear of HIV status disclosure to family members 377 (53.9%), fear of disclosing HIV status to friends 485 (69.3%), stoppage of attendance to social functions 124 (17.3%), stoppage of visiting friends 137 (19.6%), feeling ashamed of accessing medical care 206 (29.4%) and limiting social functions or gatherings attended by them 177 (25.3%). Within the last three months preceding the study, however, only 111 (29.4%) were afraid of disclosing their HIV status to family members, 128 (26.4%) were afraid of disclosing to friends (Table 4).

Table 2. HIV screening and sexual related issues.

Variable	Frequency	Percentage	P-Value
Respondents' reasons for undergoing HIV testing			
Sickness	508	72.5	
Routine HIV screening	67	9.6	
Pregnancy	65	9.3	
Spousal influence/Persuasion	51	7.3	
Radio/Media message	4	0.6	
Marriage influence	3	0.4	
Needle prick	2	0.3	
Ownership of screening centre used by respondents during the study period			
Federal Government	448	64.0	
Private	178	25.4	
NGO/CBO/FBO	46	6.7	
Mission	24	3.4	
Local Government/Health Centre	3	0.4	
State	1	0.1	
Have sexual partners			
Yes	666	95.1	
No	34	4.9	
Identity of sexual partner(s)			
	N=666		
Spouse	582	87.3	
Boyfriend/Girlfriend	55	12.4	
*Casual sex partner	29	4.4	
Awareness of partners HIV status			
Yes	508	72.6	0.03
No	192	27.4	
Respondents who had ever experienced stigmatization and/or discrimination as a result of their HIV status			
Yes	212	30.3	0.097
No	488	69.7	

*Causal sex partners including rape, NGO: Non-Governmental Organisation, CBO: Community Based Organisation, FBO: Faith Based Organisation.

As shown, Table 5 highlighted the attitudinal tendencies of others perceived by respondents to be stigmatizing. More than half of the respondents 365 (52.2%) were of the view that people with HIV are often treated as if it is their fault. Slightly above half of the respondents 363 (51.8%) agreed that people physically back away from or refuse to associate with someone because of HIV. In addition, less than half of the respondents 329 (47.0%) agreed that some close relations were afraid of rejection by the society when a family member has HIV. Four hundred and three (59.0%) of the respondents agreed that some friends withdraw from interacting or visiting after hearing that he/she has

HIV. Appreciable proportions of the respondents either disagree or strongly disagree with the attitudinal tendencies of others (Table 5).

Common strategies adopted by respondents for coping with stigma and discrimination as a result of their HIV status included the following: unmoved 376 (53.7%), ignore the person 281 (40.1%), and prayer 321 (45.9%). Others include challenging the person discriminating against them 65 (9.3%), threaten legal action 27 (3.9%) or report that experience to support group 53 (7.6%) (Table 6).

As shown in Figure 2, a small proportion of the respondents (27.7%) reported that they were members of

Table 3. Forms of induced stigma and/or discrimination experienced by PLHIV.

Stigma/discrimination	Ever experienced (N= 212)		Experienced within last 3 months*	
	Number	%	Number	%
Physical assault				
Yes	51	24.1	7	13.7
No	161	75.9	44	86.3
Abused/Insulted				
Yes	138	65.1	15	10.8
No	74	34.9	123	89.2
Subjected to ridicule				
Yes	134	63.2	16	12.0
No	78	36.8	118	88.0
Excluded religiously				
Yes	34	16.0	4	11.8
No	178	84	30	88.2
Sent out of the family				
Yes	39	18.5	4	10.3
No	172	81.5	35	89.7
Excluded from school				
Yes	24	11.3	1	4.2
No	188	88.7	23	95.8
Denied job opportunity				
Yes	46	21.7	7	15.2
No	166	78.3	39	84.8
Sacked from Job				
Yes	34	16.0	5	14.7
No	178	84.0	29	85.3
Loose promotion benefit				
Yes	32	15.1	4	12.5
No	180	84.9	28	87.5
Avoided by friends				
Yes	89	42.0	8	9.0
No	123	58.0	81	91.0
Refuse visa or entry to any country				
Yes	18	8.5	3	16.7
No	194	91.5	15	83.3
Ejected from house				
Yes	35	16.5	2	5.7
No	177	83.5	33	94.3
Refused medical care in a health care facility				
Yes	25	11.8	5	20.0

Table 3. Cont'd.

No	187	88.2	20	80.0
Refused nursing care in a health care facility				
Yes	30	14.2	8	26.7
No	181	85.8	22	73.3
Maltreated by health care personnel				
Yes	46	21.7	7	15.2
No	166	78.3	39	84.8
Disclosure of HIV status without consent by health personnel				
Yes	47	22.2	7	14.9
No	165	77.8	40	85.1
Not treated humanely like other patients				
Yes	55	25.9	5	9.1
No	157	74.1	50	90.9
Humiliated				
Yes	99	46.7	10	10.1
No	113	53.3	89	89.9

*This refers to last three months preceding the study.

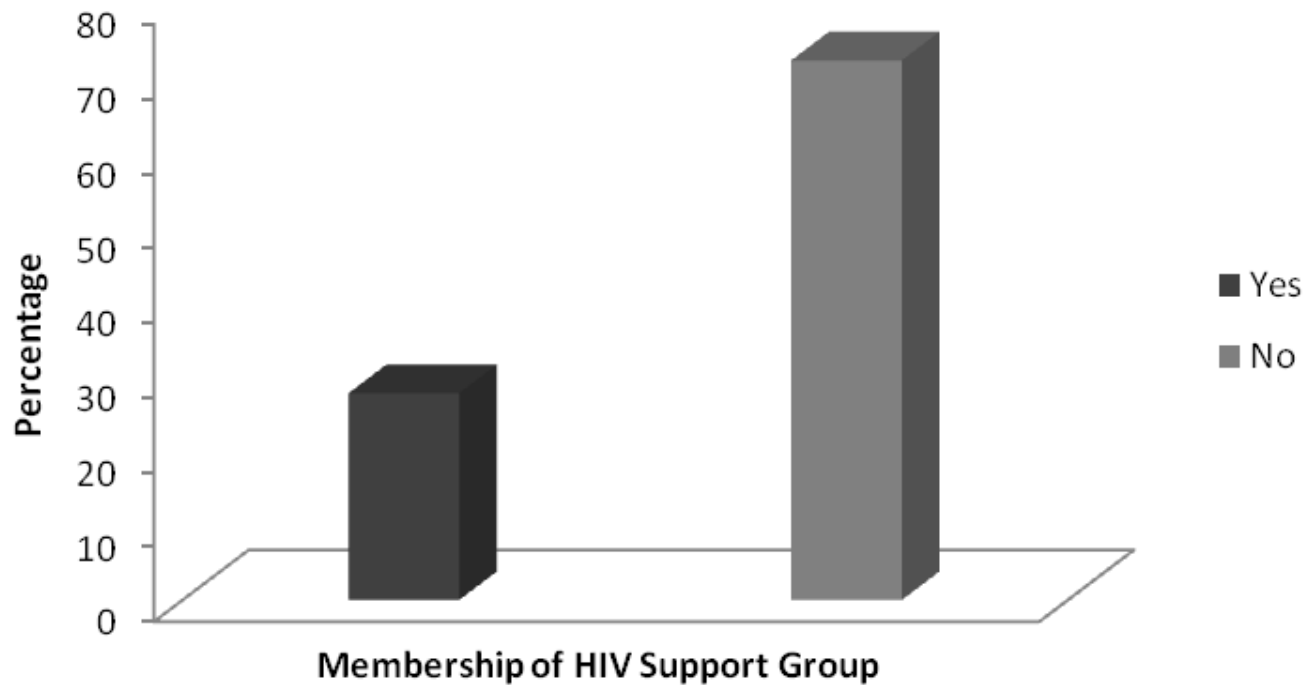


Figure 2. Respondents' membership of HIV social support groups.

a social support group for PLHIV; while 72.3% were not in any support group.

Coping strategies discussed among PLHIV in support group as highlighted by the respondents were: Not

Table 4. Respondents' experience of self-stigmatization.

Experiences of self-stigmatization by stigma indicator	Ever experienced N=700		Experienced within last 3 months	
	Number	%	Number	%
Isolate self from family functions because of HIV status				
Yes	123	17.6	24	19.5
No	577	82.4	99	80.5
Scared of disclosing status to family members				
Yes	377	53.9	111	29.4
No	323	46.1	266	70.6
Scared of disclosing status to friends				
Yes	485	69.3	128	26.4
No	215	30.7	357	73.6
Worthless because of HIV status				
Yes	137	19.6	32	23.4
No	563	80.4	105	76.6
Stopped social functions because of HIV status				
Yes	124	17.7	33	26.6
No	576	82.3	91	73.4
Exclude self from religious activities because of HIV status				
Yes	99	14.1	24	24.2
No	601	85.9	75	75.8
Stopped visiting some friends because of being looked down upon				
Yes	137	19.6	37	27.0
No	563	80.4	100	73.0
Stopped going to the office or to work because of HIV status				
Yes	83	11.9	16	19.3
No	617	88.1	67	80.7
Ashamed of accessing medical care				
Yes	206	29.4	50	24.2
No	494	70.6	156	75.8
Stopped applying for Jobs because of HIV status				
Yes	117	16.7	22	18.8
No	583	83.3	95	81.2
Limit the social functions or gatherings attended				
Yes	177	25.3	37	20.9
No	523	74.7	140	79.1
Stay indoor most times because of my HIV status				
Yes	150	21.4	32	21.3
No	550	78.6	118	78.7

Table 5. Societal attitudes towards persons with HIV perceived to be stigmatizing by respondents.

Attitudinal tendencies of others perceived to be stigmatizing	Strongly Agree (%)	Agree (%)	Undecided (%)	Disagree (%)	Strongly Disagree (%)	Total (%)
Persons with HIV are often treated as if it is their fault	17.3	34.9	5.0	19.1	23.7	100.0
People physically backing away from or refuse to associate with someone because of HIV	10.0	41.8	8.1	15.7	24.4	100.0
Close relations' fear and rejection by society when a family member has HIV	14.1	47.0	8.7	13.7	16.4	100.0
Failure to be interacting or visiting friend after hearing that he/she has HIV	13.3	45.7	8.4	15.6	17.0	100.0
Avoidance of physical contact with an HIV positive persons by people	15.6	40.3	7.4	15.7	21.0	100.0
Blaming HIV positive persons on their menial failings	14.4	42.5	10.0	16.4	16.7	100.0
People fear to relate with persons with HIV	22.7	43.1	6.9	13.3	14.0	100.0
Societal treatment of people with HIV with disdain	26.0	41.0	7.3	13.0	12.7	100.0

stigmatize one-self 34 (19.6%), living positively 66 (38.1%), not giving room for discrimination to occur 25 (14.5%) (Table 7).

DISCUSSION

The study showed majorities of the respondents were between the ages of 30 and 49 years and were females. This is similar to the findings of a study carried out in Abeokuta South-West Nigeria (Ojieabu et al., 2014). This finding is in line with those of the National Agency for the Control of AIDS 2016, report and a study by Dahlui et al. (2015), which highlighted the occurrence of stigmatization and discrimination among PLHIV. Similarly, the study reported various forms of stigmatization and discrimination which were perpetrated against the respondents. This finding is in line with previous studies which showed stigma and discrimination perpetrated against PLHIV from colleagues, friends and the community (Ogbuji and Oke, 2010; Blackstock, 2005; Zierler et al., 2000; Bharat, 2011). Furthermore, the respondents also highlighted various forms of self-stigmatization they adopted primarily to

conceal their HIV/AIDS status. This fear of revealing their HIV status might breed a culture of silence, sadness, hopelessness, anxiety and fear which can impact their quality of life negatively (Ogbuji and Oke, 2010).

The findings of the study shows that the society still exhibit some attitudinal tendencies which is stigmatizing to PLHIV. This finding is consistent with previous study which reported negative attitude such as the use of the cynical phrase "AIDS family" towards PLHIV (Alubo et al., 2002). This calls for more enlightenment campaign targeted at communities in order to reduce the attitudinal stigma and discrimination associated with HIV/AIDS.

The study also highlights various strategies adopted by the respondents in coping with HIV/AIDS-related stigma and discrimination. Some of the coping strategies highlighted are in line with a previous study in Ibadan South-West Nigeria (Ogbuji and Oke, 2010). The most important strategy as underlined by the respondents is belonging to an HIV/AIDS social support group which can act as reinforcing mechanism in coping with stigma and discrimination which according to the study is still

prevalent in the society.

The possible limitation in the study is that the authors relied absolutely on the responses of the participants of the study in reporting the various forms of stigma and discrimination. There was no independent confirmation of the various forms of stigmatization and discrimination reported in the study.

Conclusion

The study has shown prevalence of various forms of stigmatization and discrimination against PLHIV. Con-sequently, it appears that there is a general negative perception about HIV/AIDS and the people living with it; and unfortunately this has resulted in negative attitude towards PLHIV within the society. Although, the HIV and AIDS (Anti-Discrimination) Act, 2014, has been passed to protect the rights and dignity of PLWHA by eliminating all forms of discrimination based on HIV status; there is need for more health education campaigns across com-munities nationwide to translate the phobia associated with HIV/AIDS to caring for PLHIV.

Table 6. Strategies adopted for coping with HIV and AIDS-related stigma/discrimination by respondents.

Coping strategy*	Number	%
Unmoved		
Yes	376	53.7
No	324	46.3
Challenged/Confronted the person		
Yes	65	9.3
No	635	90.7
Threaten legal action		
Yes	27	3.9
No	673	96.1
Report to support group		
Yes	53	7.6
No	647	92.4
Ignore the person(s)		
Yes	281	40.1
No	419	59.9
Quarrel with the person(s)		
Yes	15	2.1
No	685	97.9
Pray		
Yes	321	45.9
No	379	54.1
Cry		
Yes	87	12.4
No	613	87.6
Singing		
Yes	16	2.3
No	684	97.7
Disclosure to partner		
Yes	7	1.0
No	693	99.0
Enlighten them		
Yes	8	1.1
No	692	98.9

*These were multiple responses.

Table 7. Coping strategies for HIV and AIDS-related stigma/discrimination discussed among PLHIV in support group meetings.

Strategy	N=173	%
Living positively	66	38.1
Not stigmatize oneself	34	19.6
Not giving room for discrimination	25	14.5

Table 7. Contd.

Disclosing ones HIV status to kill stigma	14	8.1
Ignoring the person stigmatizing one	12	6.9
Be happy with everybody	10	5.8
Reporting to Support group	8	4.6
Reporting to legal authority	4	2.4

CONFLICT OF INTERESTS

The authors have not declared any conflict of interests.

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